ENDING NEWBORN DEATHS

Ensuring every baby survives

Save the Children

EVERY ONE

Front cover: A newborn baby at a rural health unit near Tacloban in the Philippines (Photo: Lynsey Addario/Save the Children)

Save the Children works in more than 120 countries. We save children's lives. We fight for their rights. We help them fulfil their potential.

Acknowledgements

This report was written by Simon Wright with Kirsten Mathieson, Lara Brearley, Sarah Jacobs, Louise Holly and Ravi Wickremasinghe from Save the Children, with work by Alex Renton. The authors would like to thank colleagues from Johns Hopkins School of Public Health who undertook the Lives Saved Tool (LiST) analysis included in the report.

We are grateful for the comments and improvements received from several Save the Children colleagues, in particular Michel Anglade, Asma Badar, Claire Bader, Chantal Baumgarten, Anna Bauze, Rachel Bhatia, Smita Baruah, Nina Caplan, Berhanu Demeke, Valerie Foulkes, Binyam Gebru, Wanja Gironga, Steve Haines, Ben Hewitt, Louise Hill, Stephen Hodgins, Debra Jones, Anjana KC, Kate Kerber, Rajesh Khanna, Mike Kiernan, Joy Lawn, William Lynch, Mary Kinney, Sara Lindblom, Arshad Mahmood, Alice McDonald, Cicely McWilliam, Angela Muriuki, Eva Nofdfjell, Nora O'Connell, Jo David Olayemi, Olusola Ooladeji, David Oot, Ann Paradis, Martha Parsons, Joy Riggs-Perla, Sayed Rubayet, Jawara Saidykhan, Nirupama Sarma, Aleks Sawyer, Liz Stuart, Yenealem Tadess, Kim Terje Loraas, Abdul Waheed, Steve Wall, Patrick Watt, Abimbola Williams, Sarah Williams and Kate Worsley. External comments were received from Robert Marten at The Rockefeller Foundation, Rob Yates at the World Health Organization and Ceri Averill at Oxfam GB.

Some names in case studies have been changed to protect identities.

Published by
Save the Children
1 St John's Lane
London EC1M 4AR
UK
+44 (0)20 7012 6400
savethechildren.org.uk

First published 2014

Typeset by Grasshopper Design Company

CONTENTS

NEWBORN SURVIVAL

THE STORY IN NUMBERS

2 MILLION

The number of newborn babies who could be saved each year if we end preventable newborn mortality.

1 MILLION

The number of babies who did not survive their first – and only – day of life in 2012.

2.9 MILLION

The number of babies who died within 28 days of being born in 2012. The number of deaths in this newborn period is **four times higher** in Africa than it is in Europe.

6.6 MILLION

The number of children who died before their fifth birthday in 2012, most from preventable causes. This number has almost been halved since 1990, but still means that **18,000 children** died every day.

1.2 MILLION

The number of stillbirths in 2012 where the heart stopped beating during labour.

7.2 MILLION

The global shortage of midwives, nurses and doctors.

51%

The percentage of births in sub-Saharan Africa that were not attended by a midwife or other properly qualified health worker. This percentage is **41%** in south-east Asia.

950,000

The number of newborn deaths that could be prevented each year if essential health services were more equitably distributed. This would reduce newborn mortality by 38%.

40 MILLION

The number of mothers across the world who give birth each year without any help from a midwife or other trained and equipped health worker. **2 million** women report that when they last gave birth they were completely alone.

$5

Increasing health expenditure by just US$5 per person per year could prevent the deaths of 147 million children and 5 million women, and 32 million stillbirths – and result in economic and social benefits worth up to **nine times** that investment by 2035.

40% VS 76%

The percentage of deliveries attended by a skilled health worker in rural areas vs. urban areas in the least developed countries.

2025

Universal coverage of skilled qualified birth attendance could be achieved by 2025 if we double the current rate of progress. If the rate doesn't increase, this won't be achieved until 2043.

PHOTO: COLIN CROWLEY/SAVE THE CHILDREN

"OVERWHELMED WITH GRIEF"

Shefali, who lives in a village in Bangladesh, has given birth to six children, but three died within a week of being born. She gave birth at home each time, without medical assistance. Shefali lives in an isolated community in Sylhet that is surrounded by water or swamps for most of the year, and she says it takes five or six hours to get to the nearest doctor. Shefali and her husband say that they couldn't afford the costs involved, and there would be no one to look after their other children.

"I've given birth to six children, all here in my home and without a doctor. Three of these children died within a week of birth. They died because of a lack of treatment.

"We can't go to a doctor because we can't afford it. We know that's why the children die. But what can we do if we can't afford it? We can't save money. We have difficulty making enough money just to have food to eat. How can we afford to see a doctor?

"Whenever a child is born and then dies, we're overwhelmed with grief. It's terrible. We feel like we need to take the child to the doctor but we can't. I'm not the only one here who has lost children – there are many other mothers like me."

Nationwide, Bangladesh has achieved a halving of neonatal deaths in the last 20 years. Those communities with a lower risk of newborn deaths have seen major reductions in family size: as newborn babies' chances of survival have increased, families have chosen to have fewer children.

Save the Children is supporting the government by building a health clinic near Shefali's village.

EXECUTIVE SUMMARY

The world has made remarkable progress in the fight to end child mortality in recent years. Since 1990, we have almost halved the number of children who die every year before the age of five – from 12.6 million to 6.6 million.[1]

This amazing achievement – even more impressive given that the populations in the poorest countries have grown by 70% during this period[2] – allows us to start to imagine a world where no child is born to die from easily preventable causes.

And yet, in spite of this progress, child mortality remains one of the great shames of our modern world. Every day, 18,000 children under five die, and most from preventable causes.

NEWBORN CRISIS THREATENS PROGRESS

This reduction in child mortality has been achieved through action on immunisation, family planning, nutrition and treatment of childhood illnesses, as well as improving economies. However, far less attention has been paid to tackling the life-threatening dangers children face when they are newborn and most vulnerable – at birth and in their first month of life.

This report shows that, in 2012, 2.9 million babies died within 28 days of being born: two out of every five child deaths. Of these, 1 million babies died within 24 hours, their first – *and only* – day of life.[3] Causes of these deaths include premature birth, complications during birth and infections. This is heart-breaking and unacceptable.

Unless we urgently start to tackle deaths among newborn babies, there is a real danger that progress in reducing child deaths could stall and we will fail in our ambition to be the generation that can end all preventable child deaths.

This report also reveals that the crisis is much bigger than we might think. In 2012 there were another 1.2 million tragic losses: stillbirths where the heart stopped beating *during* labour. These are not part of the fourth UN Millennium Development goal, which aims to reduce child mortality by two-thirds. However, they deserve to be counted in future maternal, newborn and child health frameworks, especially to understand the specific risks around labour and delivery. This report therefore focuses on the 2.2 million combined newborn deaths on the first day and stillbirths during labour.

There's a huge amount at stake. As the 2015 deadline for the Millennium Development Goals approaches, it is vital that the world acts to make sure more countries can get on-track to achieve MDG4. It has now become clearer we won't be able to do this unless we urgently tackle the crisis of newborn deaths. We won't be able to go further and to talk about ending all preventable child deaths unless essential healthcare is the reality for every woman and baby.

THE CAUSE AND THE CURE

The causes of stillbirths, newborn and maternal deaths are closely related, and we know what needs to happen. The solution needs specific and urgent attention. The key way to stop newborn deaths is to ensure that essential care is provided around labour, delivery and immediately afterwards when the risks are greatest. That means having a skilled, well-equipped birth attendant available to assist women and newborns during delivery. While we focus on this, there are also tremendous opportunities to reduce maternal and newborn mortality and stillbirths through key interventions during pregnancy and in the later postnatal period.

In many cases, small but crucial interventions can save lives in danger. Skilled care during labour could reduce the number of stillbirths during labour by 45%

and prevent 43% of newborn deaths.[4] This report identifies the essential interventions around birth – including treatment of severe infections and special support for premature babies – which must be made universally available to reduce mortality. Around 10% of all newborns in every country need assistance to begin breathing.

40 million mothers still give birth each year without any help from a midwife or another health worker trained and equipped to save the life of the baby or the mother.[5] Many babies die each year because mothers do not get the good-quality care they need during labour and birth. Many of the women least likely to be able to get life-saving help when they give birth are those who are most at risk of losing their babies – women from the poorest communities, from rural areas, from a minority ethnic group or with little education. Despite global commitments to the universal right to survival and healthcare, in many countries the poorest families are twice as likely to lose a baby as the richest families.

Substantial reforms are needed to ensure the poorest and hardest-to-reach communities are able to access proper care at birth. This not only includes the removal of user fees – direct cash payments for maternal, newborn and child health services – which deny mothers and babies the healthcare they need because the family cannot afford them. It also means ensuring public health services are not starved of funding and that there are enough skilled healthworkers in places they are needed.

Research commissioned for this report estimates that fairer distribution of essential health services in 47 key countries could prevent the deaths of 950,000 newborns – reducing newborn mortality in these countries by 38%.

PHOTO: SUZANNE LEE/SAVE THE CHILDREN

Newborn baby Pushpa, Nepal.

2014: THE OPPORTUNITY FOR LIFE-SAVING CHANGE

2014 will be a crucial year. Political support for universal health coverage – the availability of a basic package of healthcare for everyone, a package which countries can increase as resources increase – is growing around the world. The best place to start is by ensuring that no family, however poor, is denied life-saving care at birth.

And for the first time ever, countries and institutions around the world will sit down to agree an 'Every Newborn Action Plan', an agreement to tackle this deplorable problem of lack of attention to babies in their first days of life. Save the Children is working to ensure that this plan is ambitious and robust enough to end all preventable newborn deaths as well as tackle stillbirths during labour.

However, a plan on paper is not enough. It must be followed by concerted political action at the highest levels to achieve its implementation. Stopping newborns dying unnecessarily and preventing stillbirths, and hugely accelerating progress towards ending child and maternal mortality, will require a substantial change in our approach to health services.

This change must happen in the countries where child mortality rates are high, in partnership with donors and other stakeholders. We need a new sense of purpose from the global community. The world must not squander the opportunity that 2014 offers.

THE NEWBORN PROMISE

Save the Children is calling on world leaders, philanthropists and the private sector – this year – to commit to a Newborn Promise to end all preventable newborn deaths:

- Governments and partners issue a defining and accountable declaration to end all preventable newborn mortality, saving 2 million newborn lives a year and stopping the 1.2 million stillbirths during labour[6]
- Governments, with partners, must ensure that by 2025 every birth is attended by trained and equipped health workers who can deliver essential newborn health interventions
- Governments increase expenditure on health to at least the WHO minimum of US$60 per capita to pay for the training, equipping and support of health workers
- Governments remove user fees for all maternal, newborn and child health services, including emergency obstetric care
- The private sector, including pharmaceutical companies, should help address unmet needs by developing innovative solutions and increasing availability for the poorest to new and existing products for maternal, newborn and child health.

END ALL PREVENTABLE DEATHS

We must be clear: newborn deaths are not inevitable. Most are easily avoided if the simplest of interventions are made available to all. Systemic change is needed from governments, donors and health professionals. This year, 2014, offers an unprecedented opportunity to focus on this topic and set in motion the revolutions needed.

Together, we can ensure that no baby is born to die.

PAYING WITH THEIR LIVES

Derese, a farmer in Ethiopia, is doing his best to look after his children and earn enough to feed them since his wife died three months ago during childbirth. Five of the ten children they had together did not survive. "The tenth child died at childbirth, along with my wife," says Derese.

In her last pregnancy, Derese's wife was only taken to the health centre one and a half days after going into labour. With the help of neighbours, Derese carried her on a stretcher for more than an hour to the local health centre. When she arrived there the health centre did not have the staff or equipment to help. They advised taking her to the hospital in Dessie, the nearest big town, which is located a four-hour drive away. But by then it was too late – she died shortly after they got her on the ambulance.

Most women living in rural areas of the country give birth at home, on their own, with no access to skilled health workers. So if there are complications during labour, they are often unable to get to a health centre in time. Many of them die due to the lack of a skilled birth attendant.

"If you could see inside me, you would be able to see the fire that's burning me," says Derese. "I know that it's because of the fact that I am poor and do not have money that I was unable to save my wife. Every time I think of her, I feel guilty."

Save the Children has supported government services and provided an ambulance for Derese's community to help pregnant women access skilled medical care at a health centre or hospital. But many roads, particularly during the rainy season, are still only accessible on foot. As part of our work to reduce the number of women and children who die during childbirth, we have also built new maternity wards in health centres in three other districts, and provided training for health workers and community health promoters.

PHOTO: CAROLINE TRUTMANN/SAVE THE CHILDREN

1 A CRISIS AND AN OPPORTUNITY

The global effort to tackle child mortality over the past two decades has made remarkable advances. But now, further progress – though desperately needed – is under threat.

Since 1990 the number of children dying each year has fallen sharply. In that time we have almost halved the number of children who die every year before the age of five from 12.6 million to 6.6 million.[7] It is an impressive achievement, even more so given that populations in the least developed countries have grown by 70% during this period.[8]

Progress in tackling child mortality has been achieved through the expansion of measures such as immunisation, distribution of insecticide-treated bed-nets, treatment of childhood illnesses and family planning. Strong economic development in certain countries where child mortality was once very high, such as Vietnam and China, has also been key, as have investments in education and literacy, particularly for women.

But in spite of these advances, child mortality still remains one of the great wrongs of our modern world, with 18,000 children under five dying every day, mostly from preventable causes.

And while the world has undoubtedly made progress in tackling mortality among children under five, death rates among the most vulnerable group – newborn babies – have failed to decrease at the same speed. We are still failing to prevent the deaths of millions of newborn babies who die within 28 days of their birth, including those who die on their first – and only – day of life, as well as stillbirths that occur during labour. As this report shows, the continuing high rate of newborn mortality in many developing countries is a crisis of neglect and inequality. Unless we urgently start to tackle deaths among newborn babies, there is a real danger that progress in reducing child deaths could stall.

THE CRISIS IN NEWBORN MORTALITY

DYING WITHIN 28 DAYS

Of the 6.6 million children under-five who died in 2012, almost half – 2.9 million – died within the first 28 days, the newborn period.[9] This time is the most vulnerable for a child as he or she has to adapt quickly to life outside the womb. Progress in reducing mortality among newborn babies has been much slower than among children under the age of five in general, as Figure 1 shows.

DYING WITHIN 24 HOURS

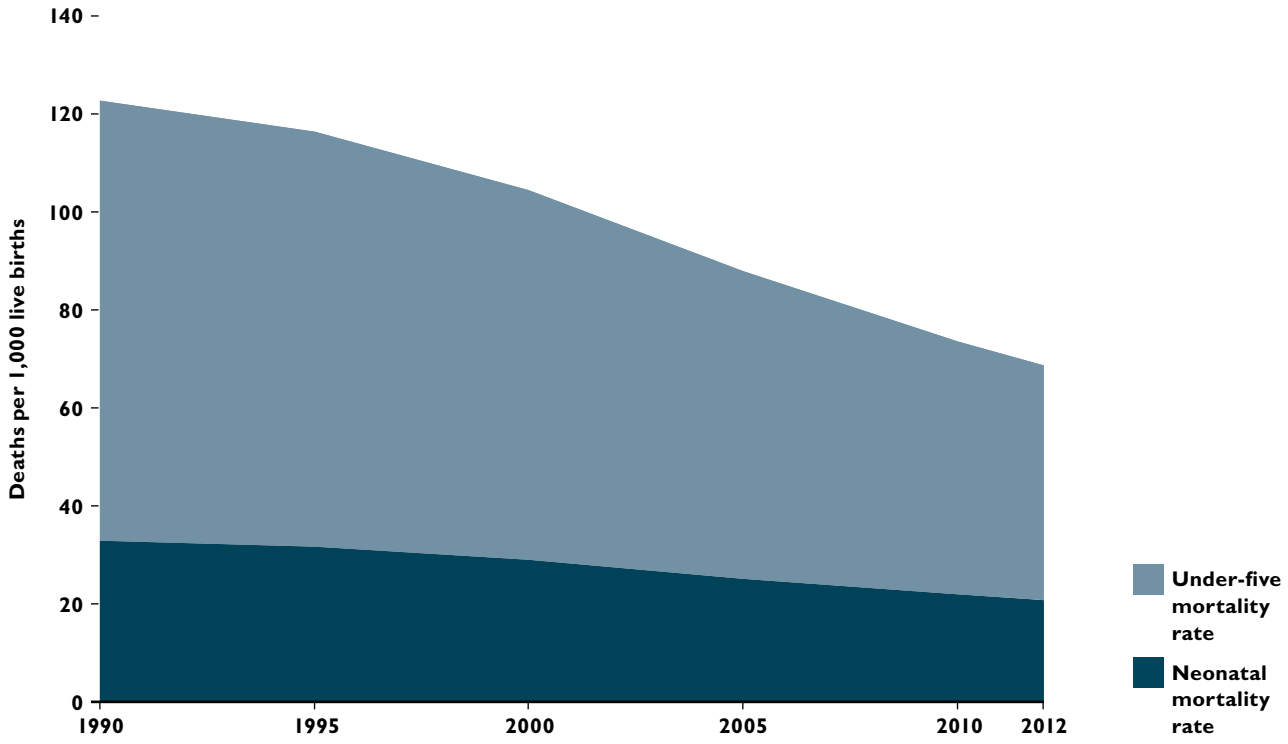
Recent data shows that the day of birth is the most dangerous day of all. In 2012, more than 1 million babies (1,013,000) did not survive their first – *and only* – day of life.[10]

Save the Children's *State of the World's Mothers 2013* report compiled a 'Birth day risk index' that ranked countries according to mortality rates on the day of birth.[11] The report found that key causes for high first-day death rates in sub-Saharan Africa and south Asia include:

- high numbers of preterm births and of low birthweight babies
- poor maternal health and nutrition
- girls and young women having children at a young age
- low contraception use
- lack of healthcare for mothers, with only half of all women in sub-Saharan Africa having skilled care during birth.

Guinea, Niger, Sierra Leone and Somalia were found to have fewer than two doctors, nurses and midwives per 10,000 people (the critical threshold is generally considered to be 23). Afghanistan, Bangladesh and Nepal have six to seven health workers per 10,000 people. The report highlighted four low-cost and under-used solutions that have the potential to save more than 1 million newborn babies if they were available to all.[12]

FIGURE 1 GLOBAL CHANGE IN UNDER-FIVE AND NEONATAL MORTALITY RATES



Source: WHO, Global Health Observatory

A HIDDEN TRAGEDY

To understand the full picture, we must also consider that many pregnancies are lost just hours or even moments before birth. An estimated 2.6 million stillbirths occurred worldwide in 2012.[13] For approximately 1.2 million stillbirths – around 45% – the moment when the heart stopped beating was during labour.[14] The rate of these 'intrapartum stillbirths' is much higher in low-income countries than in higher-income ones. These lives lost are not counted as part of the fourth UN Millennium Development Goal, which aims to reduce child mortality by two-thirds. However, stillbirths that occur in labour deserve to be acknowledged and counted in national and global health frameworks, as a sensitive marker of good-quality care and to highlight the specific risks around labour and delivery.

To understand the full magnitude of the crisis, this report therefore focuses on the 2.2 million – the newborn deaths on the first day plus the stillbirths during labour.

DYING POOR: THE INEQUALITY OF NEWBORN MORTALITY

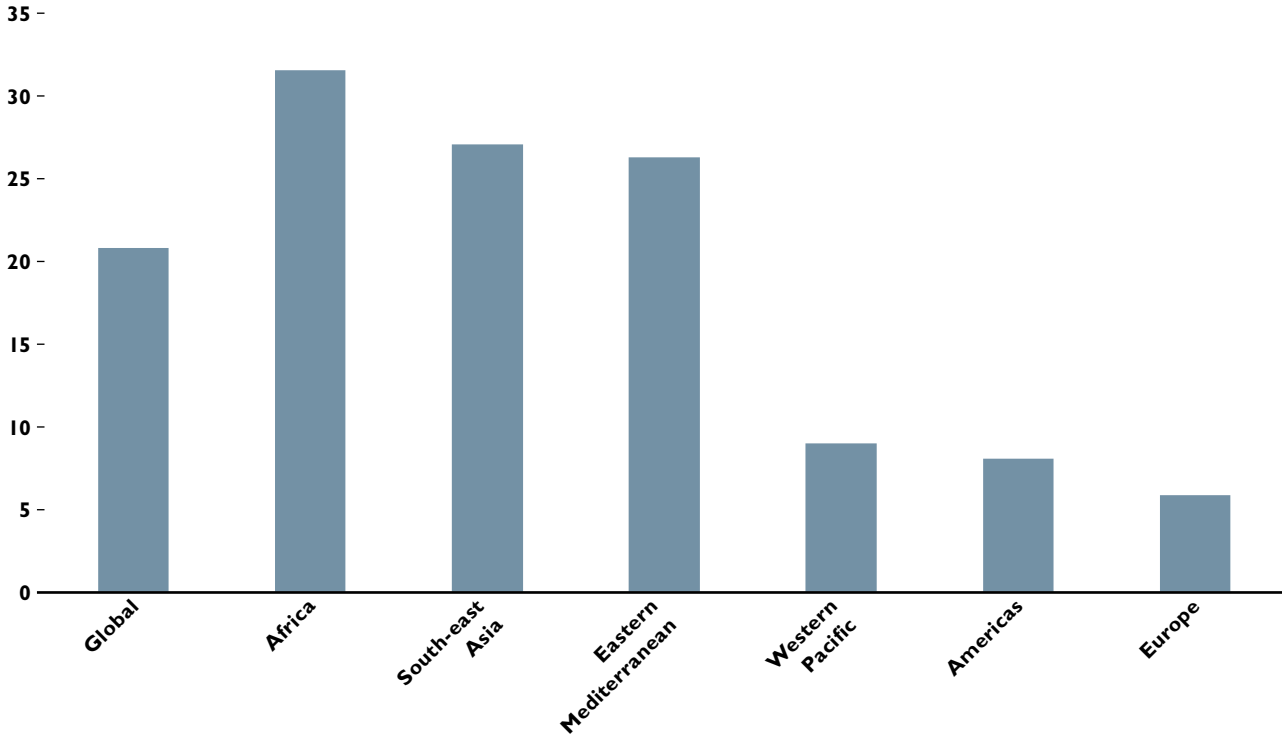
NEWBORN MORTALITY BY REGION AND COUNTRY

There is huge regional variation in newborn deaths (see Figure 2). In Europe 5.9 babies in every thousand do not survive beyond 28 days, but in Africa and parts of Asia that figure is four or five times higher.

A full range of relevant data for the 75 Countdown to 2015[15] countries – those with the highest burdens of maternal, newborn and child mortality – is given in the Appendix to this report, with data on newborn mortality, first-day deaths, stillbirths during labour, coverage of skilled birth attendance and government health financing. The ten countries with the worst combined rates for first-day mortality and stillbirths during labour are shown in Table 1.

Generally, the poorest countries have the highest mortality rates for newborns. Countries that have experienced recent conflict or are considered fragile are among the highest for preventable deaths.

FIGURE 2 NEONATAL MORTALITY RATES BY REGION (2012)



Source: WHO, Global Health Observatory

TABLE 1 TEN COUNTRIES WITH THE HIGHEST RATES OF FIRST-DAY DEATHS AND STILLBIRTHS DURING LABOUR

Country	Risk of neonatal death on day of birth (per 1,000 live births)	Intrapartum stillbirth rate (per 1,000 total births)	Intrapartum stillbirths and neonatal deaths on day of birth (per 1,000 total births)
Pakistan	15	26.4	40.7
Nigeria	14	19.4	32.7
Sierra Leone	18	13.9	30.8
Somalia	16	14.0	29.7
Guinea-Bissau	16	13.7	29.4
Afghanistan	13	16.6	29.0
Bangladesh	9	20.6	28.9
Democratic Republic of Congo	15	13.3	28.3
Lesotho	16	11.8	27.5
Angola	16	11.7	27.4

Source: See Appendix 1. Data drawn from forthcoming Lancet Global Health publication on first-day deaths. Intrapartum stillbirths from Lancet Stillbirth Series.

It is notable, however, that some countries and regions have made much more progress in reducing newborn deaths than others. Between 1990 and 2012, China and Egypt saw declines of over 60%. Steep declines achieved in some of the world's poorest nations – the 51% reduction in Cambodia, for example – show what progress is possible. In Latin America there has been a 56% drop, and in the Pacific nations newborn mortality has fallen by 39%. However, in sub-Saharan Africa the fall has been just 28%.[16]

VARIATIONS IN NEWBORN MORTALITY WITHIN COUNTRIES

Within poor countries there are dramatic inequalities in death rates for newborn babies, with the poorest communities and other marginalised groups generally experiencing considerably higher rates of newborn mortality.[17] Understanding this inequality is key to determining what is needed to end all preventable newborn deaths.

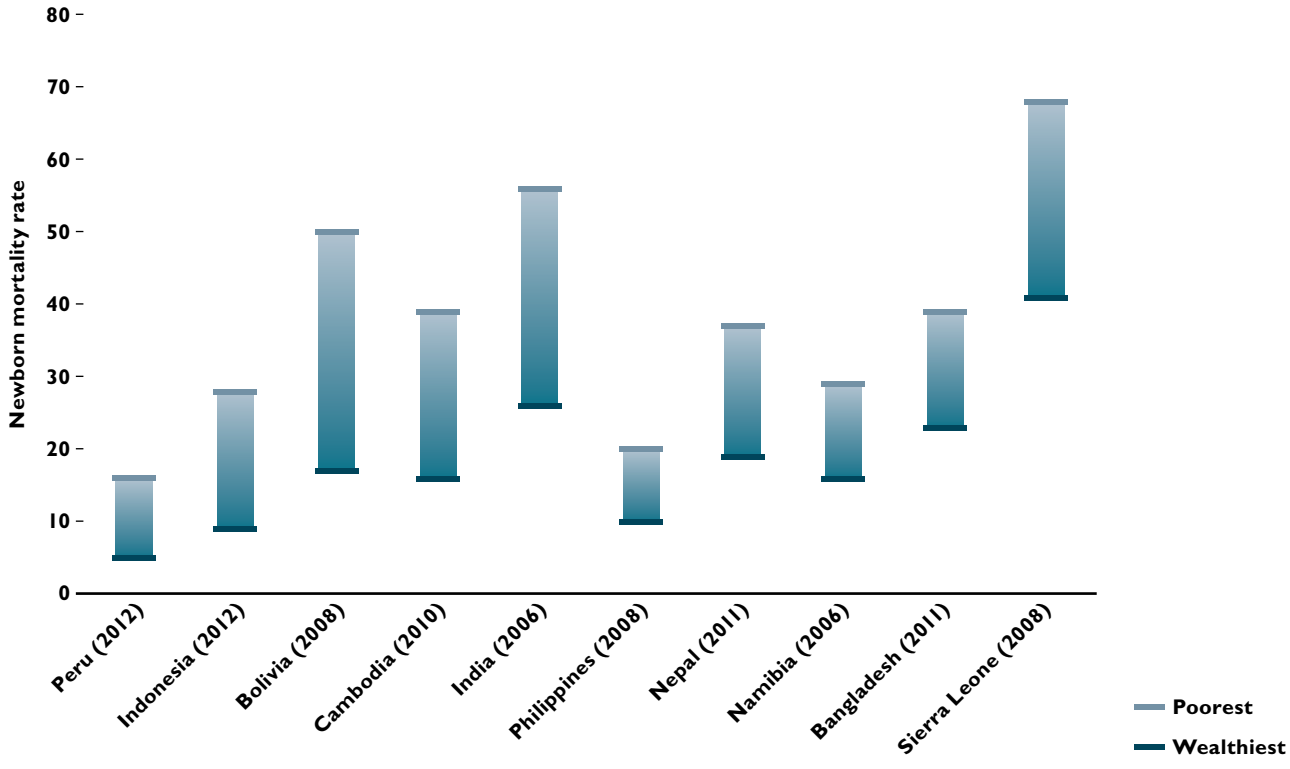
In every country where data are available, wealth is a major determinant of newborn mortality. Figure 3 shows the ten countries with the greatest inequalities. The top of each column shows the newborn mortality rate for the poorest fifth of households in a particular country; the bases of the columns show the rate for the most well-off households: the taller the column, the greater the inequality in newborn mortality.

As Figure 3 shows, in India, among the wealthiest 20% of the population the newborn mortality rate is 26 per 1,000 babies, whereas among the poorest households 56 newborn babies out of 1,000 die in their first month of life. In Sierra Leone, the newborn mortality rate among the wealthiest fifth of the population is 41 per 1,000 babies, compared with 68 newborn babies' deaths per thousand births among the poorest families. As discussed in Chapter 2, these inequalities in newborn mortality also reflect patterns of inequality in coverage of essential health services – meaning those most in need of care at birth are least likely to have it.

Other social inequalities and newborn mortality

Inequalities are not solely on the basis of wealth. Rural populations usually have higher rates of newborn mortality than urban areas. A mother's level of education is another strong predictor of the risk that she might lose a newborn baby.

FIGURE 3 GAP IN NEWBORN MORTALITY BETWEEN POOREST AND WEALTHIEST HOUSEHOLDS, TOP TEN COUNTRIES WITH HIGHEST INEQUALITIES



Source: Save the Children analysis of most recent Demographic and Household Survey data (since 2005), for the ten countries with the highest ratios for newborn mortality between wealthiest and poorest households, by wealth quintile.

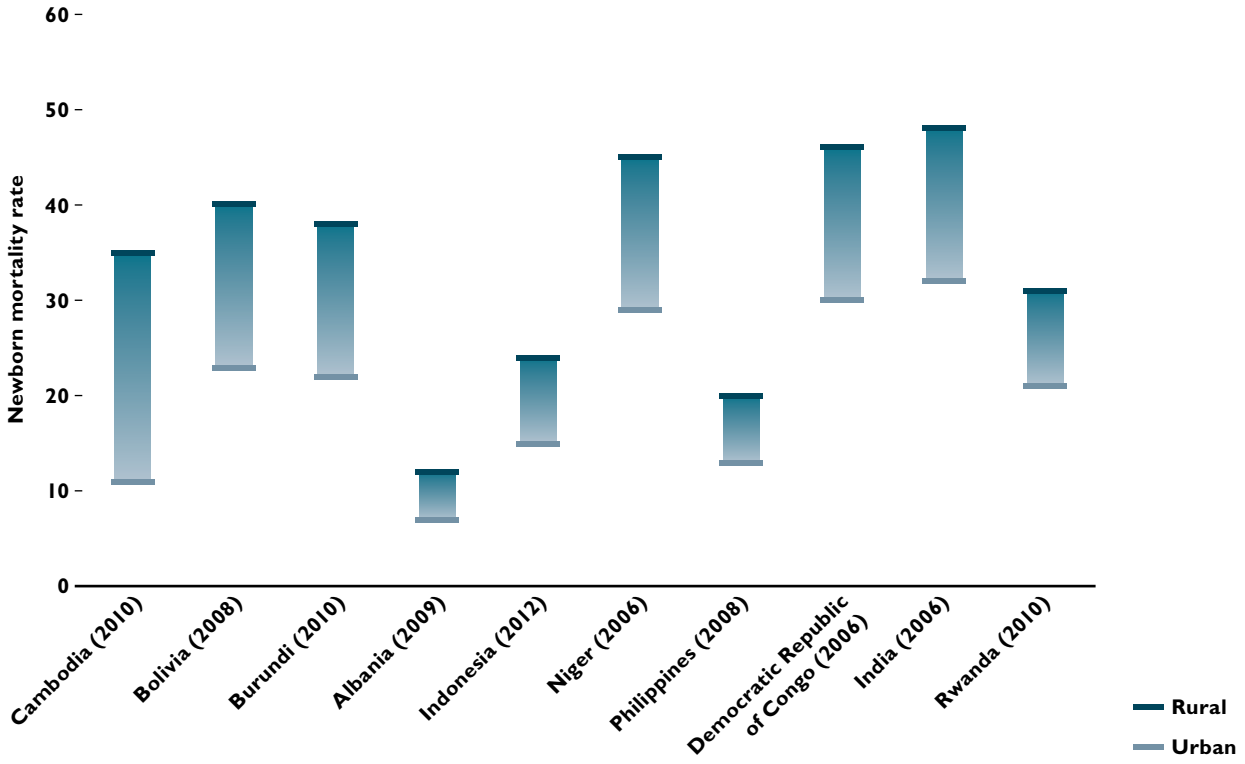

PHOTO: GREG FUNNELL/SAVE THE CHILDREN

A newborn baby at a hospital in Central African Republic.

Social, political and environmental factors are closely intertwined. Rural populations are often extremely poor, a long way from frontline medical services and without access to hospitals. Minority ethnic groups living in rural areas may be subject to discrimination and are more likely to live in areas that are remote and poorly-serviced in terms of newborn healthcare. By contrast, in urban areas it is household wealth alone that predominantly determines access to newborn healthcare.

It is unacceptable to regard low national GDP levels as a legitimate reason for countries not to make necessary progress in tackling newborn mortality. It is also unacceptable that a baby's chances of immediate survival depend on where he or she is born and on the life chances of his or her parents. The international community and national governments can and must do better than this.

FIGURE 4 GAP IN NEWBORN MORTALITY BETWEEN RURAL AND URBAN HOUSEHOLDS, TOP TEN COUNTRIES WITH HIGHEST INEQUALITIES



Source: Save the Children analysis of most recent Demographic and Household Survey data (since 2005), for the ten countries with the highest ratios for newborn mortality between urban and rural households.

2014 – THE OPPORTUNITY FOR LIFE-SAVING CHANGE

EVERY NEWBORN ACTION PLAN

In 2014 we have an unprecedented opportunity to tackle the crisis of newborn mortality and preventable stillbirths. The Every Newborn Action Plan will be presented to the World Health Assembly in May of this year, as part of the UN Secretary-General's Every Woman Every Child movement to address child and maternal mortality. The plan is in response to demand from countries and is being jointly developed with UNICEF, the World Health Organization and at least 50 others to set out the action needed on this neglected topic.

The Every Newborn Action Plan is proposing a target for a two-thirds reduction in the newborn mortality rate, which would result in a 2035 global rate of 7 per 1,000 live births, down from 21 per 1,000 in 2012. This target is close to what has been achieved in countries such as Chile, Mexico and Turkey. If this rate had been achieved in 2012, there would have been approximately 2 million fewer newborn deaths. The Every Newborn Action Plan is also proposing a target to end all preventable stillbirths during labour.

For more than ten years, Save the Children's Saving Newborn Lives programme has been at the forefront of action to address the lack of progress in tackling newborn mortality. Save the Children is calling for the Every Newborn Action Plan to be the spur for real political action to address the causes of newborn mortality, especially the lack of good-quality healthcare at birth.

PHOTO: JEFF HOLT/SAVE THE CHILDREN

A newborn baby girl the day after being delivered at a clinic in Bangladesh.

GROWING MOMENTUM FOR UNIVERSAL HEALTH COVERAGE

Following the World Health Report 2010,[18] there has been growing momentum for the principle that governments are responsible for ensuring that their whole population can access the good-quality healthcare they need without facing financial hardship – in other words, a movement for universal healthcare coverage (UHC). The World Bank and the World Health Organization have both made UHC their top priority for the world's health. In turn, many countries have made UHC their priority for health service reform. Newborn mortality is arguably a sensitive indicator for UHC.

CHILD MORTALITY AND THE POST-2015 AGENDA

Within the growing debate about what might follow the Millennium Development Goals, there is underlying recognition that the progress the world has made over the past two decades in reducing the number of children dying has brought us to a tipping point. Our generation could be the first to end preventable child deaths. The feasibility of a target to end all preventable newborn and child mortality was set out by the governments of the USA, Ethiopia and India, along with UNICEF, in the 'A Promise Renewed' movement, supported by 174 countries.

By acting now on newborn mortality – in particular, by ensuring universal access to good-quality healthcare at birth for babies and mothers – we can start to reduce newborn deaths and preventable stillbirths and build a world where no baby dies of preventable causes.

MIDWIVES AND SKILLED BIRTH ATTENDANCE

The World Health Organization defines a skilled birth attendant as "an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns."

Skilled birth attendance means not only the presence of the health worker (the attendant), but also the equipment, the medicines and the system of management, support and referral that allow them to do their job effectively. In many settings, the health worker may be a midwife, a specialist in birth techniques whose training has concentrated on this role. However, a doctor or a nurse may also be a skilled birth attendant. In many resource-poor and rural settings, it is much more likely to be a general health worker who responds to all the health problems of the community, rather than a dedicated midwife.

Coverage rates of skilled birth attendance are based on surveys of households and rely on the mother's assumption about whether a skilled health worker was present during childbirth. The rates do not measure which services were provided or their quality.

TRADITIONAL BIRTH ATTENDANTS

In many settings, the only support during a birth may be a 'traditional birth attendant' (TBA). Throughout history, other women from the community who do not have formal training have provided support during birth, based on their experience.

Where women have no support at all from professional health workers during birth, providing some medical training and close supervision to TBAs may be beneficial. For example, it may reduce harmful practices such as applying dirt to the umbilical cord or giving a newborn baby substances other than breast milk.[19] Other initiatives have been successful at enlisting TBAs to encourage community acceptance of trained health workers at birth. By contrast, some countries, including Sierra Leone, have taken the decision to ban TBAs.[20] What is clear is that there is no substitute for formal health workers during delivery.

THE STRUGGLE FOR SURVIVAL

Rose gave birth at a local health clinic in the Democratic Republic of Congo. She is fortunate to live near a clinic, so was able to get there on foot when her labour started.

Rose had a long labour, leaving her little energy to push, so the nurses at the clinic helped with the delivery. But when Rose's son was born he wasn't breathing. Thankfully, after resuscitation with a bag-and-mask device, her son started breathing.

"I was happy when I saw that my child was alive – God helped him survive," said Rose. "I was lucky that my baby survived, as many women are not so lucky here in Congo."

Rose with her newborn son at Tudikolela hospital in Democratic Republic of Congo

PHOTO: JODI BIEBER/SAVE THE CHILDREN

2 HOW CAN NEWBORN DEATHS BE PREVENTED?

Understanding the reasons why newborns die and the life-saving role that health workers can play is crucial in getting the right action to prevent these deaths. Having skilled and properly-equipped health workers delivering the right services during birth is critically important in preventing stillbirths and reducing newborn and maternal mortality.[21]

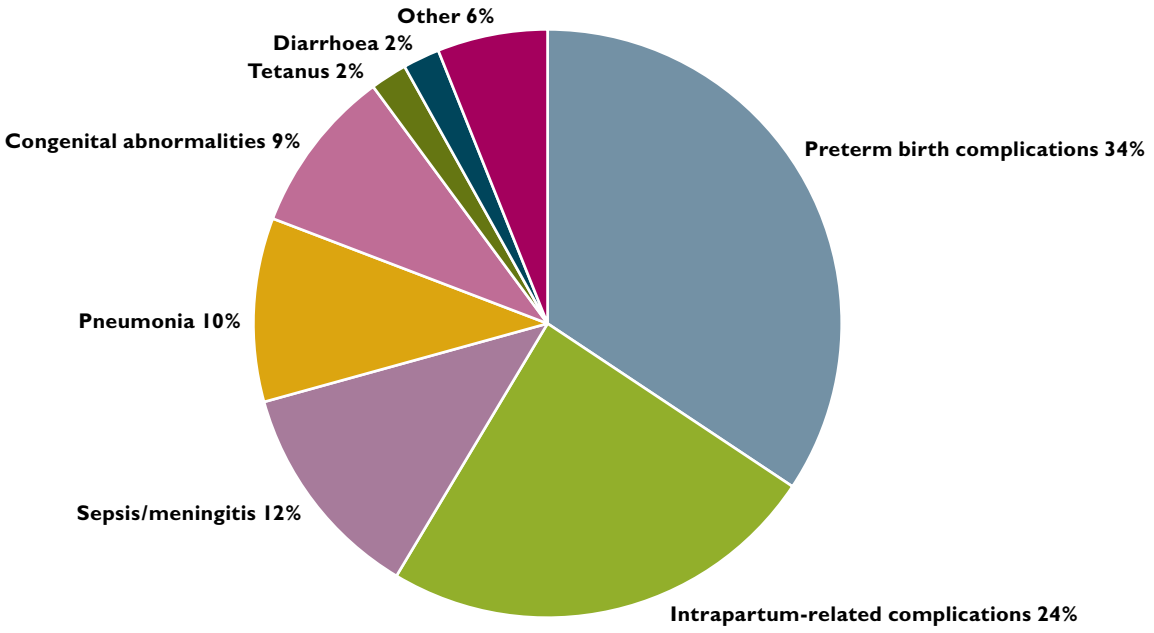
CLINICAL CAUSES OF NEWBORN MORTALITY

The main causes of newborn babies' deaths are problems arising from premature birth, complications during labour and delivery, and infections acquired by the baby during or after birth. The major causes of stillbirths include childbirth complications, maternal infections and hypertension.[22] Addressing deaths on the first day of life and reducing stillbirths during labour require different actions and a different type of health service from that needed for children who have survived beyond 28 days.

HOW HEALTH WORKERS SAVE NEWBORN BABIES' LIVES

For this report, Save the Children has identified eight essential services – which midwives and other skilled health workers should provide during labour, birth and immediately afterwards – to reduce newborn mortality and prevent intrapartum stillbirths. This list of essential interventions and packages is drawn from the Every Newborn Bottleneck Analysis Tool[23] and from the wealth of evidence in the 2005 Lancet Neonatal Series, disseminated through the Healthy Newborn Network and the Partnership for Maternal, Newborn and Child Health.[24]

FIGURE 5 GLOBAL DISTRIBUTION OF NEONATAL DEATHS, BY CAUSE (2012)



Source: UNICEF, Committing to Child Survival: A promise renewed – progress report 2013

Note: Due to rounding percentages do not add up to 100.

EIGHT ESSENTIAL, HEALTH-WORKER SUPPORTED INTERVENTIONS AROUND BIRTH

1 Skilled care at birth and emergency obstetric care (including assisted vaginal delivery and caesarean section if needed) ensuring timely care for women and babies with complications
2 Management of preterm birth (including antenatal corticosteroids for mothers with threatened preterm labour to reduce breathing and other problems in preterm babies)
3 Basic newborn care (focus on cleanliness including cord care, warmth, and support for immediate breastfeeding, recognition of danger signs and care seeking)
4 Neonatal resuscitation for babies who do not breathe spontaneously at birth
5 Kangaroo mother care (skin-to-skin, breastfeeding support especially for premature and small babies)
6 Treatment of severe newborn infections (focus on early identification and use of antibiotics)
7 Inpatient supportive care for sick and small newborns (focus on IV fluids/feeding support and safe oxygen use)
8 Prevention of mother-to-child transmission of HIV (during pregnancy, labour and the immediate newborn period).

PRETERM BIRTHS

More than a third of newborn deaths are the result of complications associated with preterm (premature) births. Some of these can be addressed before birth through family planning, screening for infections, nutrition supplements and other services as well as use of antenatal steroids. During labour, careful monitoring of the foetal heart rate and signs of distress indicates when action is needed. After birth, an underweight and premature baby needs immediate care and support to survive.[25] Health workers present when the baby is born can help the mother establish exclusive breastfeeding, and can support her to keep the baby warm through skin-to-skin contact. A brilliantly effective technique for this, especially for preterm babies, is known as kangaroo mother care (see box above).

BIRTH COMPLICATIONS

Nearly a quarter of newborn deaths are the result of complications at labour and delivery – technically called intrapartum-related deaths or birth asphyxia. The most important way to reduce these deaths is through improved care during labour, including caesarean section if needed. If babies are born and do not breathe, then health workers need to resuscitate immediately.

As many as 10% of newborn babies require some type of assistance to begin breathing, meaning that the health worker must be prepared, recognise the non-breathing baby, and immediately begin the steps of neonatal resuscitation. Lack of oxygen can also result in long-term disabilities. Skilled health workers can act quickly to stimulate breathing or air to the lungs, including by using a bag and mask.[26] Lack of oxygenated blood flow to the brain – from failure to breathe at birth – can also result in long-term disabilities. During labour, monitoring of foetal heart rate and timely action in response to signs of distress (eg, caesarean or assisted vaginal delivery) are essential to save lives.

INFECTION

A third of newborn deaths are due to infections acquired by the baby during labour and delivery or after birth. Preventive measures such as maternal tetanus immunisation, screening and treatment for syphilis can reduce the risk. Clean birth practices and hygienic care for the umbilical cord and exclusive breastfeeding reduce the risk of infections; health workers play a crucial role in ensuring these practices are followed. Early identification of severe infections and prompt and complete treatment with antibiotics dramatically increase the chance of survival.

STILLBIRTHS

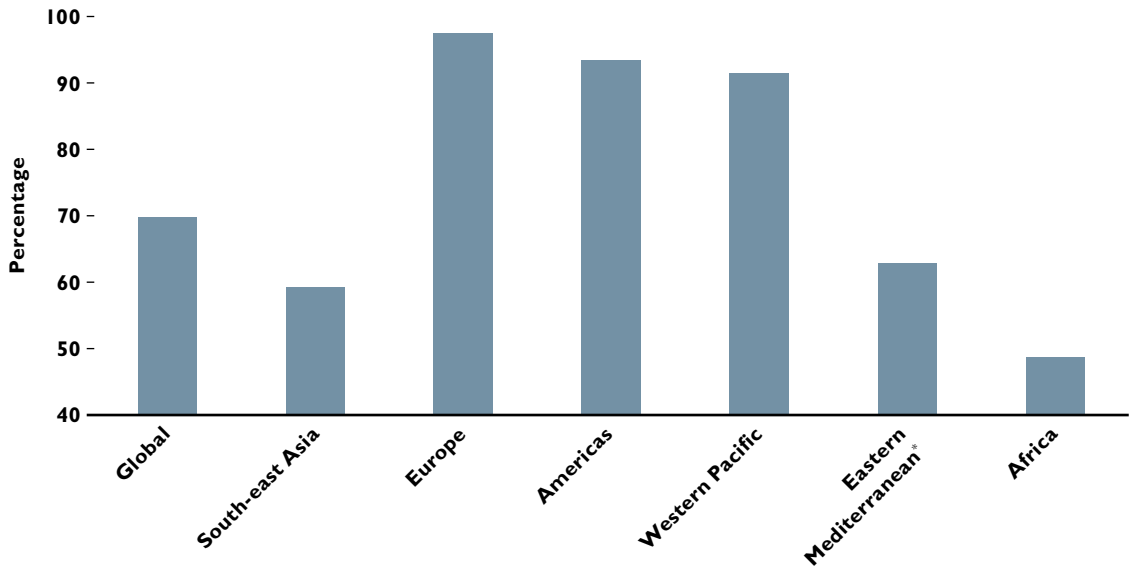
During pregnancy, preventing or treating malaria, syphilis and other conditions is important to prevent stillbirths. Skilled care at birth can reduce the number of stillbirths,[27] and comprehensive emergency obstetric care, including caesarean if needed, reduces stillbirths by 75%.[28]

THE GLOBAL SHORTAGE OF MIDWIVES AND OTHER HEALTH WORKERS AT BIRTH

Every year 40 million women give birth without support from anyone with professional qualifications.[29] 51% of births in sub-Saharan Africa and 41% in south-east Asia are not attended by a midwife or another properly qualified health worker. In Ethiopia, only 10% of births have skilled attendance at birth.[30] Globally, 2 million women report that when they last gave birth they were completely alone.[31] Many babies die each year because mothers do not get the quality care they need during labour and birth.

As with newborn mortality, coverage of skilled birth attendance is grossly unequal between countries and within them. In Europe, the Americas and the western Pacific, almost all women give birth with this vital service. In south-east Asia, Africa and parts of western Asia (or 'eastern Mediterranean' in the WHO classification) rates are much lower (see Figure 6). Unsurprisingly, national rates for skilled birth attendance are at their lowest in some of the poorest countries in the world (see Figure 7).

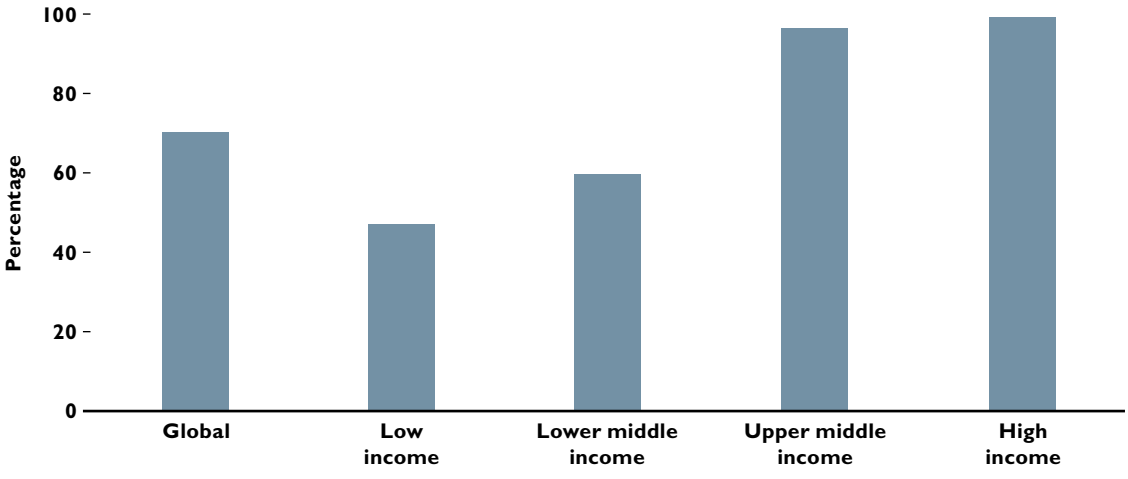
FIGURE 6 BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL (%), BY WHO REGION (2005–2012)



Source: WHO, Global Health Observatory

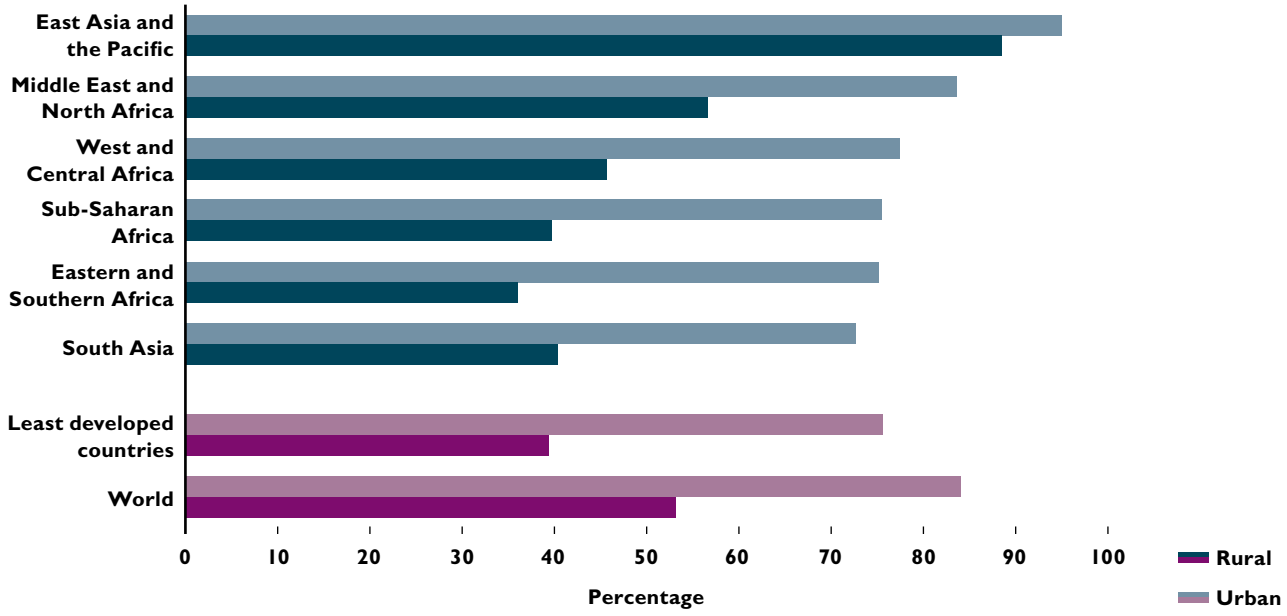
* The 'eastern Mediterranean' region includes Somalia, Yemen, Afghanistan and Pakistan.

FIGURE 7 BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL (%), BY COUNTRY INCOME GROUP (2005–2012)



Source: WHO, Global Health Observatory

FIGURE 8 BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL (%), BY AREA OF RESIDENCE (2007–2012)

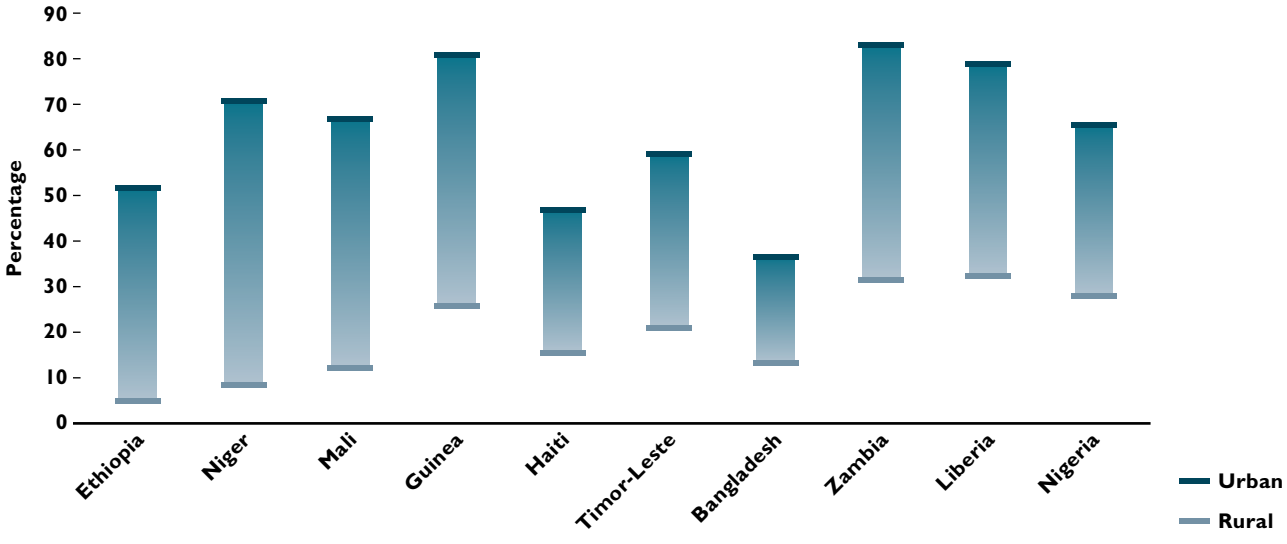


Source: *The State of the World's Children 2013*, UNICEF global databases 2012, from MICS, DHS and other nationally representative sources.

Skilled birth attendance has been designated a global priority. Millennium Development Goal 5, on reducing maternal mortality, set a target of 80% coverage of skilled birth attendance by 2005, 85% by 2010 and 90% coverage by 2015. But the world is way off track. By 2012 the global rate had only reached 70%.[32]

Between 2000 and 2009 – and even though countries such as Malawi and Rwanda have made impressive progress – global coverage of skilled birth attendance has only increased at a rate of 1.1% a year. If rates of skilled qualified birth attendance continue to increase at this rate, it will take until 2043 for the world to achieve universal coverage.[33] Save the Children has calculated that this will mean 354 million births between 2014 and 2043 would be unattended and millions of unnecessary lives lost.

FIGURE 9 GAP IN BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL (%) BETWEEN RURAL AND URBAN HOUSEHOLDS, TOP TEN COUNTRIES WITH HIGHEST INEQUALITIES



Source: Save the Children analysis of most recent DHS data (since 2005), for the ten countries with the highest ratios for SBA coverage between urban and rural households.

UNEQUAL ACCESS TO NEWBORN CARE WITHIN DEVELOPING COUNTRIES

In developing countries, skilled birth attendance is the least equitable of all maternal and child health services.[34] The inequality within some countries is shocking. In Ethiopia, for example, where 29 per 1,000 newborns die, 46% of all births in the richest fifth of households had skilled birth attendance, compared with just 2% of those in the poorest households.[35] Coverage of skilled birth attendance must be expanded and systems that are failing to reach the poorest communities must be overhauled.

In the least developed countries, 40% of deliveries in rural areas of the developing world are attended by skilled health workers; in urban areas the rate is 76%.[36]

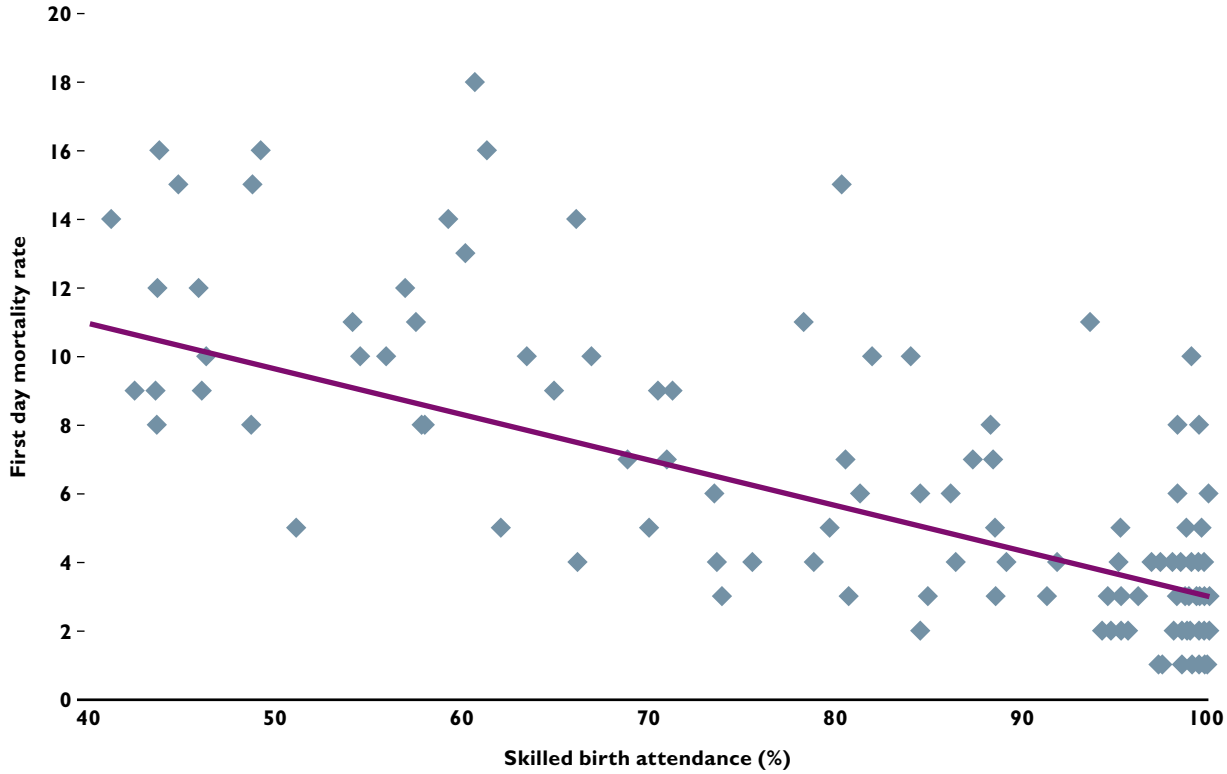
THE CHALLENGE TO HEALTH SYSTEMS

The demands that preventing newborn babies' deaths and stillbirths puts on a health system are quite different from those involved in delivering life-saving child health interventions, such as immunisation, bednet distributions or family planning. Ensuring the attendance of a skilled and equipped health worker during and after a birth is evidently not an intervention that can be scheduled for a convenient time: midwives and other skilled birth attendants must be available 24-hours-a-day, seven-days-a-week.

At the same time, improving the rate of skilled birth attendance in a country on its own may not reduce newborn mortality. As Figure 10 shows, while there is a correlation between lower rates of first-day deaths and higher rates of skilled birth attendance, the relationship is not one of simple causality, nor is it consistent across all countries. For example, the rate of skilled birth attendance in Malawi is much higher than in Bangladesh but the rate of newborn mortality is about the same.

To ensure good-quality healthcare at birth, a health system needs to deliver in-depth training in newborn care to trainee health workers, 'refreshers' for qualified birth attendants, supportive supervision, monitoring and data analysis for quality improvement. This systematic approach needs to be accompanied by community-based approaches to improve household practices and care seeking.

FIGURE 10 RELATIONSHIP BETWEEN FIRST-DAY MORTALITY AND SKILLED BIRTH ATTENDANCE BY COUNTRY



Sources: Data on first-day deaths updates from *State of the World's Mothers*, updated for 2012, from forthcoming Lancet Global Health publication; skilled birth attendance data from WHO Global Health Observatory, for 2005–2012

SOCIAL DETERMINANTS OF NEWBORN HEALTH

> *"This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics."*
>
> Sir Michael Marmot, WHO Commission on Social Determinants of Health 2008

Health services are only one part of the picture. A number of social factors also underlie the crisis in newborn mortality.

Malnutrition in pregnancy and among young children

Pregnant women who are malnourished are more likely to have low birth-weight babies. So are women who were undernourished during their own childhood.[37] In 2012, an estimated 162 million children were stunted as a result of malnutrition in the thousand days between their mother's pregnancy and their second birthday.[38]

Huge change is needed not only in health services, but in areas such as agriculture, food markets and social structures, to address access to decent food and nutrition and reduce newborn and child mortality.[39] Challenging cultural traditions – such as those that demand women eat last and least within the household – is one urgent priority.

PARTICIPATORY WOMEN'S GROUPS

Studies in Bangladesh, India, Malawi, and Nepal show how participatory women's groups reduce neonatal mortality and maternal depression. Women recruited in the local area are trained to help identify problems associated with pregnancy, childbirth and care of newborn babies. These women facilitate groups that develop strategies to tackle these problems, working with local community leaders, teachers, politicians and others to implement them. Interacting with mothers-to-be, the groups provide a support network valuable for health and happiness.

Analysis of the trial data shows that women's contact during pregnancy with these groups is associated with a 37% reduction in maternal mortality and a 23% reduction in neonatal mortality.[40]

Young mothers

In low- and middle-income countries overall almost 10% of girls become mothers by the age of 16. They are at greater risk of losing their babies than women who become mothers later – mothers under 20 are 50% more likely to have a stillbirth or to lose their baby within the first week after birth than mothers aged 20–29 years.[41]

FAIR CONDITIONS FOR HEALTH WORKERS

Low rates of skilled birth attendance reflect the wider global shortage of midwives, nurses and doctors. It is estimated that the world needs 7.2 million more.[42]

But equally important is the fact that those health workers who do exist are often least likely to be found where they are most needed.

There are many reasons health workers choose not to work where the needs are greatest. They may seek better working conditions and career opportunities abroad or outside the public health sector.[43] Health facilities in poor communities are often poorly staffed and equipped, with huge caseloads and little support or opportunities for staff development.[44] Salaries are frequently inadequate: even highly-skilled health workers may lead a hand-to-mouth existence.[45] They may also face problems with housing and with schooling for their children, and the working environment may be insecure.[46]

In order to attract and retain more health workers in communities with the highest levels of newborn deaths, governments must address these issues. Salaried workers should receive a living wage and be offered incentives to work in the least desirable areas. Many health workers are also family carers and need flexible terms and opportunities.

PHOTO: COLIN CROWLEY/SAVE THE CHILDREN

Midwife Farhiya Muse Ali holds Zakaria on his first day of life. When Zakaria was born, in a clinic in Somalia, he did not start breathing straight away. Farhiya helped save his life.

Very young mothers face more pregnancy-related problems. They are also prone to obstructed labour because their pelvic bones are still developing, and are more likely to have premature babies and are also themselves at higher risk of fistula.[47]

Spacing between pregnancies

Lack of spacing between pregnancies is also closely linked with child mortality. Children born less than two years after a sibling are two times more likely to die within the first year of life than those born after three or more years.[48]

TACKLING MATERNAL MORTALITY THROUGH SKILLED BIRTH ATTENDANCE

The solutions offered by this report, particularly improving the quality of care through skilled birth attendance, will save the lives of newborns, reduce stillbirths and save the lives of women. Maternal mortality is declining, but the rate of decline is too slow, and in too many societies the rights of women to survival, to health and to essential services are not realised. The deaths of women and their babies in childbirth are unacceptable and cause great damage to families and communities.

Pregnancy and childbirth complications are the leading cause of death of girls aged 15–19 in low- and middle-income countries. Research shows that children whose mothers died in childbirth are likely to have the worst survival rates, poorer health and less economic and educational success. There are further devastating effects to families from the loss of the person likely to be the first caregiver, and often the main source of income.

As will be discussed later, skilled birth attendance and newborn care must be delivered within a framework of wider health services for mother and child.

SAVING NEWBORN LIVES

Immediately after birth, Asha's baby girl was not breathing. Pushpa, a midwife and auxiliary nurse in a rural district in Nepal, saved the baby's life. Pushpa had recently been trained in newborn care on a Save the Children programme.

"I have seen many babies born like that, not breathing," says Pushpa. "Since the training, I have already saved a few babies with the bag and mask technique."

Pushpa was inspired to become a health worker by her own harrowing experience of childbirth. She was only 16 and, when her labour became protracted, her hands were tied to a branch of a tree for four days. "It was supposed to help me push the baby out," she says.

After that traumatic event, Pushpa decided to train to become a nurse. "I became a health worker thinking I will help women," she says, "but now I am also saving newborn babies."

PHOTO: SANJANA SHRESTHA/SAVE THE CHILDREN

3 MEETING THE CHALLENGE

ACHIEVING UNIVERSAL COVERAGE IN SKILLED BIRTH ATTENDANCE

For many countries with high rates of newborn mortality, achieving universal health coverage – especially good-quality care available for all births – requires radically different thinking about the entitlements of the poor and the way services are provided. This chapter explores the concept of universal health coverage – an approach that has built up considerable momentum in global and national debates in recent years, and which is crucial to reducing and ending preventable newborn mortality.

As momentum for the goal of universal healthcare coverage has grown (see page 7) this has set down clear challenges to countries and governments, particularly in terms of reaching poor, rural and disadvantaged communities. In particular, universal health coverage suggests three measures for the development of countries' health systems:

- Who is covered by health service schemes?
- Which services are covered?
- How fair is the way it is paid for?

INCREASING THE NUMBER OF MIDWIVES AND OTHER HEALTH WORKERS

The average annual increase in skilled birth attendance between 2000 and 2009 was just 1.1% (see page 12). However, if we double our efforts and increase coverage by 2.3% a year, it is possible to achieve universal coverage by 2025.

For most countries at risk of failing to meet their MDG4 target on reducing child mortality, this will require wide-ranging reform of the structure and staffing of their health services, as well as increased funding.

A study in *The Lancet* in 2013 concluded that without accelerated coverage of the full range of proven interventions to women and children's health, the targets could not be reached.[49] All children and mothers need access to good-quality healthcare not just on the day of birth, but right across a 'continuum of care' that covers reproductive, maternal, newborn and child health.

THE WHOLE PICTURE

Save the Children is calling on governments and multilateral agencies to compile accurate figures on stillbirths both before and during labour, as well as on first-day deaths. Only by doing this can we show the true picture of the estimated 2.2 million tragic losses around the time of labour – 1 million deaths on the first day of life and 1.2 million stillbirths that occur during labour – in addition to maternal deaths.

Compiling figures for stillbirths and first-day deaths will give a sharper focus on the importance of healthcare to all babies and mothers during labour and immediately after birth. And it will highlight the fact that, in 2012, 40 million mothers and their babies miss out on life-saving healthcare interventions at this crucial time.

What Save the Children is calling for

Governments and partners to issue a defining and accountable declaration to end all preventable newborn mortality, saving 2 million newborn lives a year and stopping the 1.2 million stillbirths during labour.[50]

PHOTO: COLIN CROWLEY/SAVE THE CHILDREN

FRONTLINE CARE

Hawa is a midwife in the Mudug region of Somalia. She has been working in a maternal health centre for 12 years. Hawa carries out antenatal check-ups and delivers babies at the centre; more complicated cases are referred to the local hospital.

"I can't tell you how many children I've delivered, but it's more than 800," says Hawa.

It's life-saving work, as Hawa describes through the following example: "Recently we had a mother who had a breach baby. During the delivery the rest of the baby's body came out but the head got stuck. We had to handle that case with a lot of care. The baby was born safely – a baby boy. He's now safe and healthy."

REACHING EVERY MOTHER AND NEWBORN BABY

Research by Imperial College London concludes that broader health coverage generally leads to better access to necessary care and improved population health. The greatest gains accrue to poorer people.[51]

For this report, we commissioned research that applied the Lives Saved Tool (LiST) to estimate the impact of more equitable coverage of essential health services on deaths averted. This considered the impact if the major inequities in access to mother and child health services – such as good-quality care at birth, family planning and treatment of newborn infections – were eliminated in 47 of the countries covered by Countdown to 2015.[52]

Our research estimated that, by 2015, the deaths of almost 950,000 newborn babies would be avoided, a reduction of 38%. Going further, achieving 95% coverage for the whole population by 2030 could save 1.8 million newborn babies – almost 60% of newborn babies' deaths in the 47 countries.[53]

It is clear that reducing inequality and tackling poverty have powerful beneficial effects on health. A study carried out by Save the Children recently found that reducing income inequality could reduce the average global under-five mortality rate from 30 per 1,000 live births to 23 per 1,000. That would mean an additional 1.4 million lives saved per year by 2030.[54]

HEALTH SYSTEMS AND NEWBORN CARE

Births cannot be 'scheduled' to fit within normal working hours; health staff, health facilities, medicines and equipment must be available around the clock. Frontline health workers need to be able to call on the support of specialist services and highly qualified workers as required. Caesarean sections and blood transfusion services are key life-saving interventions for women and babies. Those services need to be supported by systems to transport a pregnant woman quickly to emergency obstetric care as required.

Newborn and maternal mortality and stillbirths are sensitive indicators of the strength of a health system and its ability to reach all communities. Essential newborn care needs to be part of a comprehensive primary care system in every country – providing good-quality antenatal care, immunisation, nutrition, family planning and treatment of childhood illnesses – along with access to secondary care.

What Save the Children is calling for

Governments, with partners, to ensure that by 2025, every birth is attended by trained and equipped health workers who can deliver the essential newborn health interventions.

PIONEERING COMMUNITY-BASED APPROACH TO SAVING NEWBORN BABIES' LIVES

In addition to services around the time of birth, antenatal home checks for women during pregnancy and follow-up care for mothers and newborns in the days after birth are essential. Community health workers can make a difference. For example, in Gadchiroli, India, Dr Abhay Bang pioneered an approach in the 1990s where care by community health workers reduced newborn deaths by identifying high-risk babies, supporting breastfeeding and managing hypothermia and infection.[55]

PHOTO: ANDY HALL/SAVE THE CHILDREN

INNOVATIONS IN NEWBORN CARE

In places of few resources, innovations can make a big difference.

- **Corticosteroids** given to a mother going into premature labour can help the baby's lungs to develop faster.
- Simple, low-cost **bag and mask devices** are effective at helping newborn babies if breathing does not start naturally.
- **Kangaroo Mother Care** (see photo caption below) is a technique first developed to cope with situations where incubators were not available to keep a premature baby warm. But it has been shown to have beneficial long-term effects even where intensive care is available.
- The antiseptic **chlorhexidine**, used in gel form for umbilical cord care, can reduce newborn mortality by preventing acquired infections. The UN Commission on Life-Saving Commodities for Women and Children recommends more supplies of this useful product. Save the Children is working with GSK to produce a new formula and packaging, with costs as low as possible.[56]

These techniques and developments are valuable in reducing mortality. However, getting them used at full scale is impossible without systems that can reach all mothers and babies. Only a health worker who regularly supports births and is up-to-date with training and techniques can make sure they are used properly. Only a strong health system can deliver these human resources, products and techniques to every community and every birth.

KANGAROO MOTHER CARE

Abayanesu's daughter was born a month premature, and weighed just 800 grams (1lb 2oz). Nurses advised Abayanesu to practise mother kangaroo care – a method of keeping a baby warm through skin-to-skin contact – for 24 hours-a-day until her daughter was 41 weeks old. In her first month Abayanesu's daughter gained 400 grams.

Save the Children has supported the government of Ethiopia to train doctors and nurses in this method, in order to improve the survival chances of low birth-weight babies.

PHOTO: CAROLINE TRUTMANN/SAVE THE CHILDREN

ADDRESSING SOCIAL DETERMINANTS OF NEWBORN HEALTH

Addressing the social determinants of health – as part of universal health coverage[57] – is vital in tackling the crisis in newborn mortality. Access to family planning and the right to control when and how frequently they become pregnant is a vital part of women's and girls' empowerment and of a reduction of newborn mortality. Interventions include:

- preventing the marriage of under-age girls
- providing good-quality and empowering sex education
- keeping girls in education longer – and delaying the age at which they start having children.[58]

HEALTHY NEWBORN NETWORK

Save the Children has helped found the Healthy Newborn Network,[59] which brings together a wealth of resources on techniques and procedures that can reduce newborn mortality. These include the actions that communities and families should take, including reducing delays in seeking care, changing care practices in the home, addressing the role of fathers and, crucially, highlighting cultural attitudes towards women, babies and children.

WHO PAYS? FUNDING FOR UNIVERSAL HEALTHCARE

ELIMINATING 'USER FEES'

Save the Children argues that equitable systems of UHC – crucial to saving newborn babies' lives – need to be financed by resources pooled from the whole population, based on ability to pay, and that healthcare should be available based on need. Direct cash payments for maternal, newborn and child health services should be eliminated, to avoid excluding the poor from health services.[60]

Debates about which services are covered are contentious and important. No one expects that everyone in every country will be able to instantly receive all the possible healthcare services that they might need. Even in wealthy countries, difficult decisions have to be taken based on the cost-effectiveness of the most expensive treatments. But good-quality care at birth – provided by midwives and other skilled birth attendants – and newborn care must be the top priority.

High rates of child and maternal mortality have encouraged many countries to remove direct payments – 'user fees' – by patients and their families for maternal, newborn and child health services. The effects of this can be dramatic. Large reductions in child mortality in Niger are in part attributed to the removal of user fees,[61] as are significant increases in use of maternity services in Sierra Leone. However, user fees persist in some countries, for example, Democratic Republic of Congo, as do high rates of newborn mortality.

There is now a strong consensus against out-of-pocket payments for health services. The World Bank, an organisation at one time synonymous with promotion of user fees, has undergone a reversal on the issue. In 2013, its President, Jim Yong Kim, declared: "Anyone who has provided health care to poor people knows that even tiny out-of-pocket charges can drastically reduce their use of needed services. This is both unjust and unnecessary."[62] Encouragingly, many countries have decided to remove user fees first from maternal and child health services, recognising this as a priority area.[63]

What Save the Children is calling for

Governments to remove user fees for all maternal, newborn and child health services, including emergency obstetric care.

However, the removal of fees alone is insufficient to improve health outcomes, including improving the survival chances of newborn babies. Other financial barriers also deter care-seeking. When financial barriers are lifted, demand for health services surges. This threatens to undermine the quality of care provided. It puts pressure on the health workers and on stocks of medical supplies. Staff may continue to collect cash from users in the form of 'gifts' and patients may be expected to buy equipment or medicine. Some countries do not include emergency obstetric care in their free package, which can saddle families with very high unexpected bills.

PHOTO: SAVE THE CHILDREN

HELD HOSTAGE IN HOSPITAL

Marie was held in a hospital in the Democratic Republic of Congo for a month after giving birth. Due to complications with the birth, Marie had to have an emergency caesarean. She and her baby son were out of danger, but, while Marie and her husband had set aside money to pay for an 'ordinary' birth, they did not have money to pay for the operation. As a result, Marie was not allowed to leave the hospital.

The cost of the operation is 53,000 Congolese francs (£35). "I don't have the money to pay that. That's why I'm still here," she said when she was interviewed by Save the Children.

Marie has five older children who were at home with her husband. She and her husband work as *pédaleurs* – buying and selling goods, which they transport by bike.

"My husband is trying to get the money together to get me out. But I have been here a month and he hasn't been able to do so yet," she said. "I don't have any family who can help me and there is no other way for me to leave the hospital other than paying what I owe."

One of the doctors at the hospital in Kasai Oriental province where Marie is being held, Dr Josephine, says there were four other women there in the same situation. Security was tight, with guards on the door of the hospital ward to ensure patients who aren't supposed to leave are unable to do so.

Patients who cannot pay for their medical care can sometimes get their medical fees paid from an equity fund that the hospital holds, paid for by the European Union. But in the month when Marie gave birth, there was no money in the fund.

"We try to help everyone to be able to access affordable healthcare – we've reduced the price of a birth and of a caesarean operation because we want everyone to be able to afford these things," says Dr Josephine. "It's difficult in this case because we don't have any money in the equity fund at the moment. When we have the money we always use it to make sure that patients like this woman can go home."

Interviews were carried out on 22 November 2013.

PRIVATE AND PUBLIC

Private providers of healthcare

Private providers of healthcare at birth are found in every country. They range from high-quality, specialist maternity hospitals to traditional birth attendants. Many of these private providers are paid in cash as 'out-of-pocket expenditure'.

Save the Children believes that private healthcare providers can potentially form part of a publicly-financed system of fair, universal health coverage, but they would need to be integrated and strongly stewarded by the government, with services free at the point of use, at least for the poor.

Many governments and international institutions talk about looking to the private sector to raise funds for healthcare. For example, private health insurance schemes can protect their members from some catastrophic health costs but are too expensive for average families. It is unrealistic to expect these schemes to cross-subsidise from the rich to the poor for essential services. As a recent study by the World Bank and the Government of Japan notes: "No country has reached UHC relying on private voluntary funding sources."[64] Looking to private and community-based health insurance schemes is therefore a distraction from the evidence of what works.

In systems of UHC, wealthier citizens can still pay for greater convenience or comfort in the private care they receive. However, the existence of private services must not be allowed to prevent a newborn baby or a mother receiving life-saving treatment. Wealthier citizens who use private services should not be allowed to opt-out of paying into the general funds, or to discourage governments from raising fair taxes to fund healthcare for all. Crucial to any system of UHC is the mandatory subsidisation by those who are wealthy and healthy of people who are poor, and of those who are sick.

Core business

The private sector has a particularly important role in ensuring the reliable supply of good-quality products that can benefit health. Its products and services must be available to those who need them. Working with the private sector can identify unmet needs and develop innovative products and solutions, such as adaptations and delivery mechanisms that can reach the poorest and those without access to services, especially, but not only, for medicines.

Save the Children is working with RB (formerly known as Reckitt Benckiser) to develop a public–civil society–private partnership model to reduce diarrhoea and mortality, including through innovative, low-cost products and services and through influencing others.[65]

What Save the Children is calling for

The private sector, including pharmaceutical companies, should help address unmet needs by developing innovative solutions and increasing availability for the poorest to new and existing products for maternal, newborn and child health.

PAYING FOR UNIVERSAL HEALTH COVERAGE THROUGH TAXES

As the World Health Report 2010 showed,[66] there is considerable scope for governments to raise additional domestic revenues for their health sectors. Many more health services could be provided if governments improved efficiencies in how resources are raised, pooled and spent. As well as the long-standing African Union Abuja Target of 15% of government expenditure to health, recent estimates of the money needed to reach the health Millennium Development Goals suggest that countries need to spend at least US$60 per capita each year to fund a specified mix of interventions and health system costs. Countries whose general government revenues and compulsory health insurance contributions are lower than about 5–6% of gross domestic product (GDP) struggle to ensure health service coverage for the poor.[67] Recently the Global Investment Framework for Women's and Children's Health showed that increasing health expenditure by just US$5 per person per year in the 74 countries with the highest burden of child mortality could result in up to nine times that value in economic and social benefits by 2035, and prevent the deaths of 147 million children, 32 million stillbirths, and 5 million women.[68] The UN estimates that the world's least developed countries need to raise tax revenue that is equivalent to at least 20% of their GDP, to achieve the Millennium Development Goals.[69]

Fairer taxation of income and wealth, and particularly of industries that extract and export commodities from poorer countries, would make a difference to the ability of countries to fund universal health

coverage. A recent report by the Organisation for Economic Cooperation and Development judges that, were illicit flows to be curtailed, sub-Saharan Africa as a whole could achieve the child mortality MDG target by 2016, rather than 2029, projected on current trends.[70]

What Save the Children is calling for

Governments to increase expenditure on health to at least the WHO minimum of US$60 per capita to pay for the training, equipping and support of health workers.

A GLOBAL RESPONSIBILITY

It is for national governments, in consultation with their people, to make the decisions needed to move forward with UHC. However, the world's poorest countries exist in a context of harsh external pressures. In recent decades, international financial institutions demanded cuts in public spending which actively discouraged states from taking responsibility for healthcare. Donors and multilateral institutions have often prioritised different diseases and services, taking up space and energy that might have built comprehensive health systems.

The movement towards universal health coverage – led by WHO and now backed by the World Bank – provides a clear direction for countries and for donors. And donors' commitments to improve aid effectiveness and coordination through the Paris Principles of Aid Effectiveness and the International Health Partnership+ are making a difference. Through these initiatives, donors are being encouraged to put their resources behind nationally-led comprehensive health plans, rather than project-fund activities that meet their own priorities.[71]

The majority of resources to fund essential healthcare already come from domestic sources. However, even with fairer taxation, the poorest countries will struggle to fund UHC on their own in the short-term. Donor money, where it is available, should support comprehensive health services.

THE INTERNATIONAL HEALTH PARTNERSHIP

Most of the money invested in maternal, newborn and child health comes from the budgets of national governments. However, aid has played and will continue to play an important role in saving lives, particularly in the poorest countries. It is widely acknowledged that health aid is complex, inefficient and fragmented. Different donors have different priorities, reporting requirements and budget cycles, which make managing donor aid costly and time-consuming for overstretched ministries of health. Despite efforts to reduce the number of initiatives, mechanisms and funding streams, new ones continue to be announced.

Established in 2007, the International Health Partnership (IHP+) is a growing alliance of countries, donors and civil society organisations committed to try and make aid more effective. All signatories to the IHP+ Global Compact[72] have agreed to support strengthened national leadership and ownership, harmonise and align their aid, make better use of existing funds and systems and reduce duplication and transaction costs. In May 2013, three new partners – Guinea-Bissau, Haiti and USAID – joined IHP+, bringing the total number of signatories up to 59.

The IHP+ will continue to be a relevant and important mechanism for harmonising and maximising the impact of partners' efforts in support of newborn health, and in support of any health-related goals agreed within the post-2015 development framework.

Newborn babies at a health clinic in Liberia.

FRAMING HEALTHCARE AS A RIGHT – MAKING GOVERNMENTS ACCOUNTABLE

Few countries can introduce large-scale health reforms instantly. However, engaging in a process of health service reform brings its own benefits. When governments publicly commit to their responsibilities, citizens and civil society organisations invest time and energy in the process and demand good-quality health services as a right, not a privilege.

The World Bank and Government of Japan studies identify the political and social factors that have led some countries to make good progress towards UHC, and others to make only limited attempts: "Having health care access embedded in the Constitution as a right provided important institutional underpinning to UHC initiatives … providing reformers with a legal basis for UHC advocacy…In many countries, social movements helped put UHC on the political agenda initially and subsequently held governments accountable after its implementation."[73]

Where governments have made these commitments and delivered progress, they can reap electoral rewards, such as in the re-election of Sierra Leone's President – partly thanks to the Free Health Care Initiative.

4 COUNTRY CASE STUDIES

BANGLADESH

Bangladesh has made impressive progress on child mortality in recent years and is now on track to achieve its MDG 4 target. This has been achieved despite seemingly low public health expenditure. This may be partly due to a pluralistic landscape of healthcare providers. Widespread deployment of community health workers – mostly women – has no doubt been instrumental in scaling up coverage of certain interventions, such as immunisation, oral rehydration therapy for diarrhoea, TB treatment and family planning initiatives. Parallel efforts to empower women, in addition to social and behaviour change communication, have certainly contributed to the health gains.

But coverage of essential services remains low, with less than one-third of births attended by a skilled health worker.[74] Of every 1,000 live births, 24 babies die within their first month, and 41 under the age of five.[75] In the words of Mushtaque Chowdhury, "the sad reality [in Bangladesh]… is the iniquitous health system."[76]

Public investment in health is desperately low – at just 8.9% of total government spending and just over one-third of total health expenditure.[77] The system depends on out-of-pocket payments – amounting to over 60% of total health expenditure.[78] This creates major barriers to progress for the poorest people and is a substantial cause of financial hardship, with the costs of seeking health care accounting for 22% of all shocks that poor households face.[80]

Ending all preventable newborn deaths will require a concerted effort to strengthen the health system and institute health financing policy reforms, to ensure high quality services are provided free at the point of use. This must involve a shift from reliance on out-of-pocket payments towards mandatory systems for prepayment, including substantial public investment.[81] The government must also become a stronger steward, better able to regulate the proliferating private practitioners.[82]

PHOTO: COLIN CROWLEY/SAVE THE CHILDREN

Baby Popi, six days old, from Bangladesh, at her first check-up at a local health centre.

DEMOCRATIC REPUBLIC OF CONGO

Health outcomes in the Democratic Republic of Congo (DRC) are very poor and have remained relatively stagnant over the last decade. The under-five mortality rate is 146 per 1,000 live births and the rate for newborn mortality is 44.[83] These put DRC amongst the top ten worst-performing 'Countdown countries'. Moreover, estimates indicate that less than 25% of the population has access to a functional health service that they can afford to use.[84]

While per capita health expenditure has slowly risen over the years, at $32[85] it still falls well short of WHO targets of $60 per capita and, alarmingly, only a third of this amount comes from government expenditure.[86] User fees are endemic in the country and a barrier to most people accessing health services when they are available.[87]

There are indications of the Ministry of Health's desire to improve the health system, but it is constrained by resource shortages to improve health infrastructure, pay salaries, and purchase drugs and supplies.[88] A revised strategy to strengthen the health sector[89] was launched in 2010, followed by a National Plan for the Development of the Health Sector, affirming good-quality primary health care available to all, especially vulnerable groups.[90] However, this policy has yet to be fully turned into practice, due to poor dissemination (and hence application) of the plan at provincial, district and zonal health departments. More recently, in 2013, the government launched a national plan to boost the achievement of MDGs 4 and 5.

ETHIOPIA

Ethiopia has made great progress in reducing child mortality, recently achieving its MDG 4 targets.[91] Newborn mortality has also decreased from 54 to 29 between 1990 and 2012.[92] This achievement has been driven by multiple factors – among them strong political commitment and policy change, leading to health and nutrition improvements, particularly in rural areas.

Ethiopia launched its Health Extension Programme (HEP) in 2003 to promote universal coverage of primary care. It focuses on making 'promotive', preventative and some curative health services available to all, by bringing them to the community level in even the most remote areas, and free to service users.[93] More than 38,000 health extension workers (on government salaries) have been trained under the programme and are deployed to more than 15,000 health posts across the country.[94]

Despite impressive progress on child health outcomes, coverage of some essential health services is still very low, and equity is a major concern. For example, immunisation coverage is only around 60% nationally, and children from the richest households are roughly twice as likely to be immunised as the poorest. And children in urban areas are twice as likely to be immunised as those in rural areas.[95] Only 10% of women give birth with a qualified health worker present. A richer woman is over 20 times more likely than a poorer woman to have skilled birth attendance, and a woman living in an urban area is more than ten times more likely to do so than a woman in a rural area.[96] These represent huge inequalities, which are holding back further progress. While Ethiopia's MDG 4 achievements warrant recognition, the job has only just begun. Progress must be significantly accelerated and inequalities tackled so that improved health outcomes are shared by all.

GHANA

Ghana has a complex health financing system, including private insurance, out-of-pocket payments and the National Health Insurance Scheme (NHIS), which was launched in 2003. The NHIS was brought in to help guarantee universal access to good-quality healthcare. It was also a move towards curbing people having to pay for services at the point of use. NHIS coverage had only reached about one-third

of the population by 2011,[97] leaving many having to pay out of pocket for services. While formal sector workers are automatically covered, informal sector workers have to pay an annual premium, with some exceptions for vulnerable groups such as pregnant women. However, many people can't afford this premium and therefore do not benefit from the scheme.[98] There are indications that the NHIS has reduced financial barriers to accessing services and has led to better utilisation, including by the poor, but enrolment is still not pro-poor.[99]

Inequitable financial protection and uneven distribution of health workers[100] mean that not all people have the same access to health services. In 2003, when fees for childbirth services were removed, facility-based deliveries increased (with greater impact amongst the poorest households), but dropped again when fees were reinstated in 2008.[101] Currently, only about half of women have a qualified health worker when giving birth – just a quarter of the poorest women, compared with 95% of the richest.[102] This is in contrast to other services, such as immunisation, where coverage is much higher (92%) and inequalities much lower.[103]

INDIA

India has made progress in improving access to health services, but inequalities remain, arising from geographical, social, cultural and economic factors. The under-five mortality rate in India has been more than halved since 1990 – from 126 per 1,000 live births to 56.[104] While the child mortality rate has come down across all population groups, it is three times higher among the poorest households compared with the richest.[105] There was a reduction in the newborn mortality rate over the same period from 51 to 31 per 1,000 live births;[106] this figure still remains high compared to other Countdown countries. Coverage of some critical health services is also very low, with huge inequalities across the country. For example, less than 60% of women have a skilled health worker present when giving birth,[107] with coverage among the poorest households less than a quarter what it is in the richest households – 19% and 90% respectively.[108]

The government has introduced a number of policies and initiatives to address challenges and improve access to health services, particularly for the poor and vulnerable. The National Rural Health Mission (NRHM) helped improve health infrastructure and service delivery, focusing on primary care in rural areas. It also integrated a number of existing disease control and reproductive and child health programmes. Under the NRHM, more recent initiatives have been rolled out – eg, the Rashtriya Bal Swasthya Karyakram 'Child Health Screening and Early Intervention Services' programme in 2013,[109] and the Janani–Shishu Suraksha Karyakram programme in 2011, making services free at the point of use for pregnant women and newborn babies.[110]

To improve coverage among the urban poor in slums, the government launched the National Urban Health Mission (later renamed the National Health Mission). Several health insurance schemes have also been introduced at national and state levels.[111] These have initially targeted coverage of poor and rural populations, though with the aim of scaling up to universal coverage.[112]

With regards to reproductive, maternal, newborn and child health, India is addressing inequalities by systemically identifying high priority districts and allocating a higher budget for their health initiatives. A landmark achievement has been the launch of the RMNCH+A strategic approach during the Call to Action summit in February 2013. The framework marks a paradigm shift to a holistic, life-cycle approach, and the Ministry of Health and Family Welfare has ensured its integration into programmes through the establishment of state RMNCH+A units. Save the Children India is the secretariat to the RMNCH+A Coalition, leading on CSO/FBO engagement.

These are promising initiatives, yet they face challenges, and implementation remains weak. For example, coordination between schemes is poor, while limited resources mean trade-offs between extending population coverage and expanding benefits packages. Also, states with strong health systems and implementation mechanisms have done exceedingly well compared with others. More needs to be done to ensure equitable progress for all people in all states.

KENYA

At the national level, Kenya's health coverage remains low. Less than half of women have the recommended four antenatal care visits or a skilled health worker when giving birth. When giving birth, poor women are four times less likely to have a skilled health worker present than women from richer households; women in rural areas are only half as likely to have a skilled health worker present as women from urban areas.

To address low health coverage, the new government has announced the removal of user fees for maternity services in public health facilities. Kenya's National Health Sector Strategic Plan II includes a Health Sector Services Fund (HSSF) – a revolving fund providing direct cash transfers to primary healthcare facilities – targeting health centres and dispensaries that are the first point of contact for health care for most of the population. The aim of HSSF was to improve cash flow to facilities, after the Public Expenditure Tracking Survey (PETS) revealed that less than half of the funds due were actually received by facilities because of bureaucracy, inefficiencies and failure to comply with government accounting procedures.[113] There are discussions about the HSSF being increased to accommodate loss of income to healthcare facilities due to the removal of user fees.

Following its introduction in 2010, the HSSF now covers nearly 3,000 health facilities. This has led to increased utilisation of healthcare facilities from nearly 26 million in 2010/11 to around 27 million in 2011/12. Initial indications show improvements in prenatal care, deliveries by skilled health workers and immunisation coverage in target facilities.[114]

LIBERIA

Following well over a decade of civil war, Liberia was left with a broken health system and some of the poorest health indicators in the world. The country has made progress in recent years thanks in part to a National Health Policy, launched in 2007, aimed at equitably extending health service coverage. The policy introduced a basic package of health services[115] available to all citizens, free at the point of use, with the aim of tackling communicable diseases and responding to maternal and child health needs at primary care level. In 2011, the policy was revised and a ten-year strategic plan developed. This provides a more comprehensive set of services to strengthen key areas that continue to perform poorly, and adds new services necessary to address needs at all levels of the healthcare system.

With a free healthcare policy, less than 10% of people who fall ill do not seek care and the poorest households spend only around 2% of household expenditure on health.[116] This has contributed to impressive progress on health outcomes. Under-five mortality is roughly one-third what it was in 1990 (dropping from 248 deaths per 1,000 live births in 1990 to 75 deaths in 2012), while newborn mortality has been nearly halved, from 51 to 27.[117]

Coverage of health services is still poor in some areas and high inequalities are a concern. Only 46% of women give birth with a qualified health worker present and coverage is three times lower amongst the poorest households compared with the richest.[118] Critical health worker shortages are a big issue, with less than seven health workers for every 10,000 people[119] – far below the WHO target of 23.

With the recent passing of the new Health Financing Policy, it is critical that services remain free at the point of use. This is essential for the new policy to achieve its goal of "universal access for quality essential health services to all citizens in an equitable, efficient and sustainable manner".

A midwife visits a three-day-old baby at home in Liberia.

NEPAL

Despite grappling with poor infrastructure, difficult terrain and widespread poverty, Nepal has been making impressive progress in improving child survival.[120] The country is on track to reach MDG4, with the under-five mortality rate currently at 42 per 1,000 deaths – around one-third what it was in 1990. Meanwhile, newborn mortality has been halved – from 53 per 1,000 live births in 1990 to 24 currently.[121]

While improved health outcomes correspond to increasing coverage of many health services, coverage of some services remains low, and reaching the poor and marginalised is an issue.[122] Just over a third of women have a skilled health worker present when giving birth, with only one woman covered among the poorest households for every eight women among the richest.[123] Meanwhile, coverage is more than twice as high in urban areas as in rural areas.[124] For other health services, progressive coverage has been made – eg, national immunisation coverage has reached 90%, with high coverage among both the poorest and richest households.

The government of Nepal is currently implementing a number of health programmes, resulting in many essential services officially provided free for all, with additional services targeted at the poor and marginalised.[125] While coverage has surely improved as a result of these programmes, it is still far from universal. Key challenges include resource and health worker shortages (eg, currently there are around six health workers per 10,000 population); direct payments; and inadequate financial protection leading to high out-of-pocket payments – these currently account for 55% of total health expenditure.[126, 127]

To help overcome these challenges and as a major step towards UHC, the Ministry of Health and Population approved the national health insurance policy in March 2013. The new policy aims to help improve equitable access to health services by curbing out-of-pocket payments and strengthening the health system.[128]

NIGERIA

Under-five and newborn mortality rates in Nigeria are among the highest in the world, at 123.7 and 39.2 per 1,000 live births, respectively, in 2012.[129] Under-five mortality is nearly 2½ times higher among the poorest households than the richest, and nearly 30% higher when looking at newborn mortality.[130] Coverage of critical health services is extremely low and inequalities are high – only 38% of women give birth with a skilled health worker, while coverage is ten times lower for the poorest women compared with the richest; coverage in rural areas is about one-third (23%) what it is in urban areas (67%).[131] These inequalities have actually worsened over the years.

Nigeria suffers from a highly fragmented healthcare system across the country, leading to wide disparities in service coverage and health outcomes. As part of efforts to strengthen the system, the government introduced the National Health Policy in 2006. This included a re-designed National Health Insurance Scheme (NHIS) whereby formal sector workers make contributions based on income (with a contribution also from employers) and those in the informal sector make contributions based on their choice of benefits package. Several exemptions are also in place, including for the poor.

While coverage of the NHIS has increased since its introduction, its reach remains poor – just 3% of the population – with huge disparities in coverage between people in paid employment and people who are poor and in the informal sector.[132] This has meant that despite some national progress in health outcomes, this progress has been limited and unequal. Health system weaknesses need to be addressed and cultural issues tackled if Nigeria is to see improvements in health outcomes for mothers and newborn babies.

If the National Health Bill, which went through the third and final senate reading in August 2013, is signed into law by the President, it will provide a breakthrough deal for mothers and children. If the bill is fully funded and implemented, it could lead to basic life-saving healthcare services being scaled up to 90% coverage – near universal coverage – improving healthcare for huge numbers of Nigerians and helping the country achieve its MDG 4 and 5 objectives.


PHOTO: SAVE THE CHILDREN

A newborn baby's umbilical cord is cleaned with chlorhexidine at a hospital in Nepal.

PAKISTAN

With an under-five mortality rate of 86 per 1,000 live births in 2012, down from 138 in 1990, Pakistan is making insufficient progress towards MDG4 targets.[133] There has also been less of a decline in newborn mortality, from 56 in 1990 to 42 currently. This is accompanied by very low coverage of some critical health services. For example, less than half of women have a skilled health worker present when giving birth,[134] with coverage nearly five times higher among the richest women compared with the poorest.[135] Pakistan is also ranked among the countries with the highest stillbirth rates, largely due to delays in receiving appropriate care from a skilled health worker.[136]

The government of Pakistan first introduced the lady health worker (LHW) cadre in 1994, with the aim of improving access to primary health services and to address unmet health needs in rural areas and urban slums.[137] Almost 60% of the total population of Pakistan, mostly rural, is covered by the programme, with more than 90,000 LHWs all over the country,[138] contributing to improved health indicators among populations covered.[139] However, several issues persist, such as delays in the salary disbursements, 'stock outs' of medicines, unavailable and dysfunctional equipment, and an unhelpful referral system.[140]

Community midwives are another category of frontline health worker in Pakistan brought in to improve skilled birth attendance in rural areas. However, out of a total of 11,996 community midwives, only 45% had been trained and of them about 64% deployed across the country due to the lack of adherence to selection criteria, ambiguities about remuneration, lack of supervision, poor-quality training and 'acceptability issues' at community level.[141]

RWANDA

Rwanda has come a long way since the major disruption of its health system in the mid-1990s, which left it weak during the ensuing years. Since 2000, the government has taken major steps to improve access and quality of care. One of its key initiatives has been the introduction of *Mutuelles de Santé* – a community-based health insurance scheme but with national reach. Starting off as a pilot in

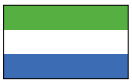
1999/2000, the *Mutuelles* Health Insurance Policy was fully implemented in 2006[142] and over 90% of the population is now covered.[143]

Around half of funding for *Mutuelles de Santé* comes from membership premiums, with the remaining 50% subsidised by government, other insurance funds and the development partners.[144] Premium payments have become more progressive over the years, with the poorest now exempt from having to pay.

Studies have shown positive impact following the introduction of *Mutuelles de Santé*, including increases in health service coverage. For example, skilled-birth attendance increased from 39% in 2000 to 67% in 2008.[145] In 2010, around 70% of women had a skilled health worker present when giving birth.[146] Inequalities have also decreased significantly over the years, though more must be done to ensure universal access – eg, coverage is still about 23% higher in urban areas than in rural areas.[147] Health outcomes have improved as a consequence, with under-five mortality now nearly one-third what it was in 1990 (a drop from 151 per 1,000 live births to 55) – and newborn mortality declined from 38 to 21.[148]

At a health centre in Rwanda a mother holds holds her newborn baby, who is just eight hours old.

SIERRA LEONE



As Sierra Leone emerged from civil war, health outcomes were atrocious and coverage of health services was extremely low. In 2008, the neonatal mortality rate was the fourth highest in the world, with 49 babies in every 1,000 dying within their first month of life. That year, just one in four of the poorest mothers had skilled attendance during birth.[149] Overcoming such a challenge is not easy. The health system was weak, underfunded and reliant on user fees from the population, which deterred the majority from seeking care.

A crucial step towards better maternal and child health outcomes has been the Free Health Care Initiative (FHCI), launched in April 2010 to remove user fees for pregnant and lactating women, and children under five. This was led by the President, Ernest Koroma, who acknowledged the scale of the crisis and thus made maternal and child health a key priority. The FHCI has been implemented with increased public financing and wider system reforms to strengthen the quality of care provided, by increasing the numbers of health workers and improving the drug supply.

In 2014, Sierra Leone will finalise and implement its Every Newborn Plan, which must be closely situated within the health sector plan to ensure an integrated approach is taken to scale up coverage of essential services. A focus on newborns, within the consolidation of the FHCI, has huge potential to accelerate progress on child survival in Sierra Leone.

SRI LANKA

In Sri Lanka, basic health services are in reach of nearly the whole population,[150] and 99% of births in 2007 were attended by qualified health personnel.[151] This has led to impressive health outcomes, including a halving of the newborn mortality rate from 12 per 1,000 live births in 1995 to six in 2012.[152] Sri Lanka has a strong commitment to free universal access to health, while prioritising equitable access for all citizens. With the introduction of democracy in the 1930s, citizens were more empowered to demand access to good-quality services and to hold the government accountable for providing this. Accountability has been important to securing and sustaining the country's progress.[153]

Sri Lanka's public health system is financed by general revenues, through income taxes, based on ability to pay. The government expects the rich to contribute even if they use private services.[154] This is seen as allowing the public system to better respond to the needs of the poor. To overcome inequalities in access, Sri Lanka has established a rural network of health facilities that extends access beyond urban areas and has ensured services are available free at the point of use.

In spite of impressive progress, pockets of poor take-up of services remain. Improvements are being seen in former conflict-affected areas in the north and east as the result of recovery and development programmes. However, health issues for women and children resident in the central tea estates and rubber plantations persist.

UGANDA

Uganda has reduced under-five mortality markedly, especially towards the end of the past decade.[155] If this recent accelerated rate of progress is maintained, the country has a chance to meet their MDG 4 target by 2015. The under-five mortality rate was 69 per 1,000 live births in 2012 (down from 178 in 1990), while newborn mortality has come down from 39 to 23.[156] However, inequalities persist between rural and urban areas and regions, as well as between the richest and poorest households. For example, the under-five mortality rate is 153 in Karamoja, compared with 65 in Kampala.[157] Coverage of some important health services also remain low and inequitable. Nationally only 58% of women have a skilled health worker present when giving birth, with coverage twice as high among the wealthiest households, compared with the poorest.[158]

The government of Uganda has taken several steps to help improve equitable access to healthcare, including a minimum package of health services for all levels of healthcare, abolishing user fees, and ensuring a health facility within reach (within 5km) of the majority of households. The government has also recently launched an improved plan for RMNCH, which includes: increasing efforts in districts where the majority of under-five deaths occur; targeting high burden populations; improving access for under-served populations; and prioritising budgets and action plans to end preventable deaths.

After user fees were removed, utilisation increased, with greater impact amongst the poorest households.[159] Despite these efforts, over a quarter of households do not have a facility within their proximity and utilisation remains low due to poor infrastructure, inadequate supplies, health worker shortages, etc.[160]

Out-of-pocket payments are still high – accounting for nearly 50% of total health expenditure[161] – and mainly affect the poorest people.[162] These payments largely stem from indirect costs such as transport, supplementary fees for medicine, and medical personnel illegally charging for services.[163] To help mitigate out-of-pocket payments and promote equitable access, the government plans to introduce a National Health Insurance Scheme (NHIS) in 2014 as part of UHC reforms.[164] While the NHIS, if brought to scale, should help to address financial barriers, inequalities won't be fully overcome unless wider health system issues and bottlenecks (eg, human resource, medicines, health facilities), as well as cultural barriers, are tackled.[165]

CONCLUSION

Although we have made substantial progress in reducing deaths of children under five, 2.9 million newborns in 2012 did not live beyond 28 days. 1 million of these babies died on their first – and only – day of life. In addition, 1.2 million stillbirths occurred where the heart stopped beating during labour.

This report has focused on these 2.2 million first-day deaths and stillbirths during labour – a tragedy for their families and communities – because they also reveal a systematic failure to respect the universal right to survival and to health when it comes to the poorest and most vulnerable people in our world. First-day deaths and stillbirths during labour reveal deep inequalities across societies, and point to the fact that many national health systems, in their very design, fail to reach everyone.

Progress on Millennium Development Goal 4, and on future targets to end all preventable newborn deaths and stillbirths, cannot be achieved without substantial and urgent progress on improving care at birth.

2014 offers a powerful opportunity to address this. The Every Newborn Action Plan will be presented to the world's ministers and will drive renewed action. By addressing this neglected topic according to the principles of universality and equity, with the aim of ending all preventable newborn deaths, the Action Plan can help to ensure ambitious, substantial change that brings lasting benefits to families and economies.

This needs to be followed by genuine political change than can transform the way that health services are delivered, so that these services can reach every birth with good-quality care and the right interventions. This is why Save the Children's five-point Newborn Promise needs the highest level of political support during 2014.

The Every Newborn Action Plan and the Newborn Promise can benefit from the momentum that universal health coverage currently has in many countries. In turn, the focus on newborn mortality will help ensure the fight for universal health coverage concentrates on the outcomes that will benefit the most vulnerable.

The scale and the inequality of newborn mortality have to be addressed. The incremental changes that we currently see cannot end all preventable child and maternal deaths within an acceptable time frame. The principles of UHC should guide how universal good-quality care at birth is to be achieved. Investment in public services, so that maternal, newborn and child healthcare is free at the point of use and of high quality, is key to the solution.

These movements offer a real promise that we can become the generation to end all preventable newborn, child and maternal deaths – and ensure that no baby is born to die.

RECOMMENDATIONS

Save the Children is calling on world leaders, philanthropists and the private sector to implement – this year – a five-point Newborn Promise to end all preventable newborn deaths:

- Governments and partners issue a defining and accountable declaration to end all preventable newborn mortality, saving 2 million newborn lives a year and stopping the 1.2 million stillbirths during labour
- Governments, with partners, ensure that by 2025 every birth is attended by trained and equipped health workers who can deliver quality care including essential newborn health interventions
- Governments increase expenditure on health to at least the WHO minimum of US$60 per capita, to pay for the training, equipping and support of health workers
- Governments remove user fees for all maternal, newborn and child health services, including emergency obstetric care
- The private sector, especially pharmaceutical companies, should help address unmet needs by developing innovative solutions and increasing availability for the poorest to new and existing products for maternal, newborn and child health.

Governments of countries with high burdens of newborn mortality need to make significant policy changes in order to:

- commit to addressing the newborn deaths and stillbirths as a top priority
- commit to universal coverage of high-quality care during birth, as part of integrated reproductive, maternal, newborn and child healthcare
- increase budget allocations for health at least to meet the African Union Abuja target of 15% of government expenditure on health
- address the health worker crisis through programmes to recruit, train, retain, deploy, support and appropriately remunerate health workers, including midwives with the skills and equipment to save newborns as well as mothers
- remove and eliminate direct payments for maternal and newborn healthcare including emergency obstetric care
- ensure that less than 20% of all national expenditure for health is from out-of-pocket payments. Governments must also tackle informal payments and other barriers such as transport and opportunity costs that deter the poor from using services
- develop integrated national reproductive, maternal, newborn and child health action plans that ensure universal access to good-quality healthcare and lay out evidence-based paths to ending preventable maternal and child deaths.

The Every Newborn Action Plan – which should be presented to the World Health Assembly in May 2014 and lead to a global push – should have as its priorities:

- ending all preventable newborn and child deaths and stillbirths. This should be achieved in all wealth quintiles and all segments of society with accountability mechanisms as part of Every Woman Every Child
- universal coverage of quality care at birth by 2025
- calling for the future monitoring and inclusion of stillbirths as an indicator in reproductive, maternal, newborn and child health frameworks
- endorsement of the principles of universal health coverage including eliminating financial and other barriers and establishing financial risk protection
- ensuring that underlying factors such as maternal nutrition, reproductive health and women's empowerment are addressed to end all preventable newborn deaths
- ensuring its targets are integrated within the post-2015 framework, so that they achieve global priority.

The post-2015 development framework must:
- contain targets for ending preventable child, maternal and newborn deaths, using the targets of seven newborn deaths per 1,000 live births and a maximum of ten in every country, as well as ten stillbirths per 1,000 total births in every country and every segment of society
- endorse the principles of universal health coverage with specific metrics to measure it, including good-quality care at birth
- set a target for ending impoverishment from healthcare costs.

Donor governments must:
- take a leading role in bringing political and financial support to ending preventable maternal, newborn and child deaths
- invest in better data to ensure accurate tracking of newborn mortality, across various dimensions of equity
- promote universal coverage of good-quality care at birth, including through promoting the principles of UHC to enable countries to transform healthcare
- share relevant knowledge, skills and experience to help low-income countries develop their health systems in line with these principles
- support the development of human resources for health (HRH) – in coordination with national governments and their HRH implementation plans – with greater emphasis on supporting pre-service training
- commit to share expertise on health financing and health system management with low- and medium-income countries to accelerate progress towards UHC and an end to preventable maternal and child deaths
- support fairer taxation in countries, transparency of financial flows and closing of tax avoidance loopholes and havens
- provide direct financial support to the poorest countries that cannot achieve UHC alone.

The **World Bank** should:
- support and encourage governments to commit to ending preventable maternal and child deaths and UHC
- support stronger data collection systems
- help countries put in place financing reforms to replace out-of-pocket payments with mandatory and equitable pooled contributions.

Civil society organisations should:
- campaign for and monitor government commitments to end preventable newborn mortality and preventable stillbirths, including through universal health coverage
- mobilise families and communities to address cultural and social barriers that drive newborn mortality. Key issues include addressing girls' empowerment, the demand for good-quality healthcare, family planning and immediate and exclusive breastfeeding.

The private sector:
- should support the Every Newborn Action Plan by making commitments to support universal coverage of healthcare
- should – especially pharmaceutical companies – help address unmet needs by developing innovative solutions and increasing availability for the poorest to new and existing products for maternal, newborn and child health
- should support, respect and comply with regulations that protect the health of newborns and children, such as the Code of Marketing of Breastmilk Substitutes.

APPENDIX: NEWBORN MORTALITY STATISTICS BY COUNTRY

This table gives key statistics on newborn mortality in the 75 Countdown to 2015 countries, which have the highest burden of newborn mortality.

Country	Total number of deaths during birth and on day of birth[1]	Number of deaths on day of birth[1]	Number of intrapartum stillbirths[1]	Risk of neonatal death on day of birth (per 1,000 live births)[1]	Intrapartum stillbirth rate (per 1,000 total births)[1]	Intrapartum stillbirths and neonatal deaths on day of birth (per 1,000 total births)[1]	Neonatal mortality rate (per 1,000 live births)[2]	Under-five mortality rate (per 1,000 live births)[2]	Maternal mortality ratio (per 100,000 live births)[3]	Skilled attendance at birth (%)[4]	Government expenditure on health (per capita)[5]	Out-of-pocket expenditure as a % of total health expenditure[5]
Central Africa												
Angola	25,485	14,600	10,885	16	11.7	27.39	45.4	163.5	450	49.4	132.04	27.31
Cameroon	17,414	7,800	9,614	10	11.9	21.55	27.9	94.9	690	63.6	39.79	56.88
Central African Republic	3,926	2,200	1,726	14	11.2	25.48	40.9	128.6	890	41.4	16.05	14.38
Chad	15,572	7,800	7,772	14	13.6	27.25	39.7	149.8	1,100	16.6	17.76	43.38
Congo	3,783	1,800	1,983	11	11.9	22.70	31.7	96.0	560	93.6	72.99	42.17
Democratic Republic of Congo	78,977	41,800	37,177	15	13.3	28.25	43.5	145.7	540	80.4	10.83	43.54
Equatorial Guinea	512	310	202	12	7.8	19.76	43.1	100.3	240	no data available	1,088.17	31.61
Gabon	883	460	423	9	8.0	16.69	24.9	62.0	230	no data available	275.01	46.55
Sao Tome & Principe	112	45	67	7	10.2	17.08	1.4	53.2	70	80.6	54.51	56.91

continued overleaf

Country	Total number of deaths during birth and on day of birth[1]	Number of deaths on day of birth[1]	Number of intrapartum stillbirths[1]	Risk of neonatal death on day of birth (per 1,000 live births)[1]	Intrapartum stillbirth rate (per 1,000 total births)[1]	Intrapartum stillbirths and neonatal deaths on day of birth (per 1,000 total births)[1]	Neonatal mortality rate (per 1,000 live births)[2]	Under-five mortality rate (per 1,000 live births)[2]	Maternal mortality ratio (per 100,000 live births)[3]	Skilled attendance at birth (%)[4]	Government expenditure on health (per capita)[5]	Out-of-pocket expenditure as a % of total health expenditure[5]
Eastern Africa												
Burundi	11,080	5,400	5,680	13	12.9	25.16	35.5	104.3	800	60.3	17.1	43.62
Comoros	593	270	323	11	12.6	23.15	31.0	77.6	280	no data available	33.98	17.02
Djibouti	646	260	386	11	15.8	26.44	31.4	80.9	200	78.4	131.63	31.62
Eritrea	3,642	1,400	2,242	6	9.9	16.08	18.2	51.8	240	no data available	8.29	51.23
Ethiopia	68,092	31,100	36,992	10	11.9	21.90	29.0	68.3	350	10	30	33.76
Kenya	29,615	14,200	15,415	9	10.1	19.40	26.8	72.9	360	43.8	30.49	46.38
Madagascar	13,536	6,000	7,536	8	9.6	17.24	22.0	58.2	240	43.9	24.96	25.20
Malawi	12,252	5,300	6,952	9	11.0	19.39	24.2	71.0	460	71.4	56.53	14.20
Mozambique	22,722	10,000	12,722	11	13.2	23.58	30.2	89.7	490	54.3	26.98	9.01
Rwanda	8,107	3,300	4,807	7	10.6	17.88	20.9	55.0	340	69	76.38	21.38
Somalia	13,619	7,200	6,419	16	14.0	29.70	45.7	147.4	1,000	9.4*	no data available	no data available
South Sudan**	no data available	4,900	no data available	13	no data available	no data available	35.7	104.0	no data available	no data available	no data available	55.43
Uganda	30,240	12,200	18,040	8	11.5	19.28	22.6	68.9	310	58	33.66	47.77
United Republic of Tanzania	36,528	14,000	22,528	8	11.9	19.30	21.4	54.0	460	48.9	42.45	31.72
Zambia	13,210	6,100	7,110	10	11.9	22.11	29.4	88.5	440	46.5	59.38	26.97
Zimbabwe	10,152	6,000	4,152	14	9.3	22.74	28.8	89.8	570	66.2	no data available	no data available
Northern Africa												
Egypt	12,398	8,100	4,298	4	2.2	6.35	11.8	21.0	66	78.9	125.32	58.17
Morocco	7,137	4,700	2,437	6	3.2	9.37	17.8	31.1	100	73.6	104.27	58.00
Sudan	26,287	12,400	13,887	10	11.1	21.01	28.6	73.1	730	no data available	50.98	69.12

Country	Total number of deaths during birth and on day of birth[1]	Number of deaths on day of birth[1]	Number of intrapartum stillbirths[1]	Risk of neonatal death on day of birth (per 1,000 live births)[1]	Intrapartum stillbirth rate (per 1,000 total births)[1]	Intrapartum stillbirths and neonatal deaths on day of birth (per 1,000 total births)[1]	Neonatal mortality rate (per 1,000 live births)[2]	Under-five mortality rate (per 1,000 live births)[2]	Maternal mortality ratio (per 100,000 live births)[3]	Skilled attendance at birth (%)[4]	Government expenditure on health (per capita)[5]	Out-of-pocket expenditure as a % of total health expenditure[5]
Southern Africa												
Botswana	860	490	370	10	7.5	17.44	28.5	53.3	160	99.1	446.37	4.97
Lesotho	1,631	930	701	16	11.8	27.46	45.3	99.6	620	61.5	162.06	17.89
South Africa	17,004	6,300	10,704	6	9.5	15.09	15.3	44.6	300	no data available	449.54	7.21
Swaziland	695	380	315	10	8.4	18.54	29.5	79.7	320	82	300.94	13.07
Western Africa												
Benin	7,638	3,500	4,138	10	11.3	20.86	27.8	89.5	350	84.1	39.69	42.62
Burkina Faso	14,618	6,400	8,218	10	12.2	21.70	27.5	102.4	300	67.1	40.79	36.57
Cote d'Ivoire	19,429	10,100	9,329	14	12.7	26.45	39.9	107.6	400	59.4	31.91	27.22
Gambia, The	1,658	740	918	10	12.0	21.67	28.0	72.9	360	56.1	50.65	22.27
Ghana	16,065	7,900	8,165	10	10.2	20.07	28.4	72.0	350	54.7	50.49	29.11
Guinea	9,662	5,000	4,662	12	11.0	22.80	34.4	101.2	610	46.1	18.38	67.35
Guinea-Bissau	1,819	970	849	16	13.7	29.35	45.7	129.1	790	44	19.84	41.33
Liberia	3,288	1,400	1,888	9	12.5	21.77	26.6	74.8	770	46.3	35.52	17.67
Mali	17,212	9,800	7,412	15	10.8	25.08	41.5	128.0	540	49	33.27	54.35
Mauritania	3,172	1,500	1,672	12	12.8	24.29	33.6	84.0	510	57.1	78.08	37.27
Niger	17,273	8,300	8,973	10	10.6	20.41	28.2	113.5	590	17.7	21.68	37.58
Nigeria	232,403	94,500	137,903	14	19.4	32.69	39.2	123.7	630	34.4	51.17	60.42
Senegal	12,712	4,400	8,312	9	15.7	24.01	24.4	59.6	370	65.1	69.1	32.74
Sierra Leone	6,737	3,700	3,037	18	13.9	30.83	49.5	181.6	890	60.8	29.74	74.92
Togo	5,637	2,800	2,837	12	11.6	23.05	32.6	95.5	300	43.9	41.84	40.39

continued overleaf

Country	Total number of deaths during birth and on day of birth[1]	Number of deaths on day of birth[1]	Number of intrapartum stillbirths[1]	Risk of neonatal death on day of birth (per 1,000 live births)[1]	Intrapartum stillbirth rate (per 1,000 total births)[1]	Intrapartum stillbirths and neonatal deaths on day of birth (per 1,000 total births)[1]	Neonatal mortality rate (per 1,000 live births)[2]	Under-five mortality rate (per 1,000 live births)[2]	Maternal mortality ratio (per 100,000 live births)[3]	Skilled attendance at birth (%)[4]	Government expenditure on health (per capita)[5]	Out-of-pocket expenditure as a % of total health expenditure[5]
Latin America and the Caribbean												
Bolivia	2,846	1,800	1,046	7	3.9	10.61	18.9	41.4	190	71.1	177.12	25.82
Brazil	16,233	9,800	6,433	3	2.2	5.55	9.2	14.4	56	98.9	476.98	31.34
Guatemala	3,582	2,500	1,082	5	2.3	7.61	15.3	32.0	120	51.3	118.43	53.41
Haiti	3,371	2,400	971	9	3.6	12.50	25.4	75.6	350	26.1	40.96	22.05
Mexico	7,587	5,300	2,287	2	1.0	3.32	7.2	16.2	50	95.3	464.86	46.52
Peru	3,382	2,000	1,382	3	2.3	5.63	9.3	18.2	67	85	278.48	38.35
Central Asia												
Kyrgyzstan	1,274	970	304	6	2.0	8.38	14.2	26.6	71	98.3	95.9	34.38
Tajikistan	2,855	2,200	655	8	2.4	10.46	23.0	58.3	65	88.4	40.03	60.12
Turkmenistan	1,073	810	263	8	2.5	10.20	21.9	52.8	67	99.5	152.54	39.24
Uzbekistan	3,826	3,000	826	5	1.3	6.02	13.5	39.6	28	99.6	97.36	43.87
Eastern Asia												
China	93,110	55,700	37,410	3	2.0	4.98	8.5	14.0	37	96.3	241.6	37.16
Democratic People's Republic of Korea	no data available	no data available	no data available	no data available	no data available	no data available	15.6	28.8	81	100	no data available	no data available
Southern Asia												
Afghanistan	30,879	13,200	17,679	13	16.6	28.99	36.0	98.5	460	36.3	7.87	79.37
Bangladesh	93,405	26,900	66,505	9	20.6	28.93	24.4	40.9	240	31.1	24.61	61.27
India	598,038	275,800	322,238	11	12.5	23.20	30.9	56.3	200	57.7	43.75	59.37
Nepal	12,672	4,900	7,772	9	13.2	21.52	24.2	41.6	170	36	26.86	54.84
Pakistan	204,542	71,700	132,842	15	26.4	40.65	42.2	85.9	260	45	18.74	63.01

Country	Total number of deaths during birth and on day of birth[1]	Number of deaths on day of birth[1]	Number of intrapartum stillbirths[1]	Risk of neonatal death on day of birth (per 1,000 live births)[1]	Intrapartum stillbirth rate (per 1,000 total births)[1]	Intrapartum stillbirths and neonatal deaths on day of birth (per 1,000 total births)[1]	Neonatal mortality rate (per 1,000 live births)[2]	Under-five mortality rate (per 1,000 live births)[2]	Maternal mortality ratio (per 100,000 live births)[3]	Skilled attendance at birth (%)[4]	Government expenditure on health (per capita)[5]	Out-of-pocket expenditure as a % of total health expenditure[5]
South-eastern Asia												
Cambodia	4,428	2,400	2,028	7	5.5	12.01	18.4	39.7	250	71	30.29	23.36
Indonesia	47,656	25,600	22,056	5	4.5	9.72	15.0	31.0	220	79.8	43.32	49.88
Lao PDR	2,744	1,900	844	10	4.3	13.98	27.2	71.8	470	37	38.42	39.68
Myanmar	14,591	8,700	5,891	9	6.2	15.36	26.3	52.3	200	70.6	3.61	80.69
Philippines	22,875	11,400	11,475	5	4.9	9.77	14.0	29.8	99	62.2	56.2	55.92
Vietnam	11,765	6,200	5,565	4	3.9	8.25	12.4	23.0	59	91.9	93.39	55.68
Western Asia												
Azerbaijan	1,325	910	415	5	2.4	7.66	15.0	35.2	43	88.6	112.28	70.10
Iraq	8,338	6,900	1,438	7	1.4	8.12	19.0	34.4	63	88.5	297.34	19.32
Yemen	9,726	6,900	2,826	10	3.8	13.08	27.0	60.0	200	35.7	31.85	78.05
Oceania												
Papua New Guinea	2,775	1,800	975	9	4.6	13.09	24.3	63.0	230	42.7	91.05	11.73
Solomon Islands	163	80	83	5	4.8	9.43	13.8	31.1	93	70.1	246.33	2.95

[1] Sources: Livebirths from UN Population Division adjusted by UN-IGME for 2012; Neonatal deaths for 2012, from The UN Inter-agency Group for Child Mortality Estimation, 2013, www.childmortality.org; Stillbirth rates for 2009, from Cousens S, Blencowe H, et al. National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis. *Lancet* 2011; 377 (9774): 1319–30; Intrapartum stillbirth rates for 2011, from Lawn JE, Blencowe H, et al. Stillbirths: Where? When? Why? How to make the data count? *Lancet* 2011; 377 (9775): 1448–63; Daily risk of neonatal death, updated from *State of the World's Mothers 2013* and in press *Lancet Global Health*, Oza S et al.; Number of stillbirths and intrapartum stillbirths updated to 2012 using live births and total births from UN Population Division.

[2] Source: WHO Global Health Observatory. Based on data from 2012.

[3] Source: Ibid. Based on data from 2010.

[4] Source: Ibid. Based on data from 2005–2012.

[5] Source: Ibid. Based on data from 2011.

* This is the figure reported in the WHO Global Health Observatory (2006 data). It should be noted that this differs from Multiple Indicator Cluster Survey (MICS) data for the same year which reports coverage of 33%. MICS data comes from household surveys, while WHO uses modelling for its estimates. Due to the country context, there are difficulties in collecting accurate representative data.

** Stillbirth and intrapartum stillbirth data are not available for South Sudan as these are based on 2009 data, before the country was formed.

ENDNOTES

EXECUTIVE SUMMARY

[1] United Nations Inter-agency Group for Child Mortality Estimation. *Levels and trends in child mortality: Report 2013*. New York, USA: UNICEF, 2013. http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf

[2] This is based on population growth in the least developed countries, which increased from 509,354,000 in 1990 to 878,097,000 in 2012. Reference: United Nations, Department of Economic and Social Affairs, Population Division. *World Population Prospects: The 2012 Revision*. New York: United Nations, 2013. http://esa.un.org/wpp/Documentation/publications.htm

[3] Intrapartum stillbirth rate is based on: Lawn JE et al, Stillbirths: Where? When? Why? How to make the data count? *Lancet*, Volume 377, Issue 9775, Pages 1448–63, 23 April 2011. Total number of intrapartum stillbirths is updated to 2012 using live births and total births from UN Pop Div latest estimates.

[4] Pattinson R, Kerber K, Buchmann E, et al. Stillbirths: how can health systems deliver for mothers and babies? *Lancet* 2011; 377: 1610–23.

[5] Calculated as the number of live births not attended by skilled health personnel. Skilled birth attendant coverage based on data from the WHO Global Health Observatory Data Repository: http://apps.who.int/gho/data/node.main (accessed 20 December 2013). Number of live births based on data from State of the World's Children statistics: http://www.unicef.org/sowc2013/statistics.html (accessed 20 December 2013).

[6] The Every Newborn Action Plan target is for a two-thirds reduction in the newborn mortality rate, which would result in a 2035 global NMR of 7 per 1,000 live births. This rate is similar to the highest NMR within the OECD countries and may be taken as a proxy for ending all preventable newborn deaths. If the target of 7/1000 had applied to the 2012 NMR (20.8/1000 which resulted in 2.9 million newborn deaths), approximately 2 million lives would have been saved.

1 A CRISIS – AND AN OPPORTUNITY

[7] See note 1.

[8] See note 2.

[9] United Nations Inter-agency Group for Child Mortality Estimation. *Levels and trends in child mortality: Report 2013*. New York, USA: UNICEF, 2013. http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf

[10] See note 3.

[11] Save the Children. *Surviving the first day: State of the World's Mothers 2013*. London, UK: Save the Children International, 2013. http://www.savethechildrenweb.org/SOWM-2013

[12] The four interventions are: corticosteroid injections for women with threatened preterm labour; resuscitation devices; chlorhexidine cord cleansing; and injectable antibiotics. Reference: Save the Children. *Surviving the first day: State of the World's Mothers 2013*. London, UK: Save the Children International, 2013. http://www.savethechildrenweb.org/SOWM-2013

[13] Stillbirth rate is based on: Cousens S, Blencowe H, Stanton C, et al. National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis. *Lancet* 2011; 377: 1319–30. Total number of stillbirths is updated to 2012 using live births and total births from UN Population Division latest estimates.

[14] Lawn JE et al, Stillbirths: Where? When? Why? How to make the data count? The Lancet, Volume 377, Issue 9775, Pages 1448–63, 23 April 2011.

[15] Countdown to 2015 for Maternal, Newborn, and Child Health is a collaboration of academics, governments, international agencies, health-care professional associations, donors, and nongovernmental organisations to promote accountability for MDGs 4 and 5. Save the Children is a member. See http://www.countdown2015mnch.org/

[16] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 20 December 2013).

[17] UNICEF. *Progress for children: achieving the MDGs with equity*. New York: UNICEF, 2010. http://www.unicef.org/protection/Progress_for_Children-No.9_EN_081710.pdf

[18] World Health Organization. *The world health report: health systems financing: the path to universal coverage*. Geneva: WHO, 2010. http://www.who.int/whr/2010/whr10_en.pdf

[19] Lassi ZS, Majeed A, Rashid S, Yakoob MY, Bhutta ZA. The interconnections between maternal and newborn health – evidence and implications for policy. *J Matern Fetal Neonatal Med*. 26(Suppl 1): 3–53.

[20] Whitaker K. Is Sierra Leone right to ban traditional birth attendants? *The Guardian*, 2012. http://www.theguardian.com/global-development/poverty-matters/2012/jan/17/traditional-birth-attendants-sierra-leone (accessed 17 January 2014).

2 HOW CAN NEWBORN DEATHS BE PREVENTED?

[21] Lawn JE, Lee AC, Kinney M, et al. Two million intrapartum-related stillbirths and neonatal deaths: where, why, and what can be done? *Int J Gynaecol Obstet* 2009; 107(Suppl 1): S5–18, S9.

[22] Lawn JE, Blencowe H, Pattinson R, et al. Stillbirths: Where? When? Why? How to make the data count? *Lancet* 2011; 377: 1448–63.

[23] *Every Newborn Bottleneck Analysis Tool*. 2013. http://www.everynewborn.org/Documents/Every-Newborn-BNA-tool-12-August-2013.docx (accessed 17 January 2014).

[24] The Partnership for Maternal, Newborn, and Child Health (PMNCH). *A global review of the key interventions related to reproductive, maternal, newborn and child health: essential interventions, commodities and guidelines*. Geneva: PMNCH, 2011. http://www.who.int/pmnch/topics/part_publications/essential_interventions_18_01_2012.pdf

[25] March of Dimes, PMNCH, Save the Children, WHO. *Born Too Soon: The Global Action Report on Preterm Birth*. Geneva: World Health Organization, 2012. http://www.marchofdimes.com/mission/global-preterm.aspx

[26] Coffey P, Kak L, Narayanan I, Bergeson L, Singhal N, Wall S, Johnson J, Schoen E. Case Study: Newborn Resuscitation Devices. United Nations Commission on Commodities for Women's and Children's Health, February 2012.

[27] Bhutta ZA, Yakoob MY, Lawn JE, et al. Stillbirths: what difference can we make and at what cost? *Lancet* 2011; 377: 1523–38.

[28] Yakoob MY, Ali MA, Ali MU, et al. The effect of providing skilled birth attendance and emergency obstetric care in preventing stillbirths. *BMC Public Health* 2011; 11 Suppl 3: S7.

[29] See note 5.

[30] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 20 December 2013).

[31] Number calculated from Demographic & Health Survey data and annual birth rates. Reference: Save the Children. *Missing Midwives*. London, UK: Save the Children, 2011. http://www.savethechildren.org.uk/sites/default/files/docs/Missing_Midwives_1.pdf

[32] Based on coverage data for 2005–2012. Reference: World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 10 January 2014).

[33] Universal coverage calculated at 95%.

[34] Barros AJ, Ronsmans C, Axelson H, et al. Equity in maternal, newborn, and child health interventions in Countdown to 2015: a retrospective review of survey data from 54 countries. *Lancet* 2012; 379: 1225–33.

[35] Based on 2011 data. World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 20 December 2013).

[36] UNICEF. *Delivery care*. http://www.childinfo.org/delivery_care.html (accessed 17 January 2014).

[37] Black RE, Victora CG, Walker SP, et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. *Lancet* 2013; 382: 427–51.

[38] UNICEF. *Current status: stunting*. http://www.childinfo.org/malnutrition_status.html (accessed 16 December 2013).

[39] Save the Children. *A life free from hunger: tackling child malnutrition*. London, UK: Save the Children, 2012. http://www.savethechildren.org.uk/sites/default/files/images/A_Life_Free_From_Hunger.pdf

[40] Prost A, Colbourn T, Seward N, et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *Lancet* 2013; 381: 1736–1746.

[41] World Health Organization. *Adolescent pregnancy*. http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/ (accessed 17 January 2014).

[42] Campbell J, Dussault G, Buchan J, et al. *A universal truth: no health without a workforce*. Recife, Brazil and Geneva: Global Health Workforce Alliance and World Health Organization, 2013. http://www.who.int/workforcealliance/knowledge/resources/GHWA_AUniversalTruthReport.pdf

[43] World Health Organization. *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*. Geneva: WHO, 2010. http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf

[44] Save the Children. *No child out of reach: time to end the health worker crisis*. London, UK: Save the Children, 2011. https://www.savethechildren.org.uk/sites/default/files/docs/No_Child_Out_of_Reach_1.pdf

[45] UNICEF. 'Protecting Salaries of Frontline Teachers and Health Workers'. *UNICEF Policy and Practice: Social and economic policy working briefs*. New York: UNICEF, 2010. http://www.unicef.org/socialpolicy/files/Protecting_Salaries_of_Frontline_Teachers_and_Healthcare_Workers_final(1).pdf

[46] Joint Learning Initiative. *Human Resources for Health: Overcoming the crisis*. Washington, DC: The President and Fellows of Harvard College, 2004. http://www.who.int/hrh/documents/JLi_hrh_report.pdf

[47] Shaikh S, Shaikh AH, Shaikh SAH, et al, Frequency of obstructed labor in teenage pregnancy. *NJOG*, 2012, (3): 37–40.

[48] Cleland J, Conde-Agudelo A, Peterson H, et al. Contraception and health. *Lancet* 2012; 380: 149–56.

3 MEETING THE CHALLENGE

[49] Walker N, Yenokyan G, Friberg IK, Bryce J. Patterns in coverage of maternal, newborn, and child health interventions: projections of neonatal and under-5 mortality to 2035. *Lancet* 2013; 382: 1029–38.

[50] See note 6.

[51] Moreno-Serra R, Smith PC. Does progress towards universal health coverage improve population health? *Lancet* 2012; 380: 917–23.

[52] Azerbaijan, Bangladesh, Benin, Bolivia, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, India, Indonesia, Kenya, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Nepal, Niger, Nigeria, Pakistan, Peru, Philippines, Rwanda, Senegal, Sierra Leone, Swaziland, Tajikistan, Togo, Uganda, United Republic of Tanzania, Yemen, Zambia, Zimbabwe.

[53] This LiST analysis was conducted for RMNCH interventions to analyse the impact of various population groups. For this report, we have focused on the impact on newborn lives saved. The major assumptions made include: that the national coverage is scaled up to its target coverage of the highest wealth quintile linearly in their period of 2013 to 2015; that interventions coverage did not change between the estimates abstracted from the most recent DHS/MICS and our base year of analysis of 2013.

[54] Save the Children. *Getting to Zero: How we can be the generation that ends poverty*. London, UK: Save the Children, 2013. https://www.savethechildren.org.uk/sites/default/files/images/Getting_to_Zero.pdf

[55] Save the Children. *Missing Midwives*. London, UK: Save the Children, 2011. http://www.savethechildren.org.uk/sites/default/files/docs/Missing_Midwives_1.pdf

[56] Save the Children has a partnership with GSK and is a recipient of funding donations.

[57] Marmot M. Universal health coverage and social determinants of health. Lancet 2013; 382: 1227–8.

[58] African Union Commission. *Nutrition and Reproductive, Maternal, Newborn and Child Health*: Policy brief. Johannesburg: African Union, 2013. http://www.who.int/pmnch/media/events/2013/au_policy_brief_nutrition.pdf

[59] See http://www.healthynewbornnetwork.org

[60] Brearley L, Marten R, O'Connell T. *Universal Health Coverage: A commitment to closing the gap*. Geneva, London, New York: WHO, Save the Children, UNICEF, Rockefeller Foundation, 2013. http://www.rockefellerfoundation.org/uploads/files/57e8a407-b2fc-4a68-95db-b6da680d8b1f.pdf

[61] Amouzou A, Habi O, Bensaid K, Niger Countdown Case Study Working G. Reduction in child mortality in Niger: a Countdown to 2015 country case study. *Lancet* 2012; 380: 1169–78.

[62] Jim Yong Kim. Speech to the World Health Assembly, 21 May 2013. http://www.worldbank.org/en/news/speech/2013/05/21/world-bank-group-president-jim-yong-kim-speech-at-world-health-assembly (accessed 16 November 2013).

[63] Yates R. Women and children first: an appropriate first step towards universal coverage', *WHO Bulletin* 2010; 88:474–75.

[64] World Bank. *Global conference on universal health coverage for inclusive and sustainable growth: a global synthesis report*. Washington, DC: World Bank, 2013.

[65] Save the Children has a partnership with RB and is a recipient of funding donations.

[66] World Health Organization. *The world health report: health systems financing: the path to universal coverage*. Geneva: WHO, 2010. http://www.who.int/whr/2010/whr10_en.pdf

[67] Ibid.

[68] Stenberg K, Axelson H, Sheehan P, et al. Advancing social and economic development by investing in women's and children's health:

a new Global Investment Framework. *Lancet* 19 November 2013, early online publication.

[69] United Nations Development Programme. *What will it take to achieve the Millennium Development Goals? An international assessment*. New York: UNDP, 2010. http://content.undp.org/go/cms-service/stream/asset/?asset_id=2620072

[70] O'Hare B, Makuta I, Bar-Zeev N, Chiwaula L, Cobham A. The effect of illicit financial flows on time to reach the fourth Millennium Development Goal in Sub-Saharan Africa: a quantitative analysis. *J R Soc Med* 2013.

[71] See http://www.internationalhealthpartnership.net/en/

[72] International Health Partnership. *IHP+ Global Compact*. http://www.internationalhealthpartnership.net/en/tools/global-compact/ (accessed 17 January 2014).

[73] World Bank. *Global conference on universal health coverage for inclusive and sustainable growth: a global synthesis report*. Washington, DC: World Bank, 2013.

4 COUNTRY CASE STUDIES

[74] Based on 2011 data. Reference: World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 9 December 2013).

[75] Based on 2012 data.

[76] Lane R. Mushtaque Chowdhury: seeking health transition in Bangladesh. *Lancet* 2013; 382:1695.

[77] Based on 2011 data. World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 9 December 2013)

[78] Ibid.

[80] Santos I, Sharif I, Rahman HZ, et al. *How do the poor cope with shocks in Bangladesh? Evidence from survey data*. Policy Research Working Paper 5810. Washington DC: World Bank, 2011. http://elibrary.worldbank.org/doi/pdf/10.1596/1813-9450-5810

[81] Bangladesh Health Watch. *Bangladesh health watch report 2011: moving towards universal health coverage*. Dhaka: BRAC, 2012. http://hpnconsortium.org/admin/essential/BHW_Report_20111.pdf

[82] Das S and Horton R. Bangladesh: innovating for health. *Lancet* 2013; 382:1681–82. Rubayet S, Shahidullah M, Hossain A, et al. Newborn survival in Bangladesh: a decade of change and future implications. *Health policy and planning* 2012; 27 Suppl 3: iii40–56.

[83] Based on 2012 data. Reference: World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 9 December 2013).

[84] The average utilisation rate of health care services is approximately 0.21 consultations per person per year compared to the expected norm of 1 per person per annum. DRC Ministry of Health and the World Bank. *Revue des Dépenses Publiques*. 2007. Cited in: see note 87.

[85] Based on per capita total expenditure on health (PPP int. $) in 2011. Reference: World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 9 December 2013).

[86] Per capita government expenditure on health (PPP int. $) was $10.8 in 2011. Reference: Ibid.

[87] DFID. *Business Case and Intervention Summary: Access to Health Care in the Democratic Republic of Congo*. http://iati.dfid.gov.uk/iati_documents/3833337.DOC. http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&cad=rja&ved=0CDIQFjAB&url=http%3A%2F%2Fiati.dfid.gov.uk%2Fiati_documents%2F3833337.DOC&ei=0MzvUrbaE4PD7AaH94CQAQ&usg=AFQjCNFAPUFiJLs41tM-_92e6kcQ2nIhrA&sig2=_fwMIbW7XVj4ar5eXLIRbQ

[88] Ibid.

[89] Stratégie pour le Renforcement du Système Santé (Strategy to Strengthen the Health System).

[90] See note 87.

[91] United Nations Inter-agency Group for Child Mortality Estimation. *Levels and trends in child mortality: Report 2013*. New York, USA: UNICEF, 2013. http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf

[92] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 9 December 2013).

[93] World Bank. *Global conference on universal health coverage for inclusive and sustainable growth: a global synthesis report*. Washington, DC: World Bank, 2013.

[94] UNICEF. *Ethiopia meets MDG 4 by cutting under 5 mortality by two-thirds since 1990*. 13 September 2013. http://www.unicef.org/ethiopia/events_13459.html (accessed 17 January 2014).

[95] Based on coverage of three doses of diphtheria-pertussis-tetanus (DPT3) vaccine. Reference: Central Statistical Agency [Ethiopia], ICF International. *Ethiopia Demographic and Health Survey 2011*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International, 2012.

[96] Based on 2011 data. World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 9 December 2013).

[97] Oxfam. *Oxfam Ghana annual report 2012–2013*. Accra: Oxfam, 2013. http://www.oxfamblogs.org/westafrica/wp-content/uploads/2013/09/2012-2013-Oxfam-Final-Annual-Report-ghana.pdf

[98] This is despite actually contributing to the system through value added tax.

[99] Oxfam. *Oxfam Ghana annual report 2012–2013*. Accra: Oxfam, 2013. http://www.oxfamblogs.org/westafrica/wp-content/uploads/2013/09/2012-2013-Oxfam-Final-Annual-Report-ghana.pdf

[100] Ibid.

[101] Penfold S, Harrison E, Bell J, Fitzmaurice A. Evaluation of the delivery fee exemption policy in Ghana: population estimates of changes in delivery service utilization in two regions. *Ghana Med J* 2007; 41(3): 100–9.

[102] Based on 2008 data. Source: WHO Global Health Observatory.

[103] Based on coverage of three doses of diphtheria-pertussis-tetanus (DPT3) vaccine. DTP3 coverage is nearly 90% amongst the poorest children, compared to 93% amongst the richest. National figures are based on 2012 data while equity data is based on 2008 data. Source: WHO Global Health Observatory.

[104] WHO Global Health Observatory data repository.

[105] The under-five mortality rate amongst the poorest households is 117 versus 39 amongst the richest, based on 2005 data. Reference: Ibid.

[106] WHO Global Health Observatory data repository.

[107] Based on 2009 data. Reference: Ibid.

[108] Based on 2005 data. Reference: Ibid.

[109] The programme covers all children aged 0–6 in rural areas and urban slums, as well as older children up to 18 years of age enrolled in Government and Government aided schools. Reference: Ministry of Health & Family Welfare. *Rashtriya Bal Swasthya Karyakram (RBSK): Child Health Screening and Early Intervention Services under NRHM*. New Dehli: Government of India, 2013. http://www.unicef.org/india/7._Rastriya_Bal_Swaasthya_karyakaram.pdf

[110] Services are free in Government health institutions in both rural & urban areas. Reference: National Health Mission. *A brief note on Janani Shishu Suraksha Karyakram, the new initiative of Ministry of Health and Family Welfare*. http://nrhm.gov.in/index.php?option=com_content&view=article&id=79&Itemid=194 (accessed 17 January 2014).

[111] The Rashtriya Swasthya Bima Yojana (RSBY) is a national-level scheme introduced in 2008; while state-level schemes include, eg, Rajiv Aarogyasri scheme in Andhra Pradesh and Yeshwaswini scheme in Karnataka, Kalinga scheme in Tamil Nadu. Reference: Nagpal S. *Expanding Health Coverage for Vulnerable Groups in India*. UNICO Studies Series 13. Washington DC: World Bank, 2013.

[112] Ibid.

[113] MOH, *Public Expenditure Tracking Survey 2007*. 2007, Government of Kenya: Nairobi.

[114] Ramana GNV. *Improving universal primary health care by Kenya: a case study of the Health Sector Services Fund*. Washington DC: World Bank, 2013, http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/02/04/000425962_20130204110301/Ren/PDF/750020NWP0Box30ry0Health0Care0KENYA.pdf

[115] Now known as the Essential Package of Health Services (EPHS).

[116] Lievens T, Witter S. *Community health financing: which role in health financing in Liberia*. Oxford: Oxford Policy Management, 2011. http://www.mohsw.gov.lr/documents/Community%20Health%20financing%20Pre%20feasibilith%20study%20OPM.pdf

[117] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 9 December 2013).

[118] Based on 2007 data. Reference: Ibid.

[119] Republic of Liberia, Ministry of Health and Social Welfare, 2012. Annual Review Report National Health and Social Welfare Plan Implementation, 2011–2012.

[120] Pradhan YV, Upreti SR, Pratap KCN, et al. Newborn survival in Nepal: a decade of change and future implications. *Health Policy and Planning* 2012; 27 Suppl 3: iii57–71.

[121] United Nations Inter-agency Group for Child Mortality Estimation. *Levels and trends in child mortality: Report 2013*. New York, USA: UNICEF, 2013. http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf

[122] Government of Nepal. *National Health Insurance Policy 2013*. http://www.who.int/providingforhealth/countries/2013_03_Nepal_Health_Insurance_Policy_fin.pdf

[123] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 17 January 2014).

[124] Ibid.

[125] Government of Nepal. *National Health Insurance Policy 2013*. http://www.who.int/providingforhealth/countries/2013_03_Nepal_Health_Insurance_Policy_fin.pdf

[126] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 17 January 2014).

[127] Government of Nepal. *National Health Insurance Policy 2013*. http://www.who.int/providingforhealth/countries/2013_03_Nepal_Health_Insurance_Policy_fin.pdf

[128] Ibid.

[129] Based on 2011 data. World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 17 January 2014).

[130] Ibid, based on 2008 data.

[131] National Population Commission. *Nigeria Demographic and Health Survey 2013: Preliminary Report*. Abuja: National Population Commission, 2013. http://www.measuredhs.com/pubs/pdf/PR41/PR41.pdf

[132] Gustafsson-Wright E and Schellekens O. *Achieving universal health coverage in Nigeria one state at a time: a public-private partnership community-based health insurance model*. Brooke Shearer Working Paper Series. Washington DC: Brookings Institution, 2013. http://www.brookings.edu/research/papers/2013/06/achieving-universal-health-coverage-nigeria-gustafsson-wright

[133] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 17 January 2014).

[134] Ibid.

[135] Coverage is 77% in the richest households, compared to 16% in the poorest, based on 2006 data. Source: World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 17 January 2014).

[136] Cousens S, Blencowe H, Stanton C, et al. National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis. *Lancet* 2011; 377: 1319–30.

[137] Global Health Workforce Alliance. *Country Case Study: Pakistan's Lady Health Worker Programme*. Geneva: World Health Organization, GHWA, 2008. http://www.who.int/workforcealliance/knowledge/case_studies/CS_Pakistan_web_en.pdf

[138] Hafeez, A, Mohamud, BK, Shiekh, MR, Shah, SAI and Jooma, R. Lady health workers programme in Pakistan: challenges, achievements and the way forward. *J Pak Med Assoc*, 2011, 61(3): 210-215.

[139] Khan A. Lady Health Workers and Social Change in Pakistan. *Economic & Political Weekly* 2011; xlvi: 30.

[140] Wazir MS, Shaikh BT, Ahmed A. National program for family planning and primary health care Pakistan: a SWOT analysis. *Reprod Health* 2013; 10(1): 60. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3842797/

[141] Technical Resource Facility. *Pakistan national maternal and child health programme: mid-term evaluation*. Islamabad: Technical Resource Facility, 2013. http://www.trfpakistan.org/LinkClick.aspx?fileticket=wrJZXuQPXJI%3D&tabid=2440

[142] Lu C, Chin B, Lewandowski JL, et al. Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in its First Eight Years. *PloS One* 2012; 7(6): e39282.

[143] Makaka A, Breen S, Binagwaho A. Universal health coverage in Rwanda: a report of innovations to increase enrolment in community-based health insurance. *Lancet* 2012, New Voices in Global Health. http://download.thelancet.com/flatcontentassets/pdfs/new-voices/newvoices2012-11.pdf

[144] Lu C, Chin B, Lewandowski JL, et al. Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in its First Eight Years. *PloS One* 2012; 7(6): e39282.

[145] Ibid.

[146] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 17 January 2014).

[147] Based on 2010 data. Reference: Ibid.

[148] Ibid.

[149] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 9 December 2013).

[150] The benefit package includes inpatient, outpatient and community care, and covers a wide range of services from antiretrovirals to coronary bypass surgery. The few exceptions to free access include: family planning commodities; some private-paying wards in a small number of government hospitals; and one tertiary care hospital that was constructed with donor funds and stipulates the charging of user fees.

[151] Department of Census and Statistics and Ministry of Healthcare and Nutrition. *Sri Lanka Demographic and Health Survey 2006–07*. Colombo: Department of Census and Statistics, 2009. http://www.statistics.gov.lk/social/DHS%20200607%20FinalReport.pdf

[152] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 9 December 2013).

[153] Rannan-Eliya RP, Sikurajapathy L. *Sri Lanka: "good practice" in expanding health care coverage*. Colombo: Institute for Health Policy, 2008.

[154] While the technical quality of services is similar in both the public and private sector, patients may opt for private care due to better amenities, less crowded facilities, shorter queues, more convenient opening times, etc.

[155] Between 1995 and 2006, the average annual rate reduction in under-five mortality was 1.2%; between 2006 and 2011 this increased to 8.1%, increasing the annual rate of progress by a factor of seven. Reference: The Republic of Uganda, Ministry of Finance, Planning and Economic Development. 2013. *Millennium Development Goals Report for Uganda 2013*. Kampala, Uganda: The Republic of Uganda.

[156] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 17 January 2014).

[157] Based on 2011 data. Reference: Uganda Bureau of Statistics and ICF International Inc. 2012. *Uganda Demographic and Health Survey 2011*. Kampala, Uganda: UBOS and Calverton, Maryland: ICF International Inc.

[158] Ibid.

[159] Orem JN, Mugisha F, Kirunga C, Macq J, Criel B. Abolition of user fees: the Uganda paradox. *Health Policy and Planning* 2011; 26: ii41–ii51.

[160] Ministry of Health. *Health Sector Strategic and Investment Plan: Promoting people's health to enhance socio-economic development, 2010/11–2014/15*. Kampala: Government of Uganda, 2010. http://www.health.go.ug/docs/HSSP_III_2010.pdf

[161] World Health Organization. Global Health Observatory Data Repository. http://apps.who.int/gho/data/node.main (accessed 17 January 2014).

[162] Orem JN, Mugisha F, Kirunga C, Macq J, Criel B. Abolition of user fees: the Uganda paradox. *Health Policy and Planning* 2011; 26: ii41–ii51.

[163] Pariyo G, Ekirapa-Kiracho E, Okui O, et al. Changes in utilization of health services among poor and rural residents in Uganda: are reforms benefitting the poor? *Int J Equity Health* 2009: 8: 39.

[164] Despite political commitment, development of NHIS has been slow and incremental. It has been in the works for several years and was expected to start in the 2012/13 financial year. However, after encountering problems the hope is now for it to be passed into law and become operational in 2014. Reference: Basaza RK, O'Connell TS, Chapcakova I. Players and processes behind the national health insurance scheme: a case study of Uganda. *BMC Health Serv Res* 2013; 13: 357.

[165] Orem JN, Zikusooka CM. Health financing reform in Uganda: How equitable is the proposed National Health Insurance scheme? *International Journal for Equity in Health* 2010; 9: 23.

ENDING NEWBORN DEATHS

Ensuring every baby survives

In 2012, 2.9 million newborn babies died within 28 days. Of these, 1 million babies died on their first – and only – day of life.

Unless we urgently start to tackle deaths among newborn babies, there is a real danger that progress in reducing child deaths will stall, and we will fail in our ambition to be the generation that can end all preventable child deaths.

But, as *Ending Newborn Deaths* reveals, the crisis is even bigger. In 2012 there were 1.2 million stillbirths where the heart stopped beating during labour.

This report sets out an agenda to tackle the crisis and identifies the essential interventions around birth that a properly skilled midwife or other trained health worker can deliver to save newborn lives and prevent stillbirths during labour. However, access to these services is deeply unequal and, globally in 2102, 40 million women – the poorest and most marginalised – gave birth without a trained health worker present.

To end all preventable newborn deaths and stillbirths during labour, there needs to be universal access to properly trained and equipped health workers at birth. This report sets out the reforms needed to achieve universal health coverage for the poorest and hardest-to-reach communities.

2014 offers an unprecedented opportunity to tackle the crisis, with countries and global institutions set to agree the Every Newborn Action Plan. In *Ending Newborn Deaths*, Save the Children calls on governments, world leaders, philanthropists and the private sector to make that opportunity count and to commit to the five-point Newborn Promise to end all preventable newborn deaths.

COVER PHOTO: LYNSEY ADDARIO/SAVE THE CHILDREN

everyone.org

Save the Children