Hidden deaths of the world's newborn babies

WHO

Joy Lawn

Joy Lawn is an African-born paediatrician and perinatal epidemiologist with British citizenship. She is based in South Africa as Senior Research and Policy Advisor with the Saving Newborn Lives programme of Save the Children-USA. She completed her medical degree in 1990 in the United Kingdom and has worked in several African countries providing newborn care services and training. She shifted to public health working at the WHO Collaborating Centre in Reproductive Health at the Centers for Disease Control and Prevention, Atlanta, United States of America (1998–2001), and then at the Institute of Child Health, in the United Kingdom (2001–2004). She co-led the Neonatal Group in the Child Health Epidemiology Reference Group (CHERG), which developed the first estimate of annual global neonatal deaths, published in the *Lancet* neonatal series and the *World health report* 2005.

Improving newborn survival rates takes more than money, says Joy Lawn. But how do you get disparate partners, countries and donors working together effectively?

Q: You and your colleagues produced the Lancet *neonatal series in 2005 helping to put 4 million annual newborn deaths on the global agenda. Why were these deaths previously invisible?*

A: Despite the huge numbers, newborn deaths were and to some extent still are invisible at many levels. This starts in the homes of the poor where most of these deaths occur and goes right up to the corridors of power. More than two-thirds of these 4 million newborns die in sub-Saharan Africa and south Asia, often in the first days of life, without a name let alone a birth certificate. There have been initiatives such as the Safe Motherhood Initiative, which was most concerned for the mother, while the child survival campaign was primarily for the older child. The newborn has fallen between the cracks. However, if all partners worked together effectively, if roles were clear and services were integrated, this would not be the case.

Q: Neonatal mortality was a neglected issue until 2005. How has this changed and how do you respond to criticism of some of the initiatives?

A: When the Millennium Development Goals (MDGs) were launched in 2000 almost no global attention was paid to newborns. As countries and partners began to track MDG progress for child survival the high and increasing proportion of under-five deaths in the neonatal period (globally now at almost 40%) raised a flag. At the same time several publications highlighted the huge numbers of deaths, but also the solutions that could save babies' lives. We have growing evidence of how many lives can be saved at the community level (through breastfeeding, warmth, cleanliness) and with simple, low-tech care in facilities. Newborn survival has moved up the global agenda partly because of better communication – between maternal and child health programmes, countries and donors, and various groups of health professionals. Partnerships such as the Healthy Newborn Partnership, now merged in the [WHO-hosted] Partnership for Maternal Newborn & Child Health, provide a forum for consensus building and enable joint action instead of duplication. Policy and programme change are more likely if there is one clear message rather than a cacophony of calls to action. In the past three years, there has been a global shift to integrated maternal, newborn and child health and this holds potential to speed up progress for all the health MDGs, and especially for newborn survival.

Q: How long does it usually take for global policy changes to permeate to action at community level?

A: The time taken varies hugely but there are examples of sudden change especially when governments prioritize a problem, there is a do-able solution and United Nations agencies and donors pull in the same direction. For example, neonatal tetanus still killed over 200 000 babies a year in 2000 despite a very do-able solution, an injection during pregnancy costing only US$ 0.20. With new funds and coordinated efforts, many more women have been reached, even in the poorest districts. The world is moving towards elimination of neonatal tetanus after missing the goal in 2000 when commitment and funds were lacking. In 2005, very few countries included newborn care in their Integrated Management for Childhood Illness (IMCI) programmes, but now more than half of the MDG Countdown Priority countries have changed their policy to add newborn case management. But policy change alone does not save lives – and nor do process changes such as new drugs or new training programmes. These changes have to reach high population coverage.

Q: Have the child and maternal health-related mortality MDGs become a stick with which to beat African countries that are not on track to meet the 2015 targets?

A: To Africans it shows the world's ongoing perception of Africa as one entity – these countries are not all the same. There are some that are on track for several if not all the MDGs, for example Mauritius. In the last few years we have seen several African countries report reductions in child mortality of 25–30%, for example Madagascar, Malawi, Mozambique and the United Republic of Tanzania. Africa starts with an unfair disadvantage. If you have 11% of the world's population but you carry the burden of 50% of child and maternal deaths, probably 95% of the HIV, more than 95% of the malaria, combined with the poorest countries, then you have to run faster. The responsibility for the MDGs is a collective one. The Group of Eight (G8) countries has committed to 0.7% of gross domestic product for development aid and there are health targets attached which very few donor countries meet.

Q: Under-five child mortality must be reduced by two thirds by 2015 to meet MDG 4. Was this target unrealistic when it was set?

A: It wasn't a deliberately unrealistic goal although, in retrospect, it was highly aspirational. From 1960 to 1990 there was wonderful progress in child survival. The goal was based on the trend observed up until then, but no one could have predicted the massive increase of HIV, particularly in southern Africa. In addition, during the 1990s many African countries also suffered through structural readjustment plans that reduced health funding and at the same time donor funding was reduced especially for regular maternal and child health programmes, even for immunization.

Q: Setting targets is a favoured public health communications strategy. But doesn't it result in failure if targets are not met?

A: If you don't set targets nothing happens. If it wasn't for a very strong MDG framework there would be a lot more dissonance among donors and there would be a lot less political will to bring change in many governments. Many African governments are very committed to the MDGs.

Q: What is necessary to bring about the integration of the policies and services and develop an understanding at community level that people have a right to good care?

A: Policy must be owned by national governments, but when it comes down to providing services you need communities to be on board. There are countries in Africa where people live close to health facilities but they give birth at home. There has to be a feeling of trust and respect and an understanding of the benefits available, as well as removing practical barriers such as catastrophic costs for emergency caesarean sections.

Q: This month South Africa is hosting the second Countdown to 2015. What do you expect to come out of this conference?

A: The Countdown tracks progress [on the MDGs] in 68 priority countries, with a focus on the population coverage of a set of selected interventions – those most likely to save the lives of women, babies and children. There is great news for immunization and malaria coverage. Investment in these programmes has gone up and the results are there. But we need investment to go up more for maternal and newborn interventions and also for the care of sick children.

Q: Overseas donor aid for vertical programmes such as immunization, malarial bednets and HIV increased dramatically over the past two years – for example 200% for malaria bednets. Is extra money the only answer to child and maternal mortality?

A: It's not just about more money, it is also about where the money goes and how this affects the health system. You can't drop extra antenatal interventions on antenatal care if the system is already overloaded. You also need to invest in the vehicle, and this is starting to happen. There is a paradigm shift at the GAVI Alliance [formerly known as the Global Alliance for Vaccines and Immunisation] which has funnelled billions into immunization. They now have a health system strengthening fund that is starting to invest considerable amount of money. Ethiopia was the first country to benefit from this. New initiatives such as the International Health Partnership hold hope for such progress. The message to the upcoming G8 summit in Japan is that maternal newborn and child mortality are the litmus test of a functioning health system. A consistent focus to strengthen health systems will reduce those deaths.

Q: One aspect of the debate on global warming is population control. Shouldn't the focus be more on birth control than saving lives?

A: Use of modern contraceptives is one of the most cost-effective ways to reduce the numbers of maternal and child deaths. But the birth rate is also connected to education and gender equality. Bangladesh, for example, has had a big drop in maternal mortality and under-five mortality despite having a low number of skilled attendants. This may be explained by increased maternal literacy and a big rise in the use of contraceptives. ■

Recent news from WHO

- More than 1.27 million people have been vaccinated against yellow fever in Paraguay, after an outbreak that has so far claimed six lives, it was reported on 7 March. They were the first cases of the mosquito-borne disease in a Latin American urban area in 60 years.
- On 6 March, the first Global Forum on Human Resources for Health called for immediate action to resolve the critical global shortage of some 4 million health workers. WHO estimates that 57 countries have an acute shortage with sub-Saharan Africa alone requiring an additional 1 million health workers.
- Multidrug-resistant tuberculosis (MDR–TB) has reached the highest recorded level so far. There are half a million new cases of MDR–TB annually, about 5% of the estimated 9 million new TB cases worldwide. WHO's report, released on 26 February, was based on a survey of 90 000 patients in 81 countries from 2002 to 2006. Surveys in Latvia and Ukraine found nearly twice the level of MDR–TB among TB patients living with HIV compared with TB patients without HIV.
- WHO has published the third edition of the *International Medical Guide for Ships* on behalf of the International Maritime Organization and the International Labour Organization. The new edition is consistent with both the WHO Model List of Essential Medicines and the International Health Regulations.

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