Innovative finance for women and children

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Eight ambitious Millennium Development Goals (MDGs) were set at the UN in 2000.[1] Three are specifically related to health: number 4 to child health, number 5 to maternal health, and number 6 to HIV/AIDS, malaria, and tuberculosis. As a result of unprecedented global commitments and funding for infectious diseases and vaccinations, some countries are making good progress—particularly in reducing deaths from HIV/AIDS, malaria, tuberculosis, and vaccine-preventable diseases.[2] The Global Fund against AIDS, Tuberculosis and Malaria, the GAVI Alliance, and PEPFAR (US President's Emergency Plan for AIDS Relief) represent new ways of providing aid to obtain results. Additionally, a range of innovative financing mechanisms are being developed to attract, channel, and use additional resources in new ways.

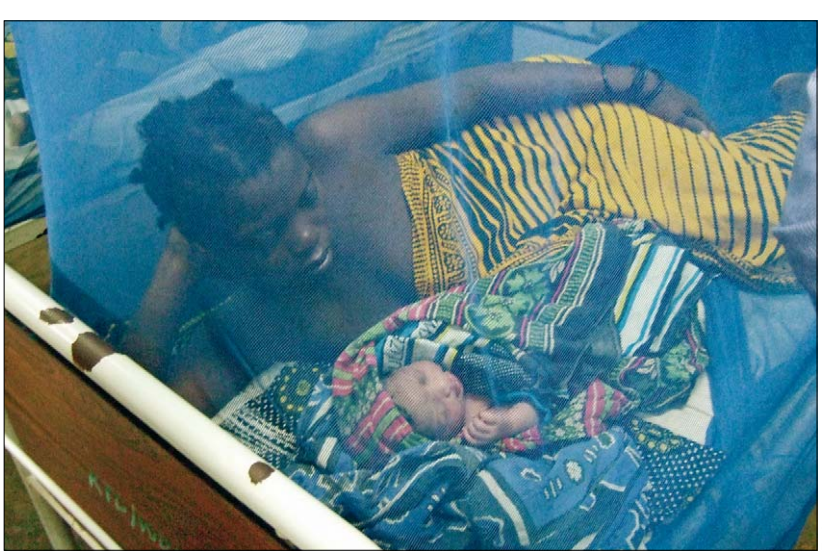
However, for the maternal, neonatal, and child goals embodied in MDGs 4 and 5, the picture is very different. Global progress is very uneven. Although many countries have made great strides over the past decade, over 85% of current maternal deaths continue to occur in sub-Saharan Africa and south Asia.[3] Efforts to reduce fertility rates and improve other aspects of sexual and reproductive health are being made in these regions. At the start of the millennium the world was bold—not only to provide more funding but also to be innovative and take risks. It paid off. Now we must mobilise the same global commitment and spirit of innovation to improve the health of mothers and children.

Millions of mothers continue to die from the same causes identified by WHO 20 years ago—ie, haemorrhage, infection, anaemia, and obstructed labour. Unsafe deliveries result in a double tragedy, killing both mothers and their newborn babies. They can be prevented with antenatal care and if women give birth in clean and effective health facilities. We urgently need to tackle the financial, physical, and cultural barriers that restrict these efforts so that women can demand, and be assured of, the safe delivery of their babies. What will this take?

First, more money is needed—in the order of US$2–7 billion per year over the next 7 years. Countries can make real progress toward MDG 5 and contribute to MDG 4 if they scale up deliveries in good-quality health facilities to 95% by 2015. The cost of doing this in the 51 poorest, high-priority countries, while also strengthening their health systems, is $2 billion in 2009, increasing up to $7 billion per year by 2015.[2] This approach includes, for example, ramping up the capacity to assure quality deliveries with an additional 1 million trained midwives, nurses, and doctors.[2]

Second, we need to use that money in new and more effective ways that address the identified gaps, strengthen health systems, and promote innovative results-based financing. This can foster local leadership and remove obstacles to good-quality health care. For example, we need to provide financial support to poor women so they can overcome the hidden costs of care—paying for transport to the facility, buying food while they are away from home, and paying for medicines or services that may not be free. We also need to pay performance incentives to health workers in health facilities—public, private, and those run by non-governmental organisations—to provide good-quality services to poor people. Innovative ways of using funds can lead to substantial changes in a short time.

In India, a programme that pays for mothers to deliver their babies in health facilities has led to a ten-fold increase in beneficiaries (from 700 000 beneficiaries in 2005–06), and is reportedly having a significant effect on increasing institutional deliveries among poor women.[4] In Gujarat, contracting with private obstetricians to provide services to poor women resulted in a major increase in obstetrician-assisted deliveries in just 2 years.[5] The introduction of results-based financing in Rwanda has contributed



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to an increase in birth deliveries in facilities from 39% to 52% over a 3-year period, and a 30% reduction in child mortality (from 152 per 1000 to 103 per 1000 livebirths).[6,7]

Governments and development partners must make room for innovation and focus on results rather than inputs. Results-based financing opens the door to addressing barriers to improved performance in decentralised national health services. During the past year, support to do much more on MDGs 4 and 5 has grown considerably.[2] The goals were a prime focus of the G8 Heads of Government meeting in the summer,[8] and the International Health Partnership[9] is building collaboration among key stakeholders in this area. Global funding plays a key catalytic role in fostering innovation and spurring progress, but more is needed. We need to develop the most effective channels for that funding and use it to deliver results on the ground.

Let us be as bold as the world was at the start of this millennium. Let us build on that same spirit of urgency and collaboration, and galvanise international action on innovative financing for health and MDG 4 and 5. Let us have an advanced proposal by the Doha Development Financing Conference[10] in late November and conclude next year. Only then will pregnancy and childbirth bring joy, not fear, to the lives of so many mothers in the developing world. We each commit to play our part to ensure a successful and rapid outcome. A child dies every 3 seconds, a mother every minute. We have no time to lose.

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We declare that we have no conflict of interest.

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Community-based newborn care: are we there yet?

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Achieving the Millennium Development Goal of reducing child mortality by two-thirds by 2015 will not be possible without targeting the 4 million deaths of newborn babies every year.[1] Most deaths of newborn babies occur at home, among poor people, and are associated with inadequate maternal health care during pregnancy and childbirth. Although lack of skilled birth attendants is a large part of the problem, maternal and newborn health is also related to complex issues, such as maternal empowerment, sociocultural taboos, and care-seeking practices and behaviours during pregnancy and child-birth.[2] Progress is also hampered by the limited repertoire of interventions for treating birth asphyxia, prematurity, and serious neonatal infections in community settings.[3] Despite a fair amount of advocacy around maternal and newborn care, real progress on the ground remains slow.[4]

Notwithstanding these barriers and limitations, the evidence base for strategies and interventions for newborn care in community settings has substantially improved, with a range of interventions that can be potentially packaged for delivery at different times during pregnancy, childbirth, and after birth, through various health-care providers.[5,6] More recently, efficacy trials in representative rural settings have added to the evidence base. Such studies used innovative approaches with community health workers (CHWs) and varied preventive and treatment interventions. In an intensive landmark study in rural Maharashtra, India,[7] CHWs were trained to resuscitate asphyxiated infants, manage infants with