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The Partnership for Maternal, Newborn & Child Health

Reaching every woman and child through Universal Health Coverage

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.

The Partnership for Maternal, Newborn & Child Health (PMNCH) is an alliance of more than 700 organisations in 77 countries from the sexual, reproductive, maternal, newborn, child and adolescent health communities. Its membership represents eight constituency groups: academic, research and training institutions; adolescents and youth; donors and foundations; health care professional associations; multilateral organisations; non-governmental organisations; partner countries; and the private sector.

Acknowledgements

This report was written by Giorgiana Rosa and Simon Wright from Save the Children, with support from Dimitri Gugushvili. The country spotlights were produced with the input and collaboration of Save the Children colleagues Tatak Ujiyati and Patricia Norimarna (Indonesia), David Olayemi and Oluseyi Abejide (Nigeria) and Adem Alo (Ethiopia). We are grateful to colleagues from across Save the Children for their comments and suggestions, in particular Luisa Hanna, Mihir Mankad, Sarah Williams, Jawara Saidykhan, Marie Rumsby, Ravi Wickremasinghe, Sue Macpherson, Thiago Luchesi, Monica Sydgård, Kjersti Koffeld, Katri Bertram and Julia Schilling.

We would also like to thank external reviewers for their very helpful comments and input to an earlier draft of the report, especially Lara Brearley (PMNCH), Alison Marshall (IPPF), Rob Yates (Chatham House), Catherine Goode, Katherine Porter and Tim Thomas (The Bill & Melinda Gates Foundation).

Published by
Save the Children
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First published 2016

Cover photo: Midwife Catherine Ojo holds baby Samson at a hospital clinic in Zaria, Nigeria. (Photo: Jane Hahn/Panos for Save the Children)

Typeset by Grasshopper Design Company

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Foreword

We are at an exciting moment for women's, adolescents' and children's health. The Sustainable Development Goals have set an ambitious agenda to end all preventable maternal, child and newborn deaths. *The Global Strategy for Women's, Children's and Adolescents' Health (2016–30)*, launched by the UN Secretary-General in September 2015, is set to galvanise action to make this a reality.

Advocates and practitioners in this area are recognising that we cannot achieve such ambitious targets through stand-alone projects or single interventions. To improve health for all women, adolescents and children, particularly the poorest and most excluded, we need to build the continuum of care and ensure that everyone receives the services they need. At the same time, there is real momentum for Universal Health Coverage and an important debate about who and which services are covered first.

This report makes the case for a shared agenda between women's, adolescents' and children's health and Universal Health Coverage. It argues that neither movement will fully succeed or gain the political support needed, unless they are working together. Maternal and child health advocates need to speak out about the kind of health system that is needed to deliver the interventions we support. This report argues further that Universal Health Coverage is not an abstract concept but can make meaningful progress in the most essential health needs of millions of people who have been excluded.

This report is a welcome addition to the debates on health and helps to bring together complementary movements to try to be build a coherent approach that can benefit the health of all women, children and adolescents.

Graça Machel
Founding member of The Elders
Chair of the Partnership
for Maternal Newborn
and Child Health

PHOTO: THE GRAÇA MACHEL TRUST

Executive summary

The world has made important progress in reducing maternal and child deaths. The under-five mortality rate has fallen by more than half since 1990,[1] while the global maternal mortality ratio fell by nearly 44%.[2] This progress is the result of sustained political and financial commitment and action by governments, civil society and the international community. However, Millennium Development Goals (MDGs) 4 and 5 – which aimed to reduce the under-five mortality rate by two-thirds and the maternal mortality ratio by three-quarters between 1990 and 2015 – were not achieved. This means that preventable deaths of babies, young children and women during pregnancy and childbirth continue in shocking numbers in many parts of the world.

These preventable deaths occur predominantly among the poorest and most marginalised sections of the population in low and lower-middle income countries. Save the Children's new campaign *Every Last Child* focuses on those children who are excluded from global progress – including life-saving healthcare – by a deadly cocktail of poverty and discrimination.

The failure thus far to give enough attention to the health needs of women, children and adolescents reflects long-standing gender inequality and a persistent tolerance of maternal and child deaths. Ongoing and extreme inequalities prevent many women and children – typically the poorest and most disadvantaged, those living in remote or rural areas, and those with the least education – from accessing the essential sexual, reproductive, maternal, newborn, child and adolescent healthcare services they need. The right to sexual, reproductive, maternal and child health – a cornerstone of the right to health – is still a distant dream for many women and children, including adolescents.

There are ongoing disparities in access to services that form the integrated 'continuum of care' from adolescence, through to pregnancy and childbirth, in the post-partum period and into early childhood. While there has been good progress in some aspects of the continuum – notably immunisation and treatment of childhood illnesses – others have been neglected. Overall, the pace of progress in reducing neonatal and maternal deaths has been slower than progress in reducing under-five deaths. This highlights a continued neglect of 24-hour care before, during and immediately after birth, and the poor-quality care experienced by many of the poorest and most disadvantaged populations.

The MDGs measured national averages that have masked continuing or even increasing inequalities in some countries. This report shows how certain socioeconomic groups, rural populations, geographic regions and marginalised communities have been excluded from the progress made. It provides some analysis of the situation in three 'spotlight' countries – Indonesia, Nigeria and Ethiopia – to illustrate the situation, the challenges that remain and efforts being made. The key challenges can be summarised as:

- addressing unequal and insufficient progress among certain parts of the population, often based on disparities in wealth, geography, and mother's level of education
- addressing unequal access to sexual, reproductive, maternal, newborn, child and adolescent health interventions along the continuum of care
- securing the political and financial investment necessary to build health systems that prioritise quality healthcare for women, children and adolescents through Universal Health Coverage (UHC).

To address these inequalities and ensure access to the range of services needed without excluding poor or marginalised communities, health services need to be organised differently. Governments and

other stakeholders must ensure that good-quality services are available to all citizens but particularly those at highest risk, with adequate funding and without discrimination. Countries that have made progress on UHC and that have included sexual, reproductive, maternal and child health services in the package of services available to their population provide a useful example of what can be done with strong political commitment and financial investment.

The 2030 Agenda for Sustainable Development has made commitments to leave no one behind, to end preventable maternal mortality, and under-five and newborn deaths, and ensure universal access to sexual and reproductive health (SRH) services. Achieving these targets will rely on the commitment to UHC set out in target 3.8 of the Sustainable Development Goals (SDGs) and the principle that everyone should have access to the health services they need without facing financial hardship.

In this report, Save the Children argues that ending preventable maternal and child deaths requires UHC, and depends on access to a continuum of care for all sections of the population, through strengthened primary healthcare with effective links to community-based interventions and referral systems to hospitals. This requires a political commitment guaranteeing essential healthcare for all women, children and adolescents, free at the point of use, with increased public investment in healthcare systems that can deliver quality care to every woman and every child.

Save the Children believes that for the movement for UHC to have widespread support from communities, policy-makers and civil society it needs to focus first on ensuring universal access to the most essential services that are needed by every family and community. This demands that governments, with the support of development partners, deliver essential sexual, reproductive, maternal, newborn and child health services, available and accessible to all women, children and adolescents, as the foundation for building UHC, not as a distant aspiration. Those furthest from coverage need to be the priority, and there must be specific and urgent efforts to reach those who are left behind.

To make real progress in reaching every woman, child and adolescent, maternal and child health advocates and practitioners need to engage with the growing global movement for UHC. The *Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)* – launched by the UN Secretary-General in September 2015 – represents a new roadmap to end all preventable deaths of women, children and adolescents, and to secure not only their survival but their health and well-being.

At the same time, the movement for UHC needs to be clear that essential services needed in every community are the priority by which progress towards UHC will be measured. Ensuring access for excluded groups to the continuum of care for women's, children's and adolescents' health, without discrimination, should be achieved before expansion of coverage to other services.

In this report we argue that UHC is the principle around which health services should be funded and organised to provide these essential services to everyone. We support primary healthcare as the environment that needs to be strengthened in order to deliver these services in the appropriate way, with effective referral systems as needed. The UHC movement should ensure that building universal primary healthcare is its foundation and priority.

UHC and the *Global Strategy* represent a common and mutually dependent agenda. Bringing these forces together is a crucial opportunity in ensuring universal access to sexual, reproductive, maternal, newborn, child and adolescent health – and in delivering the ambition to end all preventable maternal and child deaths by 2030.

KEY MESSAGES

- Despite global progress in reducing maternal and child deaths, there are persistent inequalities in women's and children's health outcomes and in access to essential services, both globally and in within countries.
- Compared with progress in reducing under-five deaths, there has been slower progress in reducing maternal and newborn deaths, and elements of the 'continuum of care' that require well-functioning health systems available around the clock have been neglected.
- UHC is key to ensuring that essential health services – the full continuum of care – needed by every family and community are available to all without deterring people by out-of-pocket payments. Countries must strive to achieve UHC and must prioritise these services. Doing so will require political leadership, commitment and investment.
- To build support for its case, the movement for UHC must make clear that the priority is coverage of essential sexual, reproductive, maternal, newborn, child and adolescent health services for all women, children and adolescents, at primary care level and through effective referral systems. This is key to addressing the most inequitable burdens of mortality and morbidity.
- Champions of maternal and child health and advocates for UHC, as well as advocates for primary healthcare, should unite around a common agenda to ensure that all women, children and adolescents can survive and thrive.

SUMMARY OF RECOMMENDATIONS:

- Advocates for women's, children's and adolescents' health should make clear that building Universal Health Coverage to enable all communities to access essential services is a vital pre-requisite to ensure that all women and children can survive and thrive.
- The movement for Universal Health Coverage should prioritise sexual, reproductive, maternal, newborn, child and adolescent health as an integrated continuum of care, free at the point of use and accessible to all sections of the population.

Save the Children is calling on governments, donors, development partners and other stakeholders to:

- guarantee an essential package of sexual, reproductive, maternal, newborn, child and adolescent health services in efforts to achieve universal health coverage, free at the point of use and accessible to all sections of the population
- ensure no one is left behind with time-bound equity targets for accelerated progress among the poorest and most marginalised sections of the population
- increase public spending on healthcare by increasing the health budget to at least the minimum levels required, improving tax revenue and increasing or maintaining official development assistance for health
- improve quality of care, and promote respectful and dignified care in health facilities
- integrate nutrition interventions on the continuum of care for women's, children's and adolescents' health, and address the nutritional needs of adolescent girls.

PHOTO: C.J. CLARKE/SAVE THE CHILDREN

Five-day-old Ayush, New Delhi, India

1 Introduction

ABOUT THIS REPORT

Ending preventable child and maternal deaths is part of Save the Children's vision and is central to our strategy. We are an active member of the maternal and child health movement, both in high-burden countries and globally through networks such as the Partnership for Maternal, Newborn & Child Health (PMNCH). At the same time, we have been long-standing champions of building comprehensive health systems that do not exclude the poor, most recently as part of the movement for Universal Health Coverage (UHC).

This report contributes to two current discourses in global health: on the one hand, the need to reach every woman and every child with good-quality healthcare; and on the other, support for Universal Health Coverage as a means to address persistent inequities in access to healthcare. It aims to show why these two related and mutually dependent movements need to join forces to make a real difference to the health of the world's poorest and most excluded people.

The report sets out why it is vital that health services for women, children and adolescents are seen as a continuum of care, from pre-pregnancy to child and adolescent health. We present analysis from studies carried out for Save the Children in Ethiopia, Indonesia and Nigeria, presented as 'spotlights' in Chapter 3. Together, they highlight disparities in maternal and child health outcomes and in access to essential health services, and the need for national health systems that can reach those who are being excluded from progress. We argue that UHC is the framework that can enable countries to build a health system capable of providing essential services for all their population.

Moreover, we argue that to continue to gain support, the movement for UHC needs to be clearer about how UHC can deliver essential healthcare for the poorest and most excluded people, and especially those services on the continuum of care for reproductive, maternal, newborn child and adolescent health. Finally, we make recommendations for how global and national stakeholders, including governments and donors, should unite around a common cause and make their shared ambitions a reality.

THE RIGHT TO HEALTHCARE AND ITS ROLE IN ADDRESSING INEQUITY

Healthcare services cannot reverse the social inequalities that underlie the unequal burden of poor health and mortality, but they can and should play a major part in redressing them. The principles of primary healthcare (PHC), as set out in the Alma-Ata Declaration of 1978 (see box on page 2), explicitly support the role of health services to take into account social inequalities and exclusion and attempt to address them. An equitable health system, therefore, is one that would ensure that those with the greatest health needs are able to access more of the health resources available in a country. Unfortunately, the opposite is generally true – those with the greatest healthcare needs due to poverty or social exclusion actually receive a far smaller proportion of available healthcare resources.

Sexual, reproductive, maternal, newborn, child and adolescent health services are universally needed. All women need health information and services to be able to make informed decisions about their sexual and reproductive health. Every birth should have a health worker present, trained in midwifery skills and ready to intervene in case of complications. All children need immunisation and health services to treat common infections that can be fatal without intervention.

International standards on the right to health highlight reproductive, maternal, newborn, child and adolescent health as fundamental to ensuring the prevention of infant, maternal and child mortality.[1]

They specify the need to provide sexual and reproductive health services – including access to family planning, pre- and postnatal care, obstetric care and immunisation, and to take other measures necessary to promote child and maternal health.[2] Article 24 of the UN Convention on the Rights of the Child (UNCRC) specifies the need for particular measures to reduce infant and child mortality and emphasises primary healthcare.

The core human rights principles of equality and non-discrimination demand that all women and children should be able to access such services, and that governments should prioritise efforts to address the needs of excluded and marginalised groups. Even where governments have only limited resources, they should prioritise key interventions to prevent maternal and child deaths, such as obstetric care.

In line with international human rights standards, Save the Children believes that universal access to sexual, reproductive, maternal, newborn, child and adolescent health is a clear human rights imperative for governments, donors and the international community. The principle of equity – ensuring that no one is left behind – demands that these stakeholders address both the underlying drivers of exclusion and discrimination, and the barriers that prevent the most deprived groups in society accessing healthcare. This is key to the concept of UHC, which puts the poorest and most disadvantaged people in society first.

PRIMARY HEALTHCARE

There are a number of frameworks that can be applied to discussions on building essential health services that reach all people. There have long been calls for all stakeholders to support health system strengthening so that health priorities – especially those supported by donors – contribute to a stronger national health system, rather than setting up parallel structures. UHC has come to be identified as a goal for global health, encapsulating the ambition and fairness of a health service that reaches everyone and does not cause financial hardship to those who need healthcare.

In 1978, the Alma-Ata Declaration prioritised primary healthcare, defining it as "an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community". It is also argued that primary healthcare is the "first level of contact of individuals, the family and community with the national health system, bringing healthcare as close as possible to where people live and work, and constitutes the first element of a continuing health care process".[3]

While the Alma-Ata goal of Health for All by the year 2000 floundered, the concept of primary healthcare has remained a powerful means of ensuring that the most essential healthcare services are available close to the communities that need them. Most of the services in the continuum of care for sexual, reproductive, maternal, newborn, child and adolescent health are most appropriately provided at the level of primary healthcare, with effective referral systems for services such as the treatment of complicated and obstructed labour. However, many national health systems have not invested enough to provide these services at local level, with disproportionate amounts invested in urban areas and capital cities. Primary healthcare is therefore a powerful framework for ensuring that health services target those people who need them, that they are provided in every community, and in ways which promote people's right to health.

Dr Margaret Chan, Director-General of the World Health Organization (WHO), has reaffirmed the primary healthcare approach as the most efficient and cost-effective way to organise a health system. She points out that international evidence overwhelmingly demonstrates that health systems oriented toward primary healthcare produce better outcomes, at lower costs, and with higher user satisfaction.

Strengthening universal primary healthcare – that can deliver essential services to all women, children and adolescents – should be a priority in efforts towards Universal Health Coverage.

RESEARCH METHODOLOGY

Research for this report was based on desk reviews of the latest literature on reproductive, maternal, newborn, child and adolescent health, and the latest data from UN sources, Demographic and Health Surveys and WHO databases. This included a literature review on social exclusion, health and nutrition carried out for Save the Children by *Anthrologica*; literature reviews carried out in Nigeria, Ethiopia and Indonesia, based on the most recent national documentation and data from Demographic and Health Surveys on reproductive, maternal and child health; and key informant interviews and focus group discussions in Nigeria and Indonesia.

A NOTE ON TERMINOLOGY

Until recently, advocates for maternal and child health have focused primarily on reproductive, maternal and child health to indicate the interventions required to eliminate preventable maternal and under-five mortality. In recent years this agenda has become broader, in recognition that a more comprehensive and integrated approach is required throughout all stages of the life-cycle of women and children. The *Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)*, which builds on the momentum of *Every Woman Every Child*, represents a broader ambition to ensure that all women, children and adolescents can both survive and thrive.

In this report, we often refer to "women's, children's and adolescents' health" as a shorthand for the need to ensure access to essential sexual, reproductive, maternal, newborn, child and adolescent healthcare services.

PHOTO: JONATHAN HYAMS/SAVE THE CHILDREN

Midwife Watta Borbor cares for T-Girl, 19, and her newborn baby at a Save the Children-supported clinic in Liberia.

2 An unfinished agenda

There has been great progress in reducing child and maternal mortality since 1990. The global under-five mortality rate has fallen by 53%, from 91 deaths per 1,000 live births to 43 deaths per 1,000 live births in 2015.[1] Over the same period, the global number of under-five deaths fell from 12.7 million to 5.9 million.[2] The accelerated decline in under-five deaths since 2000 is calculated to have saved the lives of 48 million children.[3] Rates of reduction in under-five mortality have been accelerating in sub-Saharan Africa,[4] which has the highest under-five mortality ratio. Real progress has also been made in reducing preventable maternal deaths, which have fallen globally from approximately 532,000 in 1990 to an estimated 303,000[5] in 2015. These are remarkable achievements.

MDGs 4 and 5 – which aimed to reduce under-five deaths by two-thirds and maternal mortality by three-quarters by 2015 – were important drivers for change at the national and global levels. However, neither of the goals were achieved globally and only a few low-income countries succeeded in meeting both goals.[6]

Despite the significant decline in under-five mortality worldwide, there were an estimated 16,000 under-five deaths every day in 2015.[7] Getting accurate data on the numbers and causes of maternal deaths is still a huge challenge in many countries due to weak civil registration and vital statistics. But it is clear that hundreds of thousands of women are still dying every year due to complications in pregnancy and childbirth – an estimated 830 women a day in 2015.[8] Most of these deaths could be prevented if women had access to skilled health workers delivering well-known and cost-effective interventions.

The 2030 Agenda for Sustainable Development agreed by world leaders at the UN General Assembly in September 2015 aims to end all preventable maternal and child deaths. For low-income and lower middle-income countries, this means reducing the under-five mortality rate to 25 per 1,000 live births and achieving a maternal mortality ratio of less than 70 per 100,000 live births. While this is still some way from the low mortality rates in high-income countries, it sets a very ambitious agenda for many countries. Crucially, the commitment in the SDGs to achieve these targets for all sections of the population, rather than just as a national average, poses real challenges for some countries.

Save the Children played a part in pushing for these commitments and we recognise that achieving them for all sections of society will require all stakeholders to learn lessons from the MDGs.

LACK OF PROGRESS IN MANY COUNTRIES, REGIONS AND COMMUNITIES

Despite these remarkable achievements, many countries, people and communities have simply been excluded from progress in reducing maternal and child deaths, reflecting deep and persistent inequalities between and within countries. Save the Children's analysis shows that the most significant disparities in under-five and maternal mortality rates are often based on income, geographic location, and mother's level of education.

Sub-Saharan Africa remains the region with the highest levels of under-five deaths, with one in 12 children dying before their fifth birthday.[9] Three out of ten under-five deaths occur in southern Asia, which had an estimated under-five mortality rate of 51 deaths per 1,000 live births in 2015.[10] By comparison, in high-income countries, one out of every 147 children dies before their fifth birthday.[11]

The vast majority (99%) of maternal deaths still occur in low-income and lower middle-income countries, with approximately 66% in sub-Saharan Africa.[12] But it is not just the very poorest countries where women and children continue to die from preventable causes. According to latest estimates, Nigeria and India – both classified as lower middle-income countries – accounted for over one-third of all maternal deaths worldwide in 2015, with 58,000 (19%) and 45,000 (15%) maternal deaths respectively.[13] This is partly explained by their high population levels.

Globally, the two countries with the highest estimated lifetime risk of maternal mortality are Sierra Leone and Chad (one in 17 and one in 18 respectively).[14] In high-income countries, the estimated lifetime risk of maternal death is one in 3,300 compared with one in 41 in low-income countries.[15]

Increasingly, high numbers of maternal deaths are occurring in countries affected by humanitarian crises and in fragile settings (see box below). In 2015, an estimated 185,000 maternal deaths (61% of the global estimate) occurred in 35 such countries.[16]

WOMEN AND GIRLS EXCLUDED FROM THE FULL CONTINUUM OF CARE

The progress achieved by the MDGs, although welcome, exposes insufficient progress in specific areas and among specific population groups. As Save the Children highlighted in our report *Ending Newborn Deaths*, there have been much slower reductions in newborn mortality. These fell by 47% from 1990 to 2015, compared with 53% among under-fives in the same period.[17] Newborn deaths now account for 45% of under-five mortality globally.[18] The time around birth and the newborn period (when a child is under 28 days old) is especially risky, and requires specific interventions

ENSURING ESSENTIAL HEALTHCARE IN HUMANITARIAN CRISES AND FRAGILE SETTINGS

In times of humanitarian crisis, whether due to conflict or natural disasters, health systems may collapse or function in only a limited way. In Syria, for example, the conflict has led to the collapse of what was a well-functioning health system. As witnessed in Syria and Yemen, health facilities are also increasingly being targeted in situations of war, in clear violation of humanitarian law.

Post-conflict and fragile states have some of the poorest health outcomes, and are the least able to respond to health crises due to their already weak health systems. The Ebola crises in Liberia, Guinea and Sierra Leone are clear examples.[19]

The risk of children dying before the age of five is almost twice as high in fragile contexts.[20] Women and girls are at heightened risk of sexual and gender-based violence (SGBV), of unintended or unwanted pregnancy, sexually transmitted infections (STIs) and maternal mortality and morbidity.[21] The percentage of births attended by skilled health workers is lower in fragile settings, while birth rates among adolescent girls and unmet need for family planning are higher. Increasingly, sexual and reproductive health (SRH) interventions are considered central to humanitarian action in all phases – from prevention and preparedness, to response, building resilience, recovery and long-term development.

Humanitarian action must also lay the foundations for long-term development, including strengthening or rebuilding healthcare systems that respond to people's needs and can deliver essential services, such as maternal and child health, to all families in all communities. Well-functioning public institutions such as these are key to strengthening good governance in all phases of recovery and rebuilding.

The *Global Strategy for Women's, Children's and Adolescents' Health* recognises that the SDGs will not be achieved without specific attention to humanitarian crises and fragile settings. It therefore emphasises the need to ensure a set of essential health interventions in these contexts.

delivered with appropriate facilities and skilled health personnel available round the clock, which are different from those needed for routine immunisation or to treat childhood illnesses.

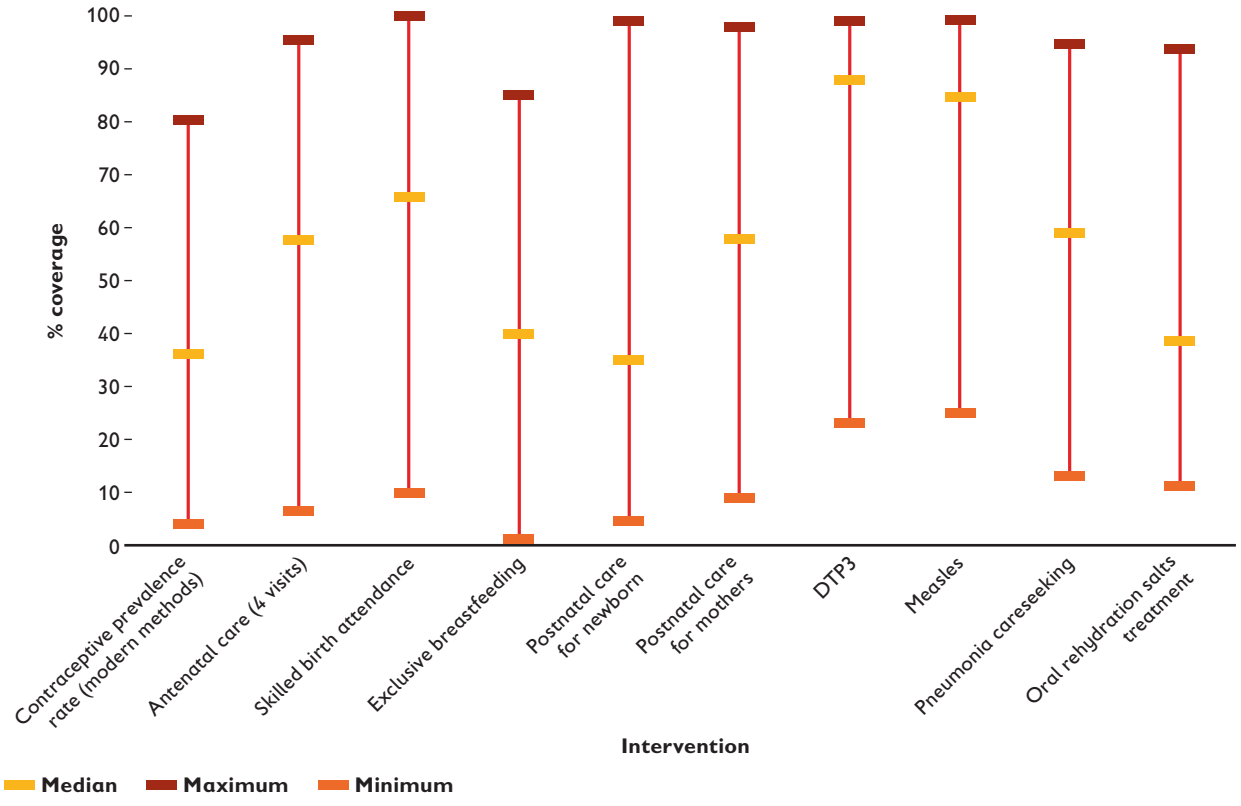
A recent study by *The Lancet* showed that around 73% of maternal deaths between 2003 and 2009 were due to obstetric complications during delivery.[22] Despite the significant global increase in the proportion of births attended by a skilled health worker, in 2014 there were approximately 36 million births in low- and middle-income countries with no midwife or skilled attendant present.[23]

Postnatal care for both mothers and newborns, especially important in the days immediately after birth, is still a challenge in many low-income settings, with some of the lowest levels of coverage within the continuum of care.[24] Yet making quality care available around the clock during childbirth and the neonatal period could prevent 113,000 maternal deaths, 531,000 stillbirths and 1.3 million newborn deaths by 2020.[25]

The provision of contraception would also prevent a significant number of maternal and child deaths. It has been estimated that meeting 90% of the 2015 unmet need for contraception could prevent 67,000 maternal deaths, 440,000 neonatal deaths and 564,000 stillbirths.[26]

There is widespread consensus that accelerated and equitable progress to eliminate maternal and child deaths requires the scaling up of an integrated package of essential services, with specific attention to contraception, care during labour and delivery, care of newborns and pre-term births, and management of infectious diseases and malnutrition. In recent years, global health debates have therefore shifted from focusing primarily on certain interventions to recognising the need for a continuum of care for reproductive, maternal, newborn, child and adolescent health (see box on page 8). This continuum is generally described as starting with SRH services in adolescence (including contraception), through to care during pregnancy and childbirth, immediate postnatal care of mother and baby, immunisation, and treatment of childhood illnesses. It includes interventions that can respond to obstetric emergencies, promote exclusive breastfeeding, and care for sick, premature or low-birthweight babies.

FIGURE 1 COVERAGE OF SELECTED INTERVENTIONS ACROSS THE CONTINUUM OF CARE



Source: Healthy Newborn Network, http://www.healthynewbornnetwork.org/, based on WHO data for low and lower-middle income countries from 2009 onwards. Note: the number of countries with available data varies across indicators. For each indicator we report sample median instead of mean as it is less affected by extreme values.

"Health services for women, children, and adolescents must be the priority in any benefit package for UHC. Effective provision requires integrated delivery across the continuum of care, making women's, children's, and adolescents' health the frontrunner for achieving UHC across the lifecycle."

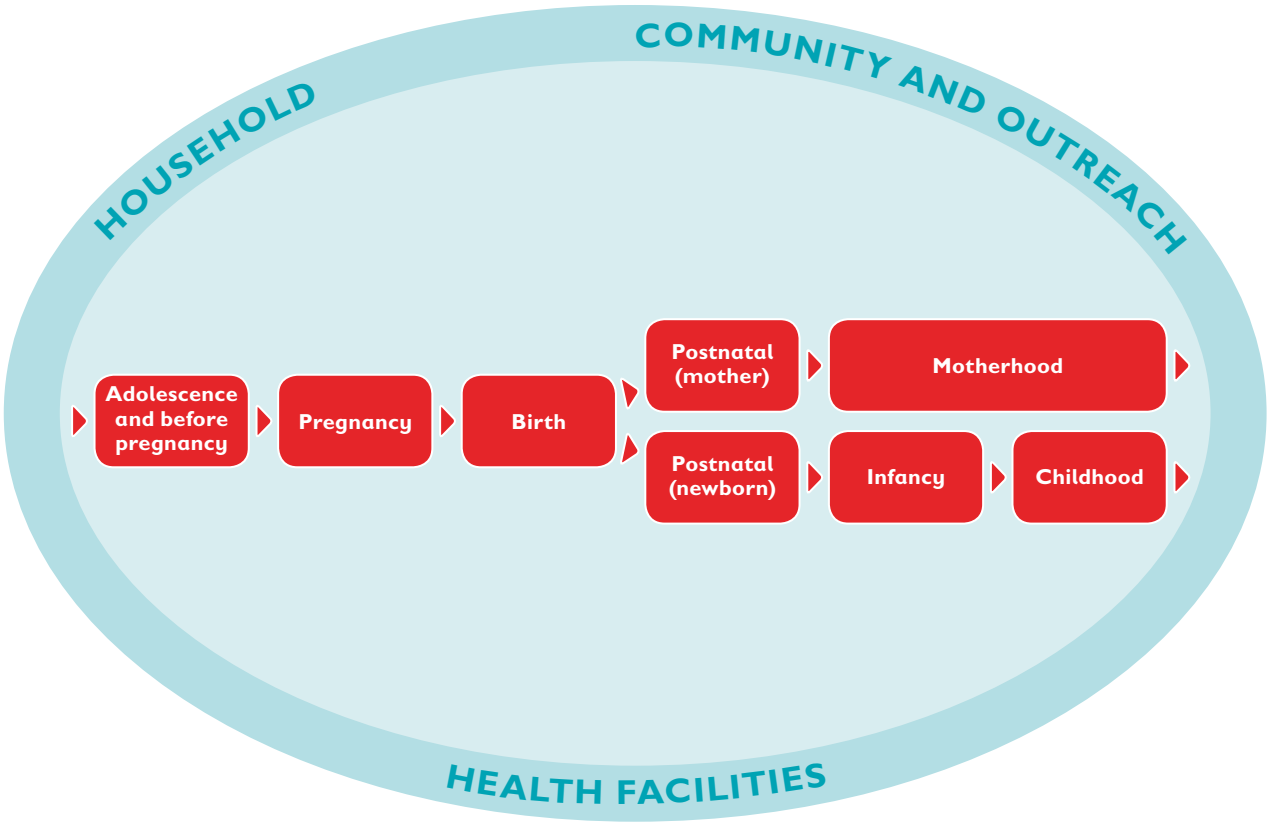
The Lancet, December 2015[27]

Most of the services needed for the continuum of care can be delivered through primary healthcare that guarantees these basic services to all women, children and adolescents, with effective links to community-based services and referral systems to secondary and tertiary levels of care. Most of the essential interventions needed for maternal and newborn health can be provided by properly trained and regulated midwives, working in such an enabling environment. It has been estimated that universal coverage of these essential interventions, which can be carried out by professional midwives, could prevent 83% of maternal and neonatal deaths and stillbirths.[28]

However, coverage of essential interventions across the continuum of care varies significantly within countries. Some key interventions, such as access to modern contraception, the recommended minimum of four antenatal visits, skilled birth attendance and postnatal care for mothers and newborns have lower coverage rates overall.

Greater attention to stillbirths[29] has also highlighted the vital role of good-quality care before and during childbirth. An estimated 2.6 million babies were stillborn in 2015, with 98% of these stillbirths occurring in low- and middle-income countries (75% in sub-Saharan Africa and south Asia).[30] Many of these deaths are still not routinely recorded or counted, and remain an unspoken trauma for women and their families. According to *The Lancet*, half of stillbirths occur during labour and the majority are due to preventable factors such as maternal infections, non-communicable diseases and obstetric complications.[31] Most are preventable with improved health systems. Stillbirth rates are therefore a very sensitive indicator of the quality of care that women

FIGURE 2 CONTINUUM OF CARE FOR SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH



ESSENTIAL INTERVENTIONS ALONG THE CONTINUUM OF CARE*

Adolescence and pre-pregnancy: Family planning/contraception; prevention and management of sexually transmitted infections (STIs), including prevention of mother-to-child transmission of HIV and syphilis; folic acid fortification/supplementation; supplements for multiple micronutrients to ensure adequate nutrition before pregnancy.

Pregnancy and antenatal care: A range of services including nutritional interventions (iron, folic acid and calcium supplementation); vaccination against tetanus; screening, prevention and management of STIs, HIV, syphilis and malaria; antihypertensive drugs; corticosteroids to prevent respiratory distress in pre-term babies; safe abortion and post-abortion care.

Childbirth: Skilled delivery with comprehensive obstetric care (including caesarean section when necessary); management of post-partum haemorrhage; social support during childbirth.

Postnatal care for mothers and newborns: Thermal care and initiation of early breastfeeding; hygienic cord and skin care; neonatal resuscitation; management of pre-term babies including extra support for feeding small and premature babies and kangaroo mother care; management of neonatal sepsis, meningitis, jaundice and pneumonia; family planning and nutrition advice and support for mothers as well as treatment of anaemia and management of post-partum sepsis and prevention/treatment of HIV.

Infancy and childhood: Promotion of breastfeeding; prevention and management of HIV, malaria; comprehensive immunisation; management of malnutrition; integrated treatment of childhood illnesses (eg, pneumonia, diarrhoea).

* This is adapted from the list of essential evidence-based interventions for reproductive, maternal, newborn and child health developed by The Partnership for Maternal, Newborn & Child Health and WHO, outlined in the publication *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health*.[32]

It is not intended to be an exhaustive list and additional interventions may be needed to respond to other health conditions.

receive during pregnancy and childbirth; they must be recorded and counted in national and global data as a key measure of progress on reaching every woman with good-quality care.

Universal coverage of the full package of women's, children's and adolescents' health services is still a distant dream in many countries, underlying the continued high numbers of maternal and child deaths. Full antenatal care for pregnant women and girls, skilled birth attendance, and postnatal care for mothers and babies are all lagging behind.

Maternal and child health is a key aspect of gender equality, and if countries are serious about addressing women's, children's and adolescents' health needs, then these services require far greater numbers of qualified staff and a much fairer distribution of resources. As we discuss later in the report, addressing this unequal coverage of interventions across the continuum of care requires leadership and political commitment to invest in the effectiveness, reach and quality of healthcare systems that can provide these essential services.

NUTRITION MUST BE AN INTEGRAL PART OF THE CONTINUUM OF CARE

Increasing attention is being given to the importance of nutrition for both maternal and child health, especially in adolescence.

The health and nutritional status of women and children is inextricably linked. Improving women's health and well-being is a key determinant of child survival and development. The fact that almost half of under-five deaths have poor nutrition as an underlying cause means that nutrition (for mothers, children and adolescents) is now receiving greater attention.[33] The nutritional and overall health status of women and girls, before, during and after pregnancy, has a direct effect on babies' early growth and development (beginning in the womb) as well as on a woman's survival chances during childbirth. The *Global Strategy for Women's, Children's and Adolescents' Health* highlights poor nutrition as one of the key challenges in ensuring that women and children can survive and thrive. It emphasises the need to improve nutrition for pregnant and breastfeeding women, adolescent girls, and their children.

Nutrition interventions in the first 1,000[34] days of life – from the start of pregnancy to a child's second birthday – are critical for healthy physical and cognitive development, enabling children to grow, learn and prosper.

Stunting (when a child is too short for his or her age) is estimated to affect 159 million children under five globally.[35] It is usually irreversible, caused by inadequate nutrition and repeated infections during the first 1,000 days of a child's life.[36]

There also needs to be greater attention to the nutrition needs of adolescent girls, which may be particularly acute during pregnancy or can be exacerbated by pre-existing nutritional deficits, as well as by anaemia, malaria, parasitic infections or other underlying health conditions. With 16 million[37] adolescent girls giving birth each year, targeting young women with nutrition interventions when they are already four or five months pregnant is too late. Family planning and access to contraception for adolescent girls is also essential to allow better timing and spacing of pregnancies, as these also have an important bearing on their own health and nutrition as well as that of any children they may have.

Nutrition interventions must therefore be fully integrated into the reproductive, maternal, newborn, child and adolescent health continuum of care,[38] including through growth monitoring, supplementary feeding and vitamin supplementation. Crucially, immediate and exclusive breastfeeding is recognised as hugely beneficial for both maternal and child health. According to *The Lancet*, universal breastfeeding could avert the deaths of 823,000 children and 20,000 deaths due to breast cancer each year[39] – saving $300 billion in the process.[40] *The Lancet* showed that while more than 80% of newborns are breastfed in nearly all countries, only about half begin breastfeeding within the first hour of life (in line with WHO's recommendation).

THE ROLE OF WEALTH, GEOGRAPHIC LOCATION AND WOMEN'S LEVEL OF EDUCATION

The MDG era showed that progress made was not shared evenly or fairly across and within countries. In many countries, the most disadvantaged women, infants and children – the poorest, those with the least education and those living in rural and remote areas – continue to have higher rates of mortality and morbidity, and least access to the range of services needed to prevent maternal and child deaths and ill-health.[41] Inequalities within countries are particularly marked in relation to maternal health interventions.[42] Levels of income, geographic location and mother's level of education are key determinants of access to services, and are discussed in more detail below.

WEALTH INEQUALITIES

Economic status is a major determinant of child survival, with under-five deaths occurring among children from the poorest sections of the population (see Figure 3).

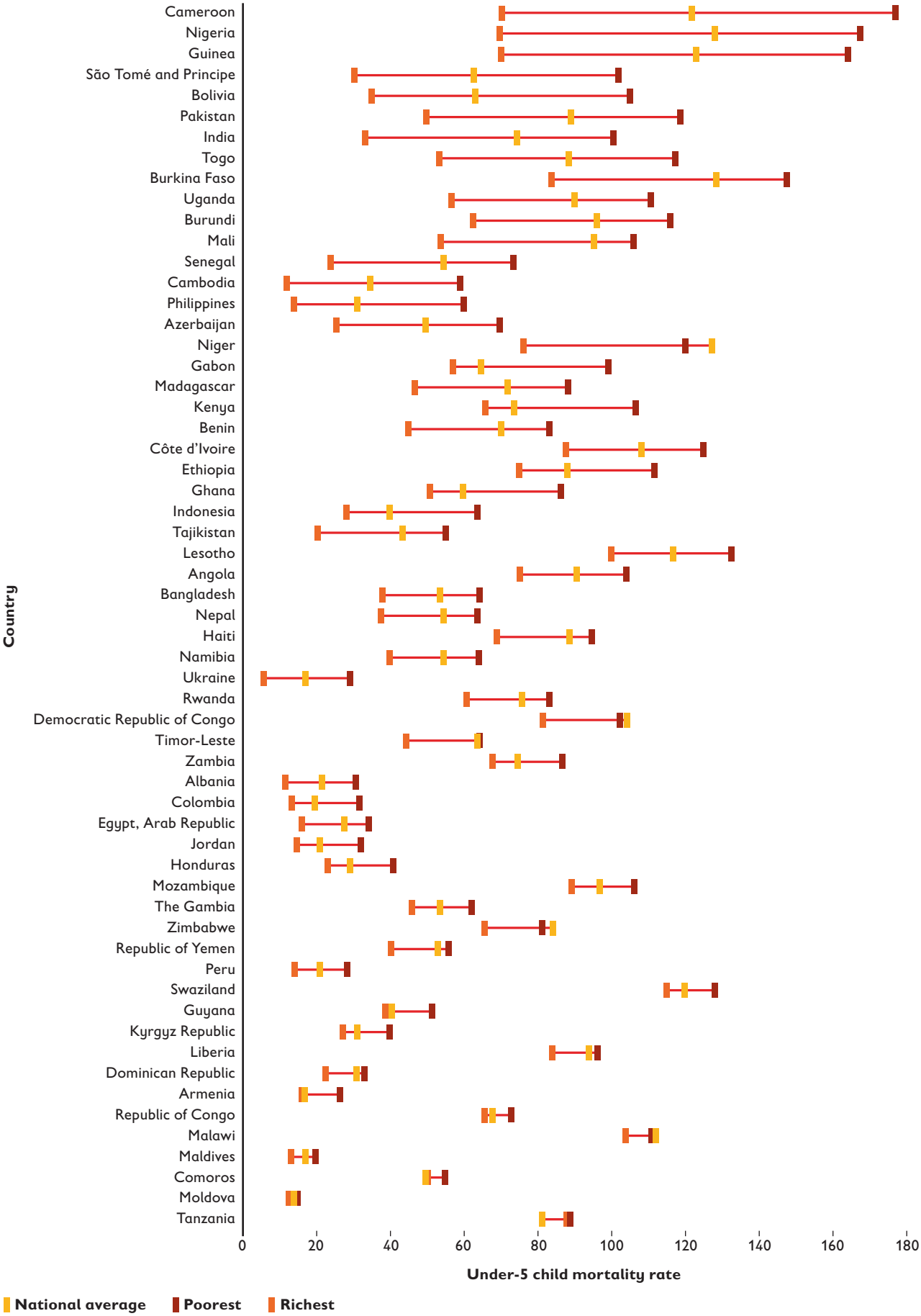
Income also continues to be a key determinant of access to health services for women and children, and this is most marked for interventions that require round-the-clock access to health facilities.[43] In low- and middle-income countries, analysis by WHO and the International Center for Equity, Pelotas, showed that there was an 80 percentage point gap between the richest and poorest women having a skilled health worker present during labour,[44] and a 25 percentage point difference in antenatal care (at least four visits) between the richest and poorest groups in half of the countries analysed.[45]

Figure 4 highlights these marked disparities between the poorest and richest quintiles in terms of access to a range of reproductive, maternal, newborn and child health interventions along the continuum of care.

The latest Demographic and Health Survey (DHS) data from Ethiopia shows a huge gap in the percentage of women receiving antenatal care from a skilled provider – 77.3% among the wealthiest quintile compared with 23.7% among the poorest.[46] Similarly, 55.6% of women from the wealthiest quintile had their baby delivered by a doctor, nurse or midwife compared with just 4.5% of women in the lowest quintile.[47]

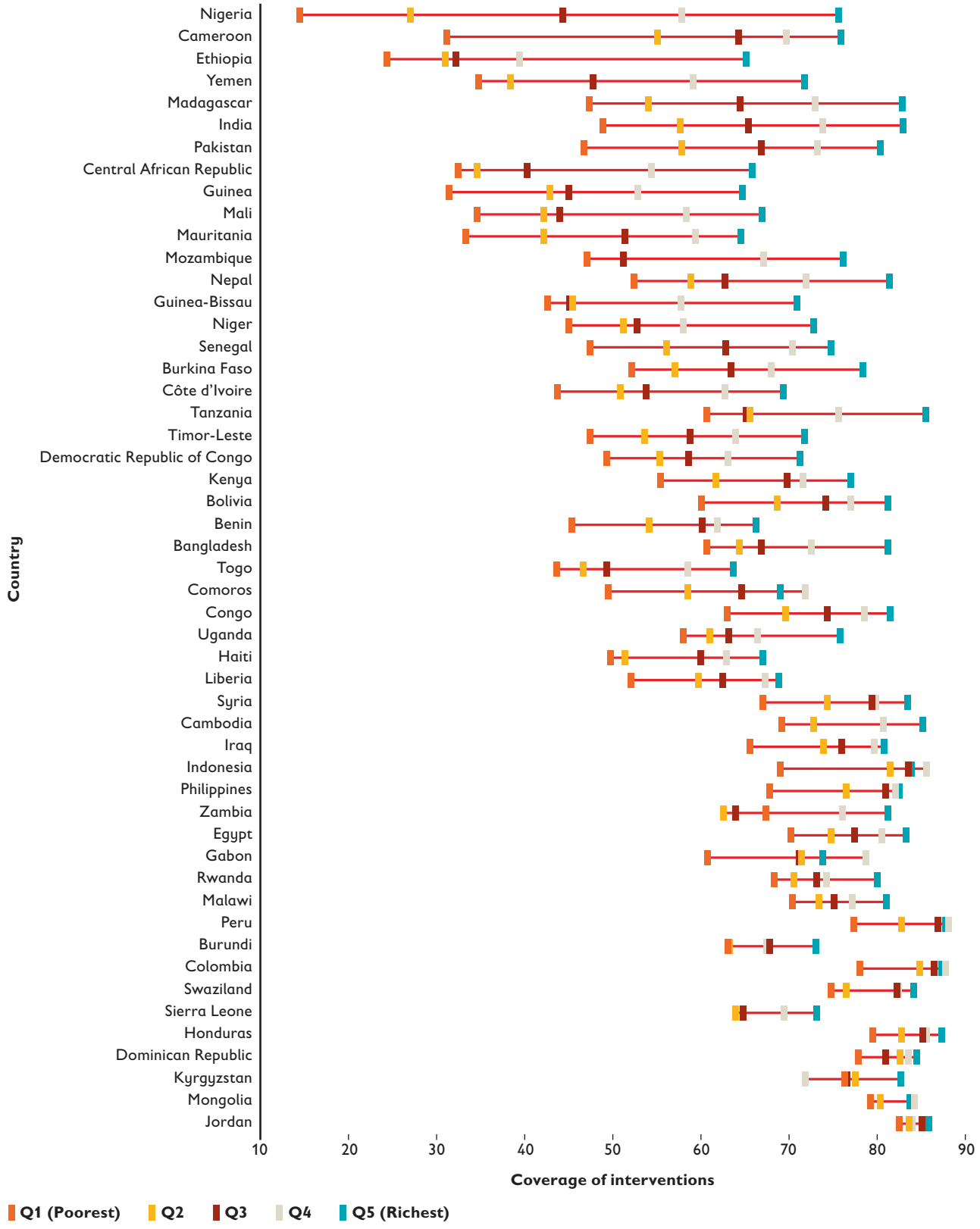
In Nigeria (see spotlight on page 25), skilled birth attendance was more than 14 times higher among the richest quintile than the poorest – 85.3% versus 5.7%.[48]

FIGURE 3 DISPARITIES IN CHILD MORTALITY BETWEEN ECONOMIC GROUPS



Source: Save the Children Group and Inequalities Database (GRID), based on DHS and MICS data from 2005–2014

FIGURE 4 REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH COMPOSITE COVERAGE INDEX* BY ECONOMIC GROUPS



Data from WHO Equity Monitor database, comprising Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) data from 2005 to 2015

* The WHO composite coverage index includes coverage of eight interventions along the continuum of care. These are: demand for family planning satisfied; antenatal care coverage (at least one visit); births attended by skilled health personnel; BCG immunisation coverage among one-year-olds; measles immunisation coverage among one-year-olds; DTP3 immunisation coverage among one-year-olds; children aged less than five years with diarrhoea receiving oral rehydration therapy and continued feeding; and children aged less than five years with pneumonia symptoms taken to a health facility.

GEOGRAPHIC INEQUALITIES

Where a woman lives can make a huge difference to her and her children's health outcomes and access to services. Overall, children from rural areas are 1.7 times more likely to die before their fifth birthday compared with children in urban areas.[49] Stunting rates among under-fives are also much higher in rural areas.[50]

There are also marked differences in rates of maternal and child mortality between geographical regions within countries, even in countries that have achieved MDG 4. Brazil, for example, has seen a significant decline in child mortality and has succeeded in reducing regional inequities over the past 25 years. But some municipalities still have much higher mortality rates than others, while indigenous children are twice as likely to die before their first birthday than other non-indigenous children.[51] In Indonesia, under-five mortality is much higher in some regions, such as Papua and West Nusa Tenggara, than in other regions such as Jakarta, with 115 deaths per 1,000 live births, 75 and 31 respectively, according to the latest Demographic and Health Survey (see Indonesia spotlight on page 20). In Ethiopia, some regions continue to have much higher under-five mortality rates than others; Gambela, Afar, and Benishangul Gumuz (for example) had significantly higher rates than Addis Ababa, Dire Dawa and Tigray in the period 2000 to 2011.[52] 80% of women in urban areas received antenatal services from a skilled provider for their most recent birth compared with 35% of women in rural areas. The proportion of women who gave birth with a skilled health provider attending was 86% in Addis Ababa compared to 10% and 11.7% in Afar and Amhara respectively (see Ethiopia spotlight on page 30).[53]

As Figure 5 shows, overall there are stark disparities in access to skilled birth attendance between rural and urban areas.

WOMEN'S EDUCATION: A KEY DETERMINANT OF HEALTH

Women's level of education is a key determinant of maternal and child health outcomes and of access to SRH, maternal and child health services. Children of uneducated mothers are 2.8 times more likely to die before their fifth birthday than children whose mothers have secondary or higher education.[54] It is also estimated that stunting prevalence in children under five is significantly higher among children of mothers who have no education compared with children whose mothers have at least secondary school education.[55]

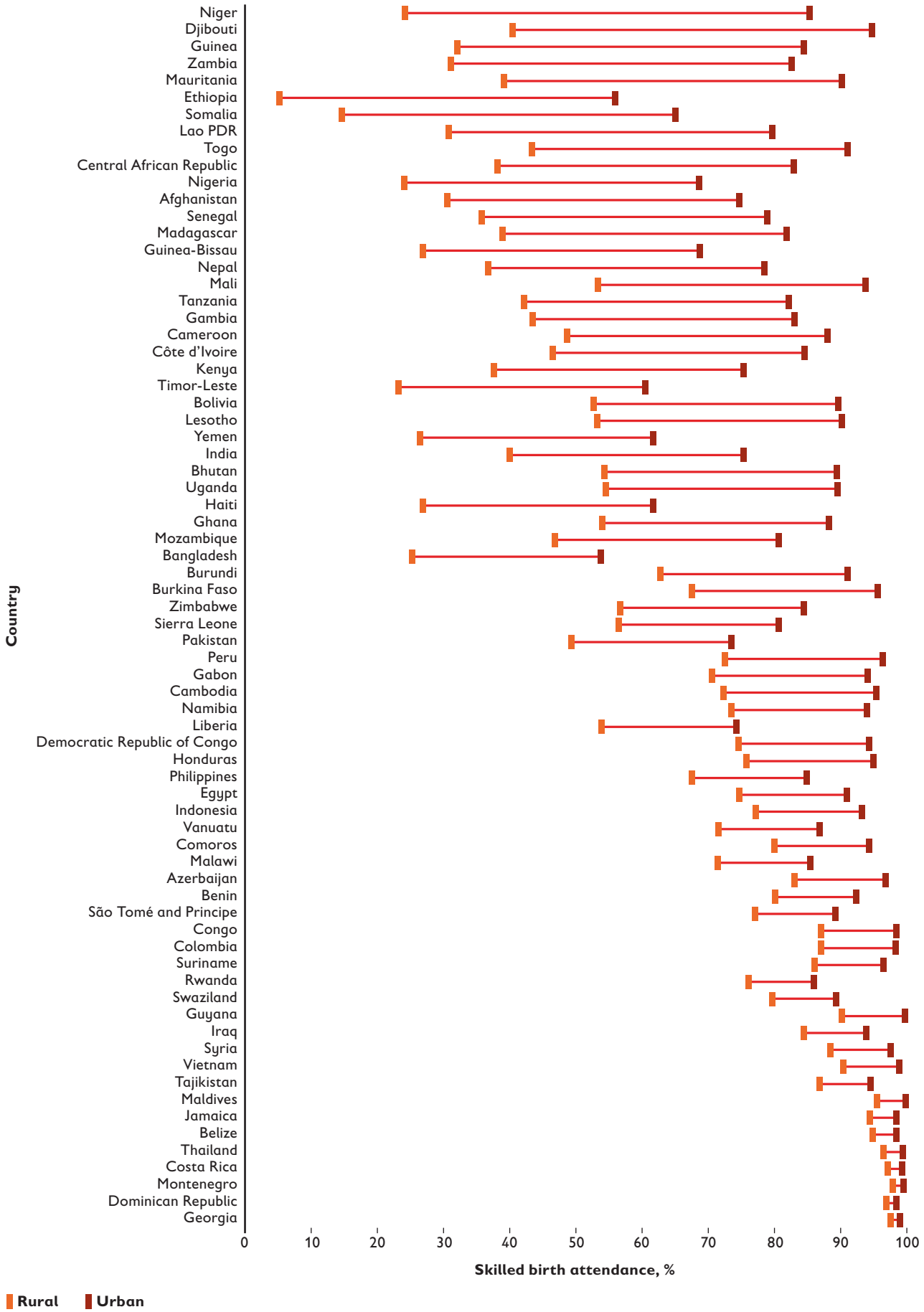
Women's level of education significantly affects the extent to which they are able to access necessary health services. Access to a range of essential sexual, reproductive, maternal and child health services is significantly higher among women with secondary education than women with no education or only primary education, as seen in Figure 6 (page 14).

In Ethiopia, for example, there are marked differences in the percentage of women receiving antenatal care from a skilled provider according to level of mother's education. Only 32% of women with no education received antenatal care compared with 50.5% of women with primary education, 81.9% of women with secondary education and 96.3% of women with more than secondary education, according the Demographic and Health Survey from 2014.[56] Mother's level of education also affects the likelihood of giving birth in the presence of a skilled attendant: 90.7% of women with more than secondary education gave birth with a nurse, doctor or midwife present compared with 69.4% of women with secondary education, 21% of women with primary education and 7.5% of women with no education.[57]

In Nigeria, women with secondary education were more than six times more likely to give birth with the help of a skilled health provider than women with no education (see Nigeria spotlight on page 25).

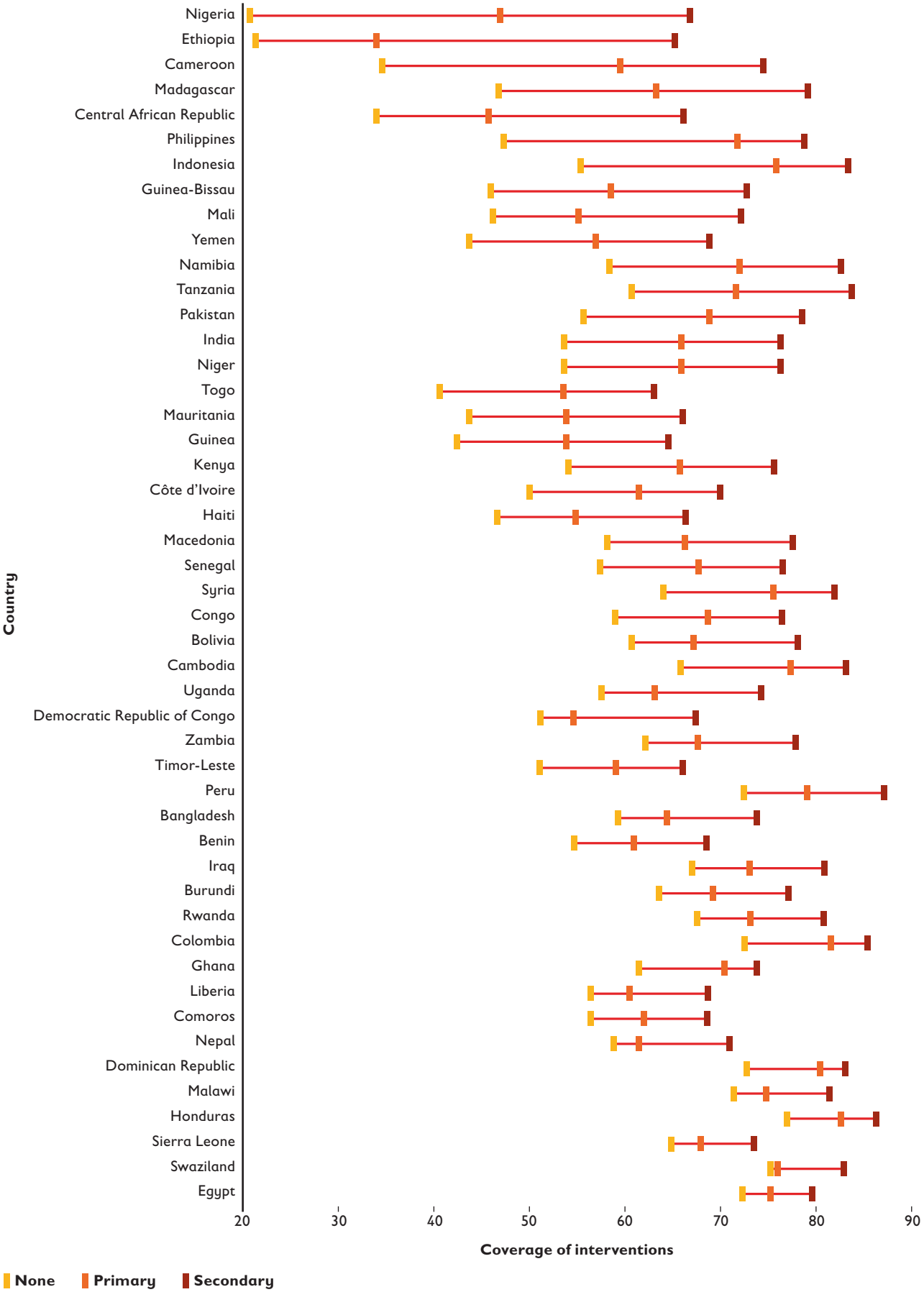
In Indonesia, children whose mother had no education were 3.3 times more likely to die before their fifth birthday than those whose mother had at least secondary education (see Indonesia spotlight on page 20).

FIGURE 5 SKILLED BIRTH ATTENDANCE IN URBAN AND RURAL AREAS



Data from WHO Equity Monitor database, comprising DHS and MICS data from 2005 to 2015

FIGURE 6 REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH COMPOSITE COVERAGE INDEX BY LEVEL OF WOMEN'S EDUCATION



Source: Data from WHO Equity Monitor database, comprising DHS and MICS data from 2005 to 2015

BARRIERS TO ACCESS

This section looks at how some women and girls face particular barriers in accessing SRH and maternal, newborn and child health services that meet their needs and enable them to realise their right to health.

The *Global Strategy for Women's, Children's and Adolescents' Health* has taken a broader approach than its predecessor strategy, Every Woman Every Child, in that it explicitly includes adolescent health. Adolescence carries particular risks for girls related to sexuality, marriage and childbearing, yet adolescent girls are often excluded from access to information and services that could protect their SRH and rights. In every region of the world, girls who are poor, who have little or no education, or who are living in rural or remote areas are at greater risk of becoming pregnant than those who are wealthier, well-educated or urban.[58]

About 16 million girls aged 15–19 give birth each year, accounting for about 11% of all births worldwide. The vast majority of these births occur in low- and middle-income countries.[59] Most births to adolescent mothers occur among those who are married, although there is generally a lack of data on adolescent girls who are sexually active but not married.[60]

Complications during pregnancy and childbirth are the second highest cause of death for 15–19-year-old girls globally, and it is estimated that every year some 3 million girls undergo unsafe abortions.[61] Pregnancy during adolescence is associated with a 50% higher risk of stillbirth and neonatal death, and a higher risk of pre-term birth, low birthweight, and being born small for gestational age – all risks that are lower among older mothers.[62] Babies born to adolescent mothers are at significantly greater risk of dying than those born to older women.[63]

Adolescents in general often do not receive comprehensive sexuality education in schools. Unmarried adolescents, in particular, are often discouraged from accessing SRH information and services because of a widespread presumption that they are not, and should not be, sexually active; because of stigma and fears over confidentiality; or because they don't receive services that are appropriate for their needs. Third-party consent by parents or other adults may be required for adolescents to access contraception or other services such as HIV testing.

Girls who marry very young have particular difficulties in accessing SRH services, including prenatal and postnatal care; they may not have the knowledge or means to access these services and make informed choices about pregnancy and childbearing. They are at greater risk of domestic violence and are generally less able to negotiate contraceptive use within their marriage and thus protect their own health.

Women, children and adolescents living with HIV often face particular challenges in accessing healthcare services – also due to fear of stigma and discrimination from service providers or the wider community.

In rich and poor countries alike, minority ethnic communities and indigenous communities tend to have higher rates of ill-health and less access to quality healthcare than other sections of the population, leading to lower life expectancy and higher rates of disease and disability.[64] Even in a rich country like Australia, the mortality rate among indigenous children under-five is still higher than that of non-indigenous children.[65] A study on the health of indigenous peoples by *The Lancet* and the Lowitja Institute in Australia showed disparities between indigenous and non-indigenous populations in low-, middle- and high-income countries in life expectancy at birth, infant mortality and frequency of low or high birthweight, as well as gaps in measures related to nutrition. On the whole, indigenous populations had poorer health and social outcomes, with some exceptions and variations.[66]

The MDGs' focus on national targets has masked continuing health and nutrition disparities among indigenous populations. They are typically among the most marginalised communities in any society in political and socioeconomic terms, which again leads to poorer health and nutritional outcomes.[67] Globally, indigenous peoples have disproportionately higher levels of maternal mortality and morbidity, higher infant and child mortality, and higher levels of malnutrition;[68] and they face multiple challenges in accessing essential healthcare due to their ethnicity, minority or indigenous status. Indigenous women have also been subject to gross violations of their sexual and reproductive rights, with documented cases of forced or involuntary sterilisation.[69, 70] Discrimination, abuse and disrespect of indigenous women during pregnancy and childbirth are well-documented and represent a major barrier to accessing maternal healthcare.[71]

Barriers preventing indigenous women and children accessing health services include a lack of health facilities in remote areas (which is where minority groups and nomadic or indigenous peoples tend to live), concentration of health facilities in urban areas, geographical distance to facilities and lack of transport to reach them, as well as discriminatory attitudes among health workers. The former UN Special Rapporteur on the Rights of Indigenous Peoples, James Anaya, cited these and other factors – including a lack of sufficient healthcare workers and a lack of culturally sensitive birthing facilities, and unaffordable costs for indigenous women and their families – as key obstacles to accessing effective maternal care.[72] Indigenous women often experience the most acute disadvantage in their contact with the health system. They are disregarded or treated disrespectfully because they are poor and from marginalised communities. These women confront a health system that generally does not respond to their needs or understand their language and customs.

The sexual and reproductive health and rights of people with disabilities are often neglected and violated. People with disabilities are often denied access to SRH information and services based on assumptions that they are not sexually active or are not able to have children, or to make informed decisions about family life. In addition, health services are often either physically inaccessible to people with disabilities or may not provide information in accessible formats and materials. Service providers may not have the necessary skills and knowledge to meet the needs of people with disabilities, or may even have negative or prejudiced attitudes towards them. At worse, women with disabilities have been subject to forced sterilisations and forced abortions.[73] Efforts should be made to ensure that women, children and adolescents with disabilities have equal access to essential services, provided in a respectful and dignified environment, in a manner that does not exacerbate marginalisation and discrimination.[74]

PHOTO: COLIN CROWLEY/SAVE THE CHILDREN

Newborn baby Popi gets her first postnatal check-up at a clinic in Bangladesh.

3 Tackling the drivers of exclusion

The inequalities in women's, children's and adolescents' access to health and their exclusion from health services represent a persistent failure to uphold the right to health for the poorest people in the most disadvantaged communities. Save the Children believes that the principles of universality, progressive realisation and shared responsibility should guide all stakeholders to the solutions for addressing these inequalities. This section looks at how health inequities are perpetuated by certain factors: gender inequality and discrimination; laws, policies and social norms; and financial barriers, highlighting failures to invest in universal health systems that respond to the needs of the poorest and most vulnerable people in society.

Gender discrimination and the persistent lack of empowerment of women and girls are not often acknowledged as reasons for the neglect of reproductive, maternal and child health. Deaths in pregnancy and childbirth are often regarded as tragic but inevitable, and maternal deaths are still not routinely recorded, counted or investigated in many countries.

The poorest and most excluded women and girls bear the brunt of this situation and still lack access to health services – whether due to distance from facilities or financial barriers such as inability to afford out-of-pocket payments. Women and children in some low-income settings have been detained in health facilities until bills have been paid, or denied care altogether until they provide money to pay for basic supplies, as we discuss in the section on 'Financial barriers and out-of-pocket expenditure' (see page 18). These delays often have devastating consequences, with reported cases of women and their babies dying because they did not have the money to pay the costs demanded at health facilities.[1]

Laws, policies and social norms that restrict access to SRH services – for example, on the basis of marital status, sexual orientation or age – also deny women and girls their right to health. The stigmatisation or criminalisation of sexual behaviour can lead to the denial of essential healthcare, particularly to groups that already experience discrimination and marginalisation.

GENDER INEQUALITY AND DISCRIMINATION

Women and girls' status in their family, community and society are key determinants of health and are therefore critical to any strategy to eliminate preventable maternal and child deaths and ill-health. In most countries across the world, girls are treated very differently from boys, and their perceived role in the family and in society restricts their choices and autonomous decision-making, especially in relation to their sexual and reproductive health and rights. Early and/or forced marriage, gender-based violence (including sexual violence), female genital mutilation/cutting (FGM/C) and a lack of information, education and services on sexual and reproductive health, all affect the survival and health of women and girls.

Many women and girls have less information and power than men and boys, so are less able to make choices that affect not just their own health and lives but the lives of their children and family. In many countries, women's and girls' ability to make their own decisions about their sexual and reproductive lives, about whether and when to have children (and how many), and whether to access SRH information and services is curtailed by legal, social and/or religious norms. Decisions on the use of contraception or other SRH services may be made by other family members and not by women themselves.

The Zika outbreak in Latin America has highlighted the need to ensure universal access to comprehensive sexual and reproductive health information and services for all women and girls; an estimated 23 million women in this region have an unmet need for contraception.[2]

Education is a key driver of health inequity. Women who have had an education are much more likely to be able to protect their health and that of their children. There are clear positive correlations between women's levels of education and maternal and child survival rates.[3] It has been estimated that the lives of 2.1 million children were saved between 1990 and 2009 as a result of improvements in women's education.[4]

LEGAL AND POLICY ENVIRONMENT AND SOCIAL NORMS

A legal and policy environment that restricts access to SRH information and services drives discrimination and health inequity. Such restrictions can include requirements for spousal or third-party consent to access family planning,[5] or parental consent for adolescents seeking contraception information and services.

As discussed earlier, limitations on access to information and services for adolescents – by not providing comprehensive sexuality education in the school curriculum, or not ensuring that health services are adolescent-friendly and take their specific needs into account – hinder their ability to realise their right to health. In Indonesia, for example, the legal and policy environment hinders access to SRH services for unmarried women and adolescents. Two pieces of legislation[6] stipulate that access to such services are intended for legally married couples. In practice, this means that some contraception and family planning services are not available at public health facilities to unmarried women or couples, including adolescents. Married women may be required to have their husbands' permission to get more permanent types of contraception from government health facilities.[7] Adolescents and other unmarried people can access some types of contraception from private shops provided they are available where they live and they can afford to buy them.[8]

Stigma and discrimination[9] against particular groups of people with specific health needs (such as people living with disabilities; lesbian, gay, bisexual, transgender and intersex (LGBTI) persons; people living with HIV; sex workers; or unmarried women and girls) can discourage them from seeking healthcare or lead them to receive biased, inadequate or inappropriate healthcare. In some cases, stigma can deny those groups access to SRH information and services altogether.

FINANCIAL BARRIERS AND OUT-OF-POCKET EXPENDITURE

The costs of essential maternal and child healthcare – whether formal or informal costs – are a major barrier preventing the poorest and most excluded women and children getting the services they need. User fees have been shown to be highly regressive, with a particularly negative impact on the poor, reducing uptake of essential health services. Sierra Leone's 2010 Free Health Care Initiative for pregnant women and children resulted in a significant rise in demand for services. Burundi introduced a new policy to allow all pregnant women and children under five to access health services free of charge (including skilled delivery at birth) following evidence[10] of women and their babies being detained in public health facilities because they could not afford to pay hospital bills. While this resulted in health facilities being overwhelmed with demand, in 2011 the government – with the support of bilateral and multilateral donors[11] – strengthened the healthcare system by providing more resources to front-line services and giving pay increases to health workers.[12]

Even the World Bank, which promoted user fees in the 1980s and 1990s, has now publicly stated that they are damaging and inequitable. Its President, Jim Yong Kim, declared in 2013: "Anyone who has provided healthcare 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."[13]

Out-of-pocket (OOP) expenditure for healthcare during pregnancy and childbirth is still common in many low- and middle-income countries. Women often have to pay formal or informal charges to receive care, and have to buy their own medicines and basic necessities, such as soap and clean sheets, when going into hospital to give birth. Lack of funding of public health services and the resulting poor quality or unavailability of services forces

many poor people to use costly private providers whose services vary widely in quality.

In several countries (including Ghana, Kenya, Nigeria, Burundi, the Philippines and Zimbabwe), there have been documented cases of women and their children being detained in health facilities after giving birth – for weeks or even months, often overseen by security guards – because they could not afford to pay the hospital fees.[14] Where costs are high – for example, in the case of a caesarean section – women and their babies are held in facilities until their families can raise the necessary funds. Fear of being detained due to inability to pay can prevent women from going to a health facility to give birth, and instead opting for other (cheaper) solutions, such as resorting to traditional birth attendants. Detention due to inability to pay is a clear violation of women and children's rights. It is a direct consequence of chronic under-financing of the health sector in many countries, the lack of social protection afforded to those in need, and ongoing failures to guarantee all women and children access to vital healthcare, free at the point of use.

In order to fulfil their human rights obligations, to address inequalities in access to services due to gender discrimination, and to end all preventable maternal and child deaths, governments must commit to providing Universal Health Coverage that prioritises women's, children's and adolescents' health needs. Save the Children supports the movement for UHC and calls on other maternal and child health advocates to give their support too. The next section describes a vision of UHC that prioritises women's, children's and adolescents' health.

Newborn baby Arther, 4 days old, is treated for fever at a Save the Children-supported clinic in Liberia.

4 Spotlights

This chapter presents 'spotlights' on Indonesia, Nigeria and Ethiopia. They look at the progress made so far by each country in reducing maternal and child deaths, as well as disparities and challenges in each national context.

Spotlight on Indonesia

PHOTO: DAVID WARDELL/SAVE THE CHILDREN

Tia from Indonesia holds her newborn son, born just 30 minutes earlier.

PROGRESS SO FAR

Indonesia has seen progress on maternal and child health during the period of the MDGs. It has achieved a marked reduction in neonatal, infant and under-five mortality, with the most significant decline in under-five deaths.[1] It succeeded in meeting its MDG 4 target, reducing under-five mortality from 85 deaths per 1,000 live births in 1990 to 27 in 2015,[2] but has seen slower progress in reducing neonatal mortality. Indonesia did not meet the MDG target on maternal mortality. An estimated 6,400 maternal deaths occurred in 2015;[3] the 2012 Demographic and Health Survey (DHS) suggested that maternal deaths may have actually increased since the previous survey in 2007.[4]

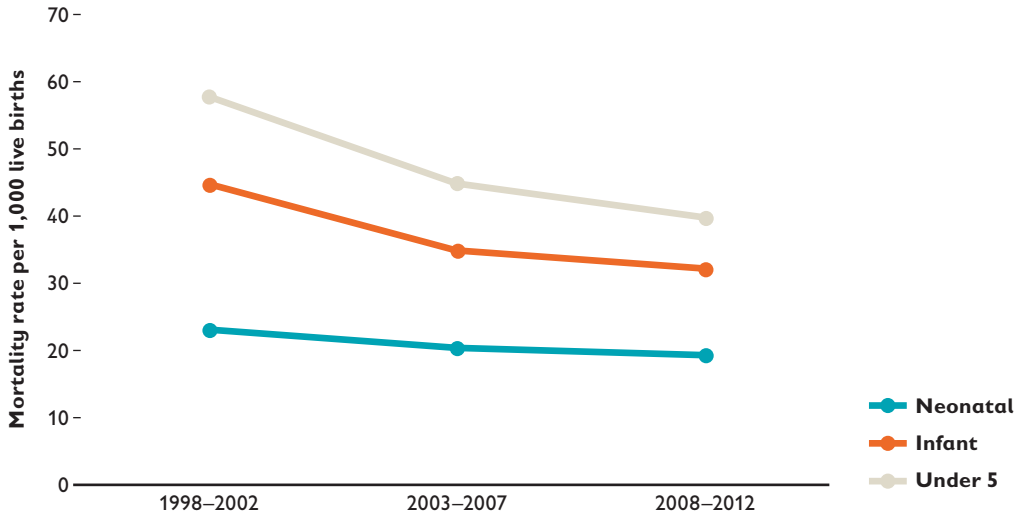
CHALLENGES

Despite this progress, data from the 2012 DHS reveals substantial disparities – both in access to maternal and child health services and in health outcomes – based on people's income, level of education, and place of residence (covering rural–urban and regional differences). There were significant differences in child mortality rates between socioeconomic groups.

- Under-five mortality was three times higher among children in the lowest wealth quintile compared with those in the highest quintile (70 versus 22).
- It was also 1.5 times higher in rural areas than in urban areas (52 versus 34).
- The widest disparities in under-five mortality rates were linked to levels of education.
- Children whose mother had no education were three times more likely to die before their fifth birthday than those whose mother had some secondary level education.
- Education also plays an important role in reproductive and maternal health interventions.
- Women who had completed secondary school were almost three times more likely to give birth in the presence of a skilled health worker than those with no schooling.

Indonesia has succeeded in reducing some inequalities, such as the rural-urban differential in skilled birth attendance. While births in rural areas were nearly three times less likely to be attended by a skilled health worker in 1994, this ratio reduced to 1.2 in 2012.[5] This is a positive development. However, as child mortality rates have declined, there has been slower progress in reducing neonatal deaths (see Figure 7).

FIGURE 7 NEONATAL, INFANT AND UNDER-FIVE MORTALITY RATES IN INDONESIA, 1998–2012



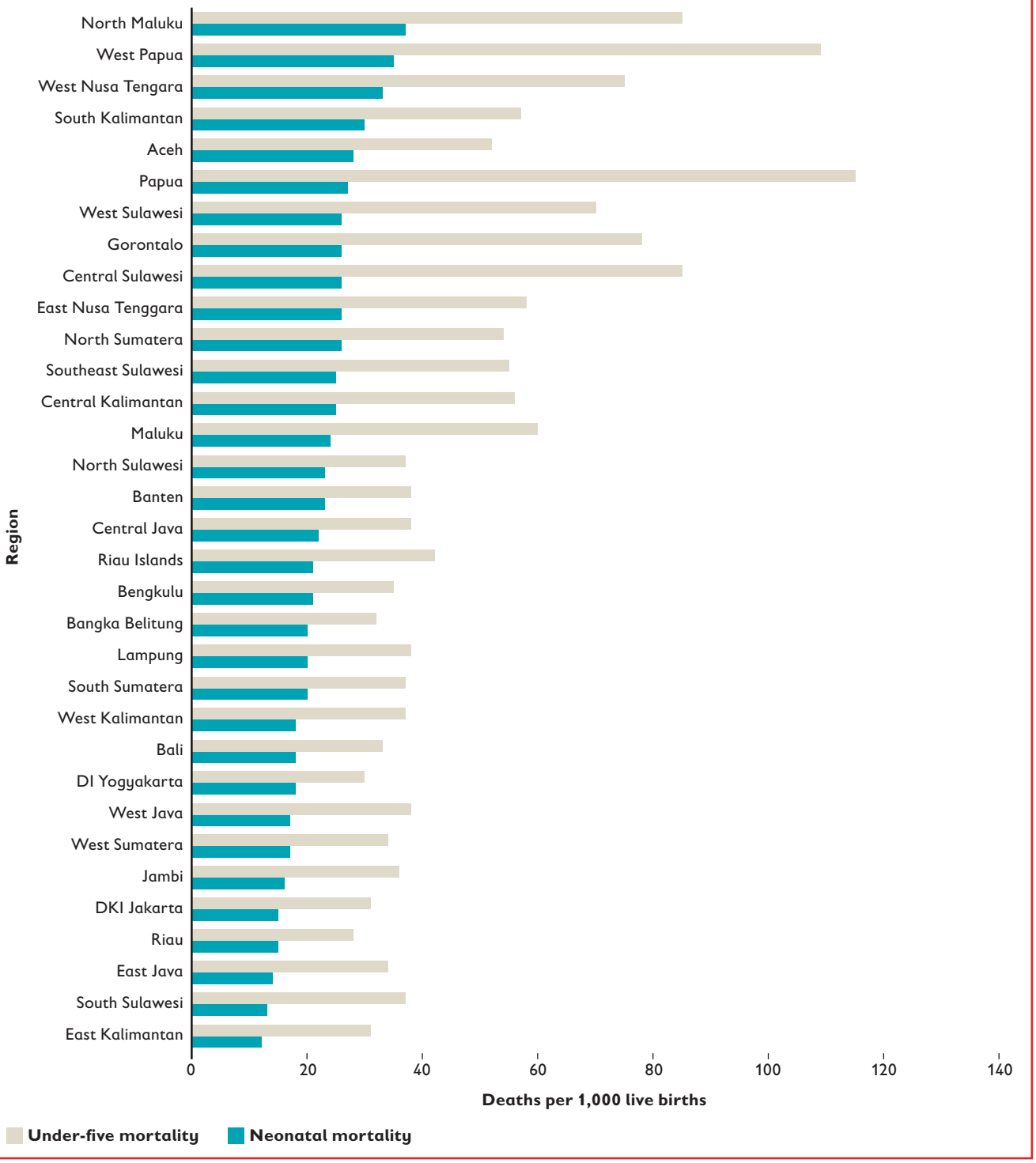
Source: Badan Pusat Statistika (Central Statistical Agency, Indonesia)

GEOGRAPHIC INEQUALITIES

Based on the most recent DHS data, there are substantial regional disparities in child mortality rates. The under-five mortality rate in Papua, for example, was more than four times higher than in Riau and more than twice as high in West Nusa Tenggara and Gorontalo than in DKI Jakarta (see Figure 8).[6]

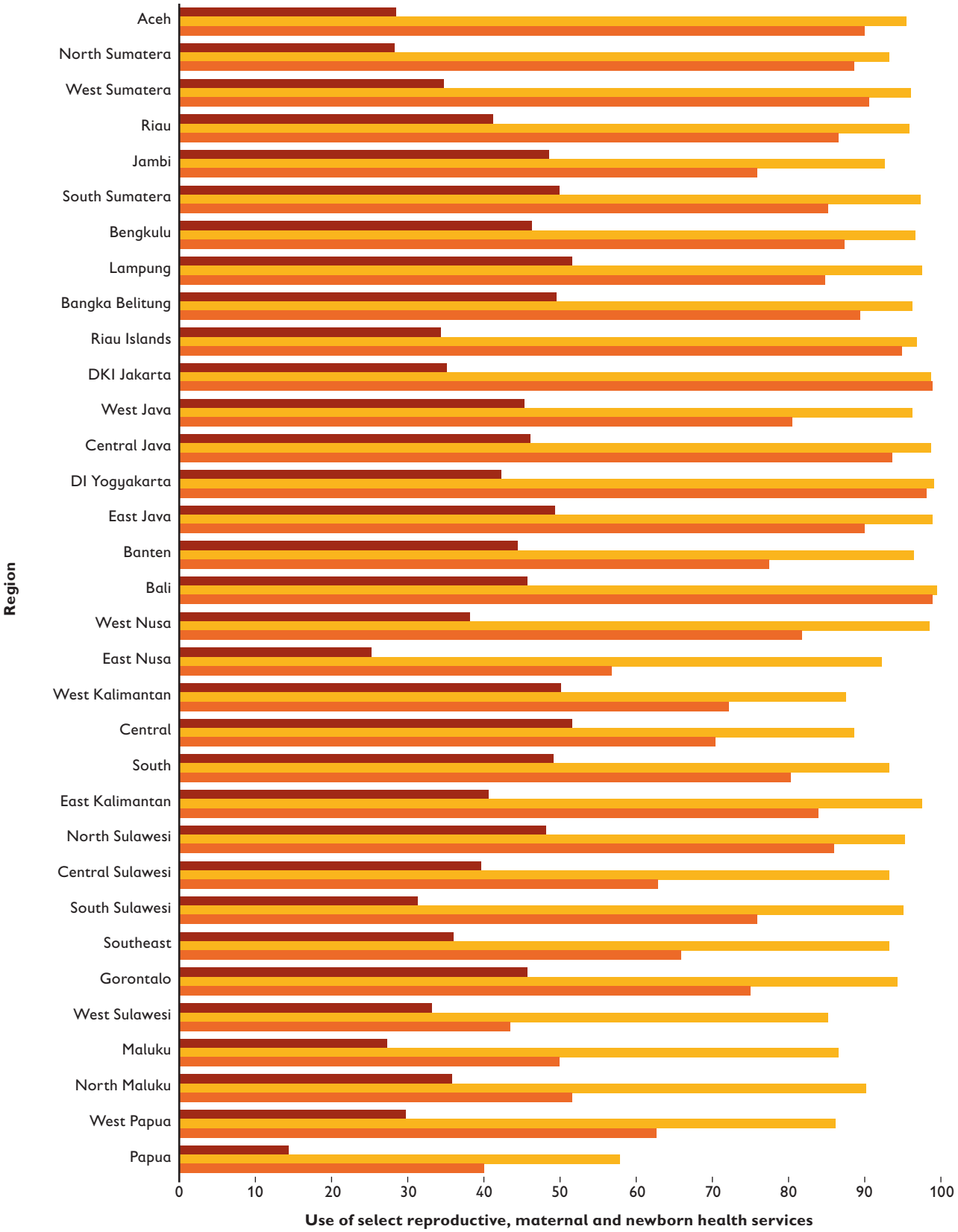
There are also considerable regional disparities in access to key maternal and newborn services (see Figure 9).

FIGURE 8 CHILD MORTALITY RATES BY PROVINCES IN INDONESIA, BASED ON DATA FROM THE TEN-YEAR PERIOD PRECEDING THE 2012 DHS SURVEY



Source: Indonesia DHS 2012

FIGURE 9 ACCESS TO SELECT MATERNAL AND CHILD HEALTH SERVICES BY GEOGRAPHIC REGION (INDONESIA)



Source: Indonesia DHS 2012

LOW PUBLIC INVESTMENT AND HIGH OUT-OF-POCKET EXPENDITURE

Indonesia's level of public funding for health is extremely low, while people have to pay for almost half of their health expenses out of pocket. The country spent just over 1% of its gross domestic product (GDP) on health in 2014.[7] Out-of-pocket (OOP) payments represent a substantial share of total health expenditure – 47% in 2014.[8]

In 2014 Indonesia introduced a new National Health Insurance Scheme (JKN) to provide social protection for all Indonesians. Social health insurance is supposed to be mandatory, and to form part of Indonesia's roadmap towards UHC. The premium for the poorest groups is fully subsidised by the government. However, this is not the case for those who are just above the poverty threshold; as poverty is dynamic and people's circumstances can change very easily, there is a risk that some of the poorest people and other low-income groups may be excluded from the scheme. The benefit package includes reproductive, maternal and child healthcare, family planning, antenatal care, childbirth care (including caesarean sections), childhood immunisation and postnatal care. However, in practice, not all regions are equipped to provide many of these services. Services are supposed to be free at the point of use for JKN scheme participants.

But Save the Children's research has highlighted a number of challenges in its implementation.

The scheme potentially excludes people who do not have the necessary documentation, such as those with 'illegal' residential status in cities, people living in informal settlements, homeless people (including street children), indigenous and/or nomadic people, and domestic workers. There is low public awareness and understanding of the scheme (in urban and rural areas); poorer people have particularly limited knowledge of how it works, its coverage, what it entitles them to, and the referral system. Among the issues raised by participants in focus group discussions was the complexity of the registration and referral procedures of the scheme, especially for women with little education and living in rural areas.

Indonesia also suffers from a shortage of health facilities and insufficient skilled health workers. Hospitals and community health centres (Puskesmas) do not have adequate facilities to provide reproductive, maternal, newborn and child health services for all who need them. Shortages of health facilities and medical staff remain key barriers to the availability and accessibility of services.

Health facilities are concentrated in certain parts of the country, with wide disparities in the availability of facilities and medical personnel between rural and urban areas. Despite efforts by the Ministry of Health to provide incentives for midwives and doctors assigned to remote areas (including small islands), the distribution of medical personnel in rural/remote and urban areas remains unequal.

Spotlight on Nigeria

PHOTO: JANE HAHN/PANOS FOR SAVE THE CHILDREN

Mariam, age six months, with her mother at a hospital clinic in Nigeria.

PROGRESS SO FAR

Nigeria's rates of maternal and under-five deaths are among the highest worldwide. Estimates for 2015 indicate that it is among the 10 countries with the highest rates of under-five and neonatal mortality. While it has not met the MDG 4 target on under-five deaths, the rate has decreased from 213 per 1,000 live births in 1990 to 109 in 2015.[9]

It has also not met the MDG 5 target on maternal mortality reduction; in 2015, Nigeria was estimated to account for approximately 58,000 maternal deaths – 19% of the global total.[10] According to the country's most recent Demographic and Health Survey (DHS), maternal deaths accounted for almost a third (32%) of all deaths among women aged 15–49.[11]

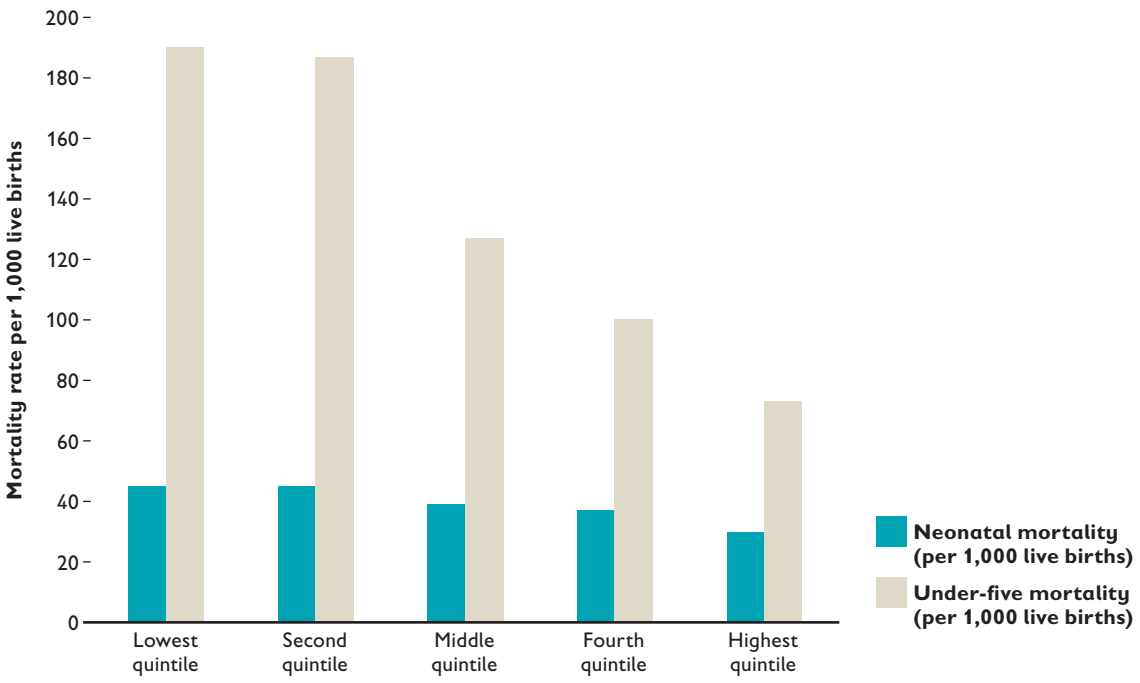
Save the Children in Nigeria commissioned a study to identify the factors affecting access to reproductive, maternal, newborn and child health (RMNCH) services, especially among poor people and other excluded groups. The study included a literature review and key informant interviews and focus groups discussions at national level and in two states (Gombe and Katsina, in the North East and the North West respectively) where Save the Children has been working for some time, and which have poor maternal and child health outcomes.

CHALLENGES

HIGHER RATES OF UNDER-FIVE DEATHS AMONG THE POOREST, THOSE WITH LEAST EDUCATION AND RURAL POPULATIONS

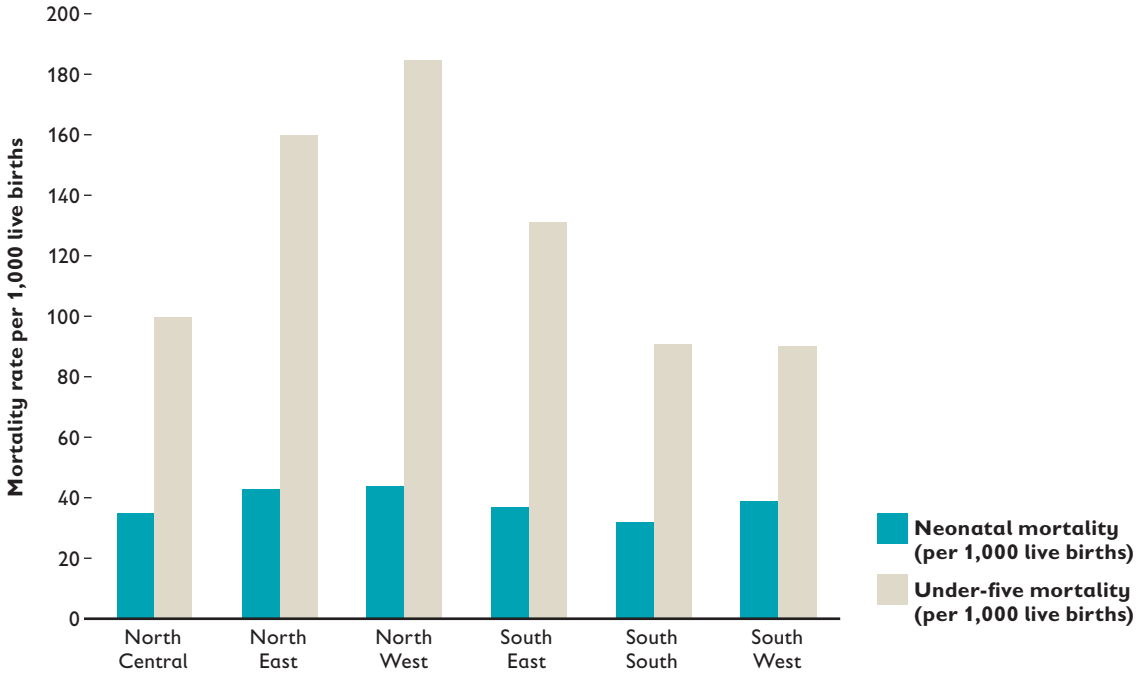
The latest DHS in Nigeria (2013) reveals significant disparities in both maternal and child health outcomes and access to RMNCH services. According to the DHS data, in the ten-year period preceding the survey, there were marked differences in neonatal and under-five deaths based on income, region, and mother's level of education (see Figures 10 to 12). The under-five mortality rate was 167 per 1,000 live births in rural areas, compared with 100 deaths per 1,000 live births in urban areas. The under-five mortality rate for the poorest quintile was more than 2.6 times higher than the richest quintile. And the under-five mortality rate among women with no education was double that of women who had completed secondary education.

FIGURE 10 NEONATAL AND UNDER-FIVE MORTALITY RATES BY WEALTH QUINTILES (NIGERIA)



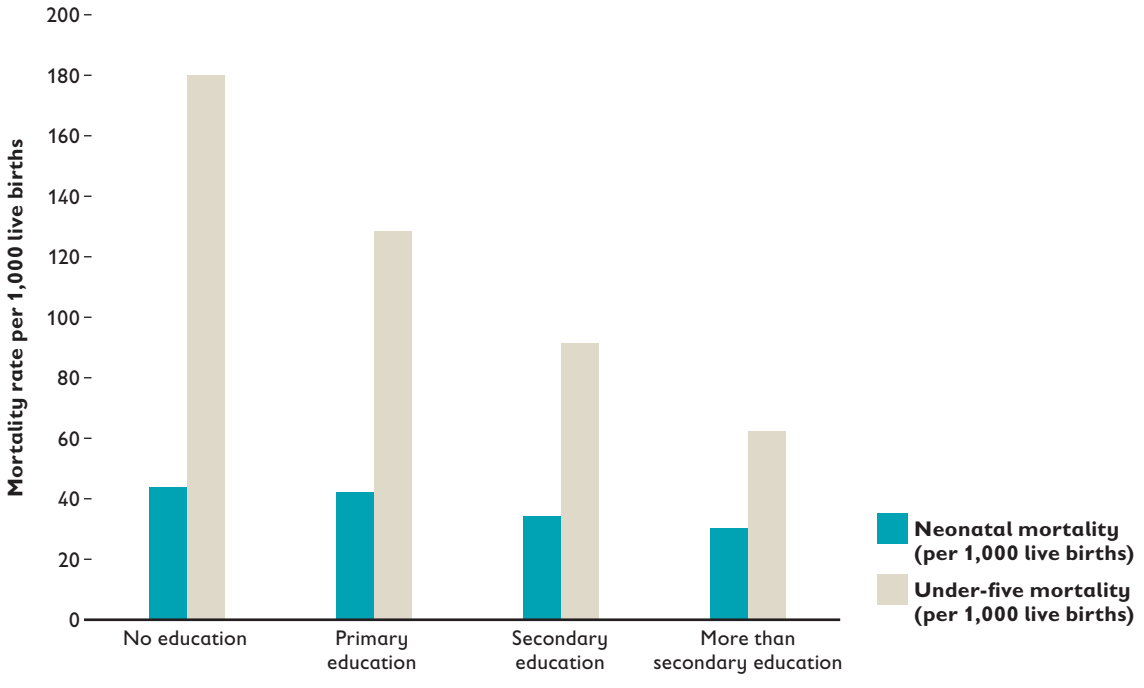
Source: Nigeria DHS, 2013, data based on the ten-year period preceding the survey

FIGURE 11 NEONATAL AND UNDER-FIVE MORTALITY RATES BY REGIONS (NIGERIA)



Source: Nigeria DHS, 2013, data based on the ten-year period preceding the survey

FIGURE 12 NEONATAL AND UNDER-FIVE MORTALITY RATES BY LEVEL OF MOTHER'S EDUCATION (NIGERIA)



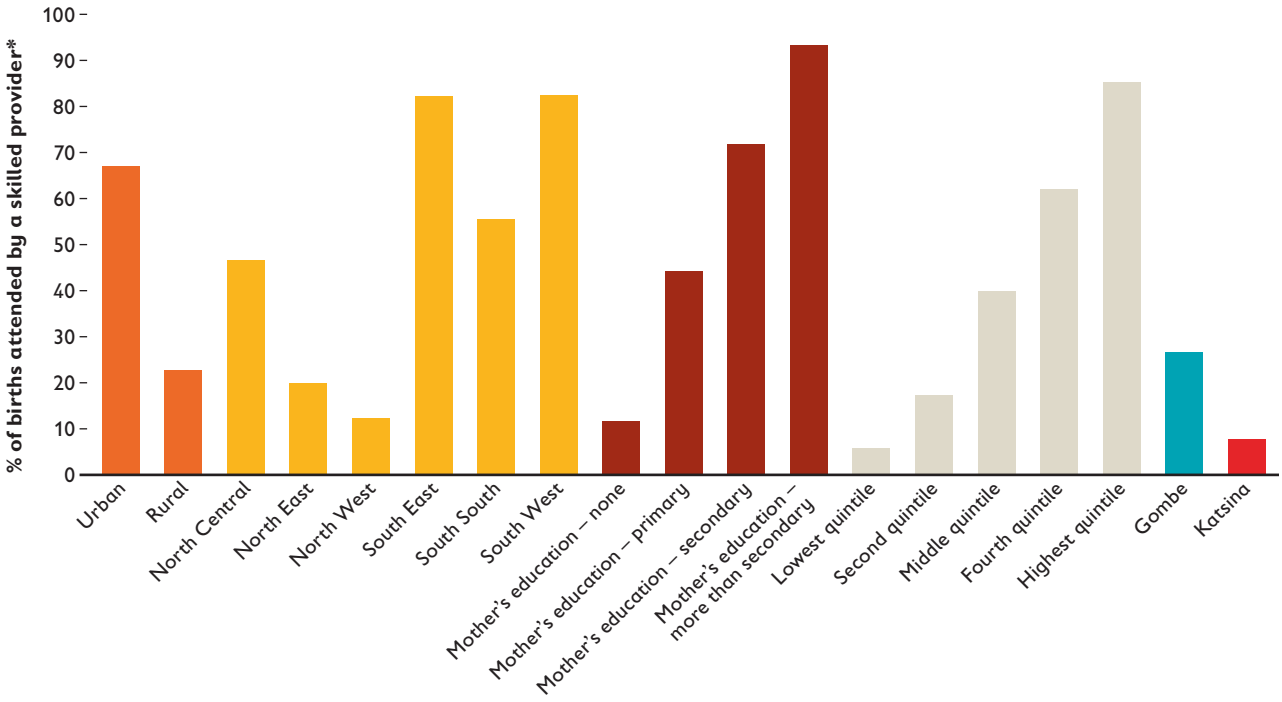
Source: Nigeria DHS, 2013, data based on the ten-year period preceding the survey

DISPARITIES IN USE OF CORE MATERNAL AND CHILD HEALTH SERVICES

Disaggregating the data by location, women's level of education and wealth quintile shows that those living in rural areas, in the North East and North West regions, those with limited or no education, and those in the poorest groups are much less likely to give birth in the presence of a skilled health provider.

Inequality between wealth quintiles has increased over time in relation to coverage of key maternal health interventions (see Figure 14).

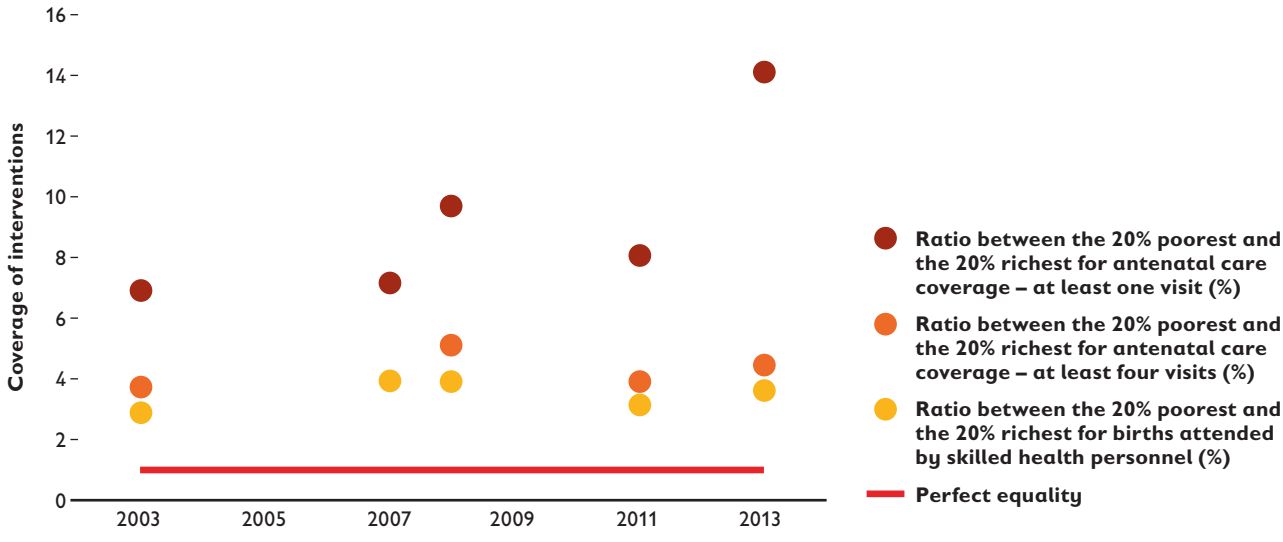
FIGURE 13 PERCENTAGE OF LIVE BIRTHS DELIVERED BY A SKILLED PROVIDER* IN THE FIVE YEARS PRECEDING THE 2013 DHS (NIGERIA)



Source: Nigeria DHS, 2013

* Doctor, nurse, midwife and auxiliary nurse/midwife

FIGURE 14 DISPARITIES IN COVERAGE OF KEY MATERNAL HEALTH INTERVENTIONS BY WEALTH (2003–13; NIGERIA)



Source: WHO Health Equity Monitor (MICS 2007 and 2011 and DHS 2003, 2008 and 2013)

KATSINA AND GOMBE

Neonatal and under-five mortality rates in Gombe and Katsina states are disproportionately higher than the national rates.[12] The number of women who receive antenatal care, the proportion of deliveries attended by a skilled provider, and children's nutritional status are also of concern in these states. For example, the percentage of women receiving antenatal care from a skilled provider (doctor, nurse, midwife, or auxiliary nurse/midwife) was 58.2 in Gombe and 22.7 in Katsina, and the percentage of women whose babies were delivered by a skilled provider was only 26.6 in Gombe and 7.7 in Katsina in the period preceding the last DHS survey.[13]

Key informant interviews and focus group discussions for the Nigeria research highlighted a lack of accessibility to RMNCH services by those who need them most – poor women and women living in hard-to-reach areas. Almost all interviewees described the inaccessibility of health services in broad terms, including the lack of functioning health facilities, medicines and personnel, and the long distances people in remote areas have to travel to reach health facilities. Respondents reported the deplorable state of some healthcare facilities, lack of medicines and other necessities, equipment that either does not work or cannot be used because health workers lack the skills to operate it, and lack of stationery for record-keeping.

Participants also reported a shortage of health workers in both states, which puts even more pressure on existing staff to the point that facilities set limits on the number of patients they can see each day. Some reported harassment and undue delays by some health workers.

In both states, RMNCH services are nominally provided free of charge to pregnant women and children under five. However, facilities often run out of medicines and other necessities, so clients are expected to buy prescribed medicines out of pocket. Evidence from interviews with stakeholders in both Katsina and Gombe shows that there is no clear policy in place to ensure that RMNCH services are free at the point of use. Accessing healthcare services definitely has cost implications, which many find difficult to afford. Out-of-pocket costs include medicines (when not available at health facilities), and transportation to facilities where medicines are available. Those who cannot afford all the medicines prescribed have to reduce the number on their list or choose to buy cheaper medicines from unauthorised sellers.

Most government stakeholders interviewed attributed these shortcomings to inadequate levels of funding. Other stakeholders voiced concerns about the poor state of health services due to mismanagement and lack of accountability.

HIGH OUT-OF-POCKET EXPENDITURE, LOW PUBLIC FINANCING AND UNEQUAL DISTRIBUTION OF HEALTH FACILITIES

The Nigerian government's expenditure on health averaged 7.2% of total government expenditure from 2008 to 2012.[14] During this period, private out-of-pocket expenditure as a percentage of total expenditure on health amounted to nearly 70% – hitting poor people hardest, as well as those in the informal sector and those living in disadvantaged rural and hard-to-reach areas. In 2014, the government's health expenditure as a proportion of GDP was just 1%.[15]

The distribution of health facilities and of the health workforce is skewed, disadvantaging rural areas. Though Nigeria has a relatively high number of skilled health workers compared with other countries in sub-Saharan Africa, most are in urban areas. In some Nigerian states, more than 90% of doctors are in the state capital.

The National Health Bill was signed into law on 30 October 2014 – a major initiative that is intended to move Nigeria's health system towards UHC. It provides for greater coverage and strengthening of primary healthcare through a Basic Health Care Fund. When fully implemented, the law has the potential to improve Nigeria's poor record on maternal and child health.

Spotlight on Ethiopia

A baby girl is fed by a nurse and her mother at Kobe refugee camp in Ethiopia.

PROGRESS SO FAR

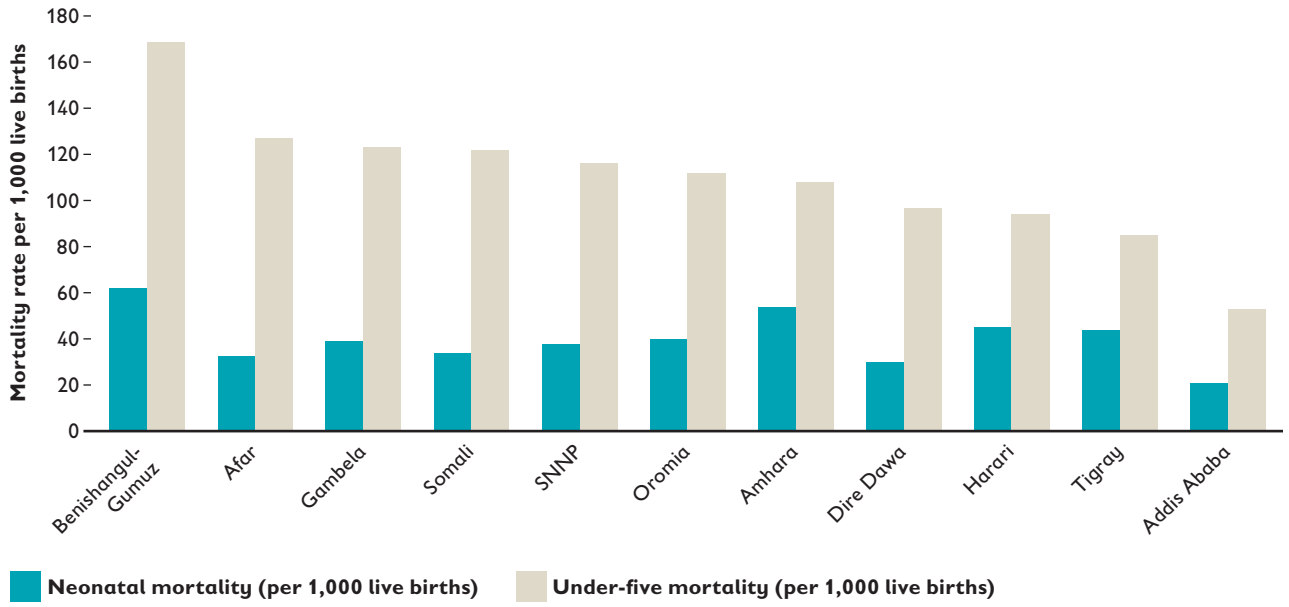
Ethiopia took strong ownership of the MDGs agenda and integrated the MDG targets into successive national development plans. Through sustained national commitment, it has achieved remarkable progress on reducing preventable child deaths, meeting its MDG 4 target ahead of time.[16] In 1990, it had one of the highest under-five mortality rates in the world, at 205 deaths per 1,000 live births, but by 2012 this had fallen to 68,[17] falling further to 59 by 2015.[18] This was achieved with one of the fastest rates of decline among low- and middle-income countries. Health and nutrition interventions – including scaling up of health extension workers, immunisation, food security programmes and improved access to water – all contributed to this marked decline in under-five deaths. From 2000 to 2011, Ethiopia prevented an estimated 469,000 child deaths through scaling up high-impact interventions.[19]

Ethiopia's Health Extension Programme (HEP) was introduced in 2004. It aimed to extend the reach of key maternal, neonatal and child health interventions in the community. Between 2005 and 2011, about 38,000 health extension workers were trained and deployed, and there was a significant increase in the number of health posts, health centres and hospitals.[20] There was also more investment in other human resources, including doctors and nurses. This is part of government efforts to strengthen primary healthcare so as to deliver more and better healthcare for women and children. There has been less progress in strengthening midwifery personnel, and more accelerated training and deployment of midwives is needed.[21] The HEP was accelerated with a key emphasis on increasing interventions that were lagging behind, such as maternal and newborn health. It also focused on improving delivery services at health facilities and expanding basic and comprehensive emergency obstetric care, as well as family planning services.

CHALLENGES

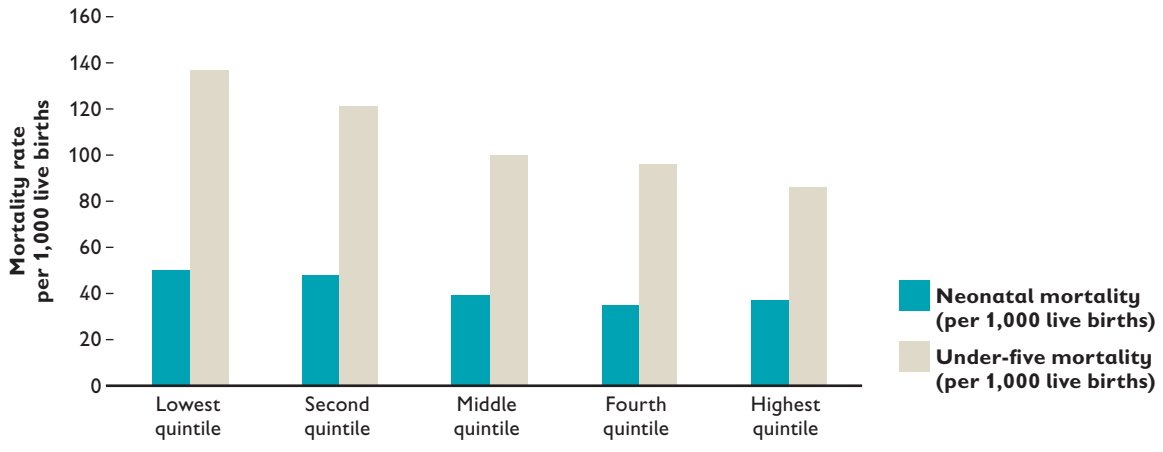
There has been much slower progress in the reduction of newborn deaths, while progress in maternal and child health is marked by significant disparities based on income, geographic location and mother's level of education.[23] Ethiopia's continued progress hinges on addressing high levels of neonatal mortality. Coverage of services that are essential for newborn health continues to be very low, including coverage of skilled birth attendance, which was only 15% in 2014.[24] And while substantial progress has been made in reducing preventable maternal deaths – from a very high maternal mortality ratio of 1,250 per 100,000 live births in 1990 to an estimated 353 per 100,000 in 2015 – this has not been sufficient for Ethiopia to meet its MDG 5 target.[25] Ending preventable maternal deaths, an estimated 11,000 in 2015,[26] remains a key challenge for Ethiopia.

FIGURE 15 UNDER-FIVE AND NEONATAL MORTALITY BY REGION, FOR THE TEN-YEAR PERIOD PRECEDING THE 2011 DHS (ETHIOPIA)[22]



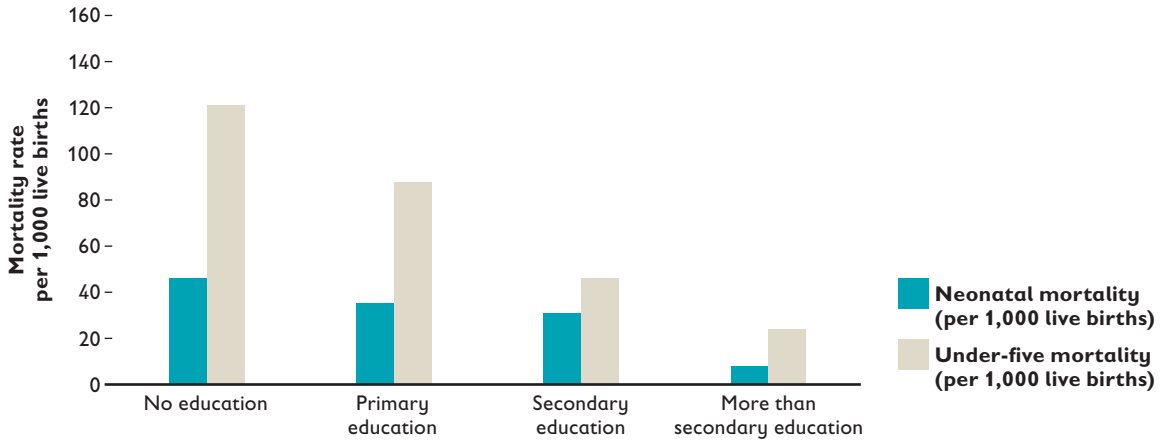
Source: Ethiopia DHS, 2011

FIGURE 16 UNDER-FIVE AND NEONATAL MORTALITY BY WEALTH QUINTILE, FOR THE TEN-YEAR PERIOD PRECEDING THE 2011 DHS (ETHIOPIA)



Source: Ethiopia DHS, 2011

FIGURE 17 UNDER-FIVE AND NEONATAL MORTALITY BY LEVEL OF MOTHER'S EDUCATION, FOR THE TEN-YEAR PERIOD PRECEDING THE 2011 DHS (ETHIOPIA)



Source: Ethiopia DHS, 2011

The country's impressive progress overall has, however, highlighted major disparities in mortality rates and coverage of services across different regions. Women and children living in remote and rural areas continue to be excluded from overall progress. The most recent comprehensive Demographic and Health Survey (DHS), from 2011, showed wide differences in maternal and child survival rates based on income, geographic location and mother's level of education.

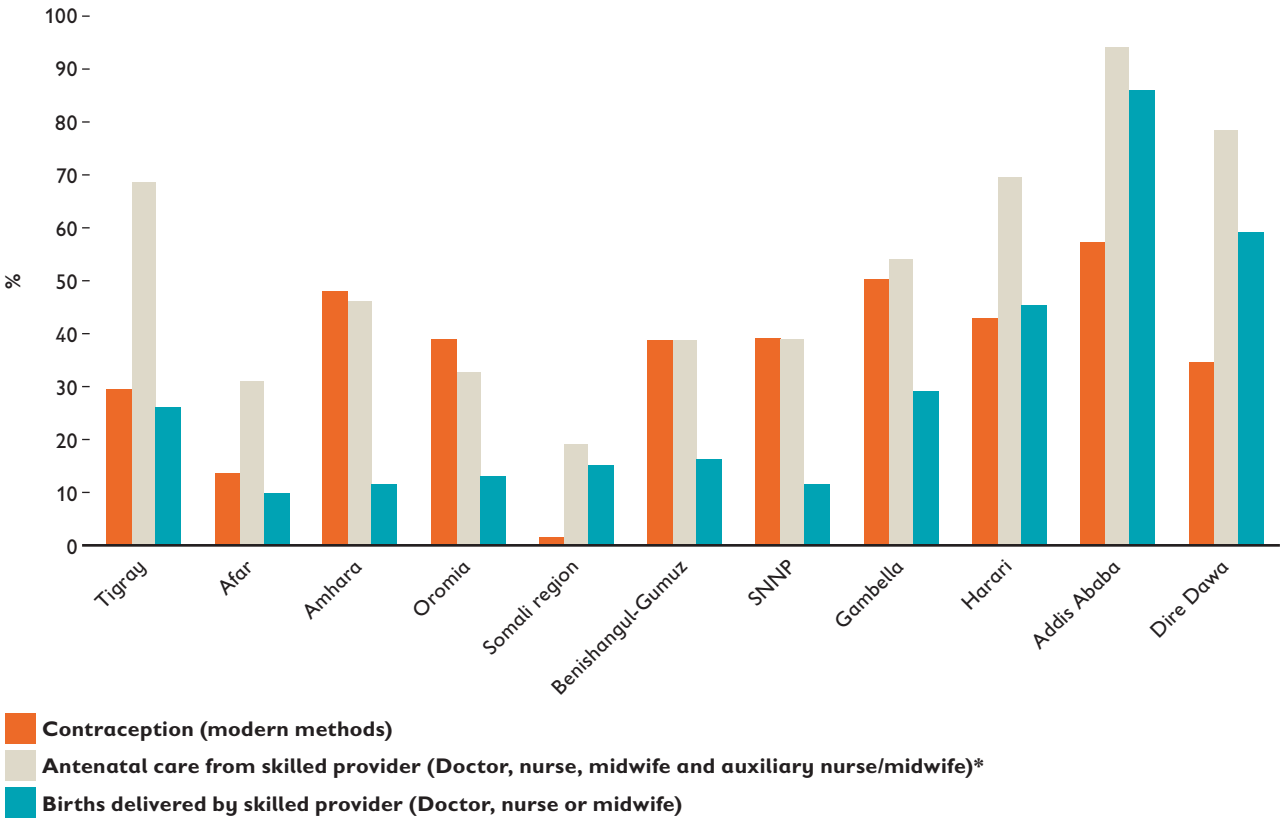
A 2014 mini DHS in Ethiopia also showed marked disparities between regions in access to key RMNCH services in the continuum of care (see Figure 18). Services tend to be concentrated in the capital, and populations in pastoral regions such as Afar and Somali have much lower coverage of key RMNCH interventions. Eighty percent of women in urban areas received antenatal services from a skilled provider for their most recent birth, compared with 35% of women in rural areas. Antenatal care from a skilled provider ranges from a low of 19% in Somali region to a high of 94% in Addis Ababa. The percentage of women who gave birth with a skilled health provider attending was 86% in Addis Ababa compared to 10% and 11.7% in Afar and Amhara regions respectively.[27] Despite a significant decline in fertility rates in recent years, women in rural areas, those with the least education and from the poorest groups tend to have more children in their lifetime than women from urban areas and those who are relatively wealthier and who have more education.

At a national level, the proportion of deliveries with a skilled birth attendant present has more than doubled since 2005, although it still remains very low. The percentage of deliveries attended by a skilled health provider increased from 6% in 2000 to 15% in 2014, although there is significant variation between urban and rural areas and also between regions.

Ongoing challenges in eliminating preventable maternal, newborn and child mortality, especially in pastoralist areas, include insufficient access to safe drinking water and sanitation, low coverage of skilled delivery and newborn care, a shortage of midwives and doctors, low coverage of maternal health services, inadequate supplies of water and electricity at health posts and clinics, and the limited skills of health extension workers and other health professionals.

In its transition from the MDGs to the SDGs, Ethiopia has developed a five year Health Sector Transformation Plan (HSTP) for the period 2016–2020. This emphasises quality of care (including compassionate and respectful care), and a focus on addressing coverage gaps and ensuring improved and more equitable access to maternal, newborn and child health services. There will need to be sustained, increased and fair financing for health, especially for pastoralist regions, to ensure the HSTP's implementation.

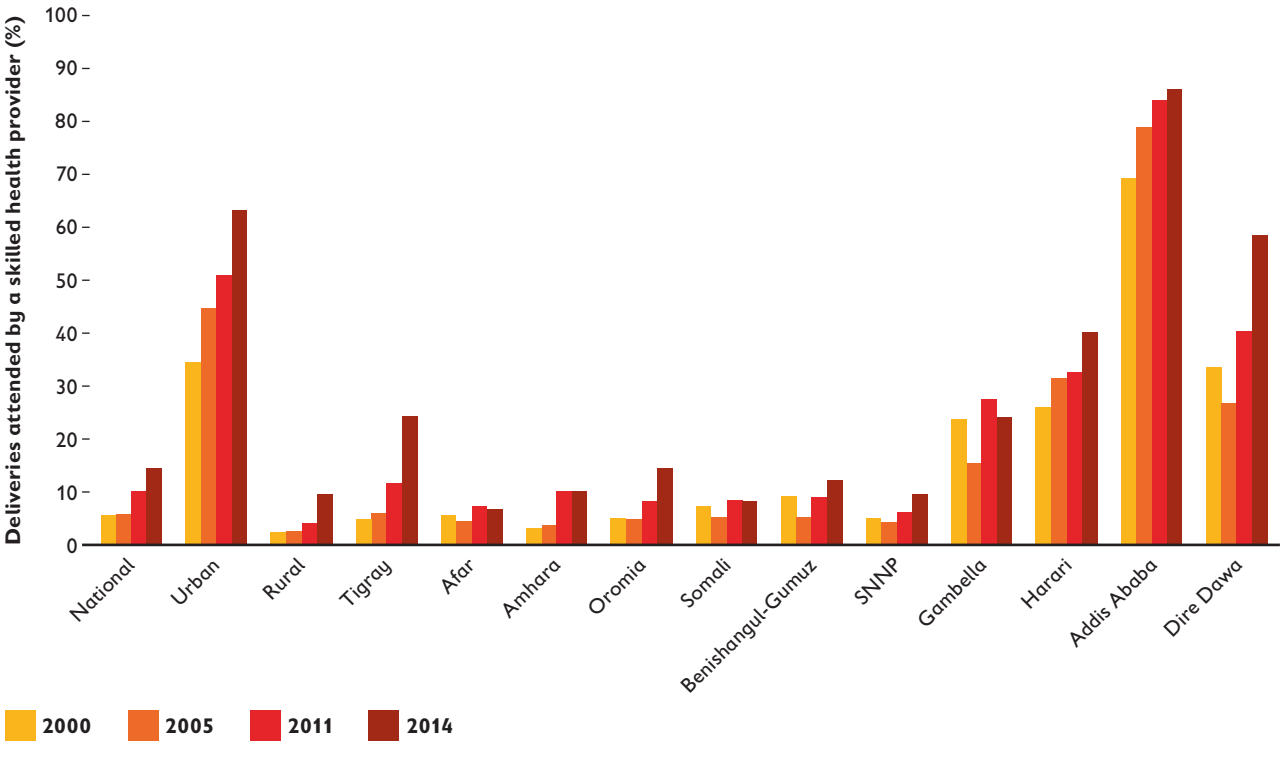
FIGURE 18 GEOGRAPHIC DISPARITIES IN KEY REPRODUCTIVE, MATERNAL AND NEWBORN INTERVENTIONS (ETHIOPIA)



Source: Ethiopia Mini Demographic and Health Survey 2014 Central Statistical Agency, Addis Ababa, Ethiopia, August 2014

* Does not state how many antenatal visits this data refers to.

FIGURE 19 DELIVERIES ATTENDED BY A SKILLED HEALTH PROVIDER (ETHIOPIA)



Source: Millennium Development Goals Report, Ethiopia, 2014 (published 2015), based on DHS data from 2000 to 2014[28]

5 Finding solutions: universal health coverage that reaches all women, children and adolescents

Women, children and adolescents in many communities continue to face multiple barriers in accessing healthcare. There is a systematic lack of prioritisation of the health services needed by women and children from the poorest sections of society. There has been some (albeit unequal) progress in certain aspects of the continuum of care, but less in other aspects. Save the Children believes that the movement for Universal Health Coverage (UHC) must play a central role in addressing such exclusion and inequality. But it can only do so if UHC is conceived in a way that focuses first on delivering essential services to those who need them most.

THE GLOBAL COMMITMENT TO UHC

WHO defines Universal Health Coverage as ensuring that 'all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality, to be effective, while also ensuring that the use of these services does not expose the user to financial hardship'.[1] There is now a growing consensus on UHC; a UN General Assembly resolution was passed in 2012[2] and UHC has been embedded in the SDGs (target 3.8).

Despite these commitments, there is not yet enough action; many governments are not raising and spending enough money to guarantee access to essential healthcare for their whole population. Although experts agree that countries can only achieve UHC through increased public financing, governments are still failing to introduce fair and mandatory pooling of resources through progressive taxation, or to prevent illicit financial flows out of the country that could be used to finance health and other essential services. In addition, many donors and multilaterals have a continued preference for specific "vertical" projects on which they can report results to their stakeholders, instead of supporting the development of national health systems.

Despite the lessons purportedly learned from the Ebola crisis – that countries without comprehensive and universal primary healthcare cannot cope with outbreaks of infectious diseases – the task of supporting UHC is often dismissed as too ambitious.

PATHWAYS TO UHC – WHY WOMEN'S AND CHILDREN'S HEALTH IS A PRIORITY

Countries that are genuinely committed to achieving UHC are taking many different approaches, depending on national contexts. All governments, and especially those with severe constraints on resources, are faced with difficult choices about how to pay for, and provide, a range of health services, to whom, and with what level of financial risk protection.

A group of experts,[3] convened by WHO, recommended that countries take action in three areas in order to make fair and equitable progress:

- expand priority health services, based on cost-effectiveness, giving priority to the most disadvantaged and ensuring financial risk protection
- include more people in health coverage – ie, first expand coverage for low-income groups, rural populations, and the most disadvantaged in terms of health outcomes and service coverage
- prioritise eliminating out-of-pocket payments for essential services and for disadvantaged groups, and ensure a progressive system of pre-payment such as tax.

Save the Children believes there is a clear and compelling case for putting core services for women's, children's and adolescents' health, with strengthened primary health care, at the heart of UHC. These universally needed services should be made available to every community as the first priority, before expanding coverage to other services.

A PUBLIC HEALTH PRIORITY

Health services for women, children and adolescents are necessary for the health and well-being of every family and community. Therefore, they are critical for human, social and economic development. Maternal health and nutrition are inextricably linked to child health outcomes and there is overwhelming evidence that early childhood care and development are pre-conditions for children's healthy cognitive, physical and emotional development throughout the life-cycle. The first 1,000 days of life in particular, but also adolescence and women's childbearing years, are known to be "critical junctures for lifelong health, and by extension, thriving and productive populations".[4] So it is critical to invest in women's health and child development.

KEY FOR GENDER EQUALITY

Women's universal access to sexual and reproductive health (SRH) information and services is vital to reverse the unequal status of women and girls and to protect their own rights and health, as well as that of their children.

Women and children tend to be most affected by healthcare inequalities. They are more likely to experience lower coverage of basic health services and to have poor financial protection, and therefore face unmet health needs. In many contexts, they have limited access to financial resources and less control over them[5] and so are particularly deterred by out-of-pocket payments for healthcare.

Women and children therefore have the most to gain from healthcare systems that respond to their needs.[6] This requires ensuring that they can access quality health services (see box on 'Quality of care') without facing financial hardship. Making these services free at the point of use and eliminating out-of-pocket payments for sexual, reproductive, maternal, newborn, child and adolescent health should be an important first step. The Committee on the Elimination of All Forms of Discrimination against Women has stressed that measures to eliminate gender discrimination must include the provision of health services that are needed specifically by women.[7]

KEY TO ELIMINATING HEALTH INEQUITIES

An equitable approach that prioritises reducing health inequalities and exclusion is possible and necessary, and leads to faster progress. Research commissioned by Save the Children and others, using the *Lives Saved* tool, estimated that eliminating in-country wealth inequities in coverage of essential maternal and child health interventions would prevent 1.8 million under-five deaths and 100,000 maternal deaths, reducing child mortality by one-fifth and maternal mortality by almost one-third.[8] Save the Children's *Lottery of Birth* report found that faster progress on reducing child mortality rates is more common in countries that narrowed the gap between advantaged and disadvantaged groups.[9]

PRIORITISING WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH SERVICES WITHIN UHC IS AFFORDABLE AND MAKES ECONOMIC SENSE

The case for pro-poor pathways to UHC is clear and compelling. Making women's, children's and adolescents' health services a priority in UHC also makes sound economic sense. Some low and middle-income countries have already made great strides in reforming how their public health systems are funded and delivered, reducing out-of-pocket payments and tackling health inequities (see box for examples from Thailand and Rwanda).

Save the Children has calculated that all developing countries can afford to increase their spending on health by making different policy decisions about how they raise and spend public money for health. In *Within our Means: Why countries can afford Universal Health Coverage*, we calculated that the poorest countries with the highest burden of maternal, newborn and child mortality could meet the minimum level of public spending for UHC – mostly prioritising maternal and child health services at primary care level – by expanding public revenue (including through more and fairer taxation), increasing spending on health, and making efficiencies.[10] For many low-income countries, aid will continue to be an important source of revenue but needs to be targeted to support universal services.

The Global Investment Framework for Women's and Children's Health demonstrated that an additional investment of $5 per person per year in the 74 countries that account for 95% of global maternal and child mortality would produce "up to nine times the economic and social benefit by 2035".[11] It would result in 147 million fewer child deaths and 5 million fewer maternal deaths by 2035, and prevent 32 million stillbirths.[12]

In conclusion, fairness and equity – key principles that should underpin priority-setting – require that health service coverage and access be expanded, as a matter of priority, for those who are most disadvantaged (in terms of health and socioeconomic status).[13] A first priority for UHC must therefore be to make an essential package of healthcare services available to all, putting women's, children's and adolescents' health services at the centre of this package.

But universal availability of these services will not, on its own, ensure that all women have access to such services. As well as addressing the supply-side barriers to maternal and child healthcare, other obstacles – such as exclusion and discrimination based on gender, age, caste, race or ethnicity – must be addressed to ensure that all women and girls, and their children, are able to access quality services. Gender-sensitive and adolescent-friendly services, quality of care, women's education, and greater autonomy and decision-making power are key "to moving from universal coverage to universal access".[14]

QUALITY OF CARE: A NEGLECTED ISSUE THAT MUST BE A NATIONAL AND GLOBAL PRIORITY

Increasingly, efforts to achieve improvements in maternal and child health outcomes are addressing quality of healthcare as well as access to care. This is reflected in the strategic objectives of the *Every Newborn: An Action Plan to End Preventable Deaths*, and is a clear commitment in the *Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)*. To make real headway in eliminating preventable maternal and newborn deaths, health systems and facilities must be viewed as more than just clinical settings; they are social institutions that can respond to the needs of women and girls and enable them to realise their right to health.[15]

WHO defines quality of care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people-centred."[16] Quality of care for pregnant women and newborns refers to both the *provision* of healthcare and the *experience* of care.[17] It requires the necessary infrastructure, a skilled and motivated workforce, effective supplies and information systems, as well as best practice standards and guidelines for clinical and patient care, and effective systems of supervision, regulation and accountability.

The experience of healthcare takes into account the ways in which women experience the care they receive, for themselves and their children. While research and documented evidence of disrespect and abuse of women in health facilities is still limited, this is increasingly being raised as an area of concern among maternal and child health advocates and practitioners. An analysis[18] carried out in 2010 identified several categories of mistreatment of childbearing women in healthcare facilities: these ranged from subtle abuse and mistreatment to overt violence; clinical care without informed consent; discrimination based on patient characteristics (eg, abuse directed at indigenous women); abandonment or denial of care; and detention of women and their babies in health facilities.

The White Ribbon Alliance, in collaboration with a multi-stakeholder group, has developed the *Respectful Maternity Care (RMC) Charter*[19] to highlight the importance of upholding women's rights in childbearing. This issue has also led WHO to develop a statement on *The Prevention and Elimination of Disrespect and Abuse During Facility-based Childbirth*,[20] which highlights the right of all women to dignified and respectful care.

EXAMPLES OF COUNTRIES TAKING AN EXPLICITLY PRO-POOR APPROACH TO UHC

THAILAND

Thailand adopted a UHC scheme in 2001, by reforming its public health financing. Since then, it has expanded its universal healthcare programme to almost 100% of its population. Its Universal Coverage Scheme (UCS) was the main instrument to expand health coverage to the poor and those in the informal sector. The scheme provides a comprehensive package of health services, including a wide range of sexual, reproductive, maternal and child health services. It has succeeded in reducing out-of-pocket spending and almost eliminated impoverishment due to health expenses.[21] It has relied on general taxation – direct, indirect and other government revenues – and the health benefit package is made available free at the point of use, thereby removing direct out-of-pocket payments.[22]

Evidence has indicated an increased uptake of services following the introduction of the scheme, especially among the poorest groups,[23] as well as reductions in infant and child mortality.[24] One of the factors that has contributed to its success is the decision to start with a comprehensive health benefits package that specifically covered the poor and those working in the informal sector, who had not been insured or covered in previous health schemes.[25] Sustained financial and political commitment, popular support for the scheme and economic growth have all contributed to its implementation. Health coverage, through the payment of a premium, is also being extended to migrants, including those who are undocumented.[26]

However, there are still many barriers to migrants actually accessing this health insurance scheme, including demands for identification, resistance from some health workers and administrators, and gaps in health facility reimbursement procedures.

RWANDA

Rwanda has made great progress towards UHC in recent years, by investing in its health system, especially primary healthcare. It introduced a national health insurance system, which covers almost the whole population with essential health services. This provides subsidies for the poorest people, with a substantial decline in out-of-pocket spending on health.

Immunisation coverage stands at 92.6% for basic vaccinations and a very high percentage of women give birth with a skilled health provider – 90.7% according to the latest data published in 2015.[27] Total health expenditure per capita has increased steadily – from US$25 in 2000–2009 to US$135 in 2011.[28]

Rwanda also prioritised reproductive, maternal, newborn and child health in its policies and health sector reforms, focusing on strengthening health systems, government-led planning, evidence-based policy, strong community involvement, health workforce and infrastructure development, and performance-based health financing. It also developed a National Strategic Plan to Accelerate the Reduction of Maternal and Neonatal Morbidity and Mortality, and norms and standards to improve quality of care.

All these measures, together with financial protection, have led to improvements in coverage and access to health services.[29]

CITIZENS' HEARINGS – VOICES FOR CHANGE AND ACCOUNTABILITY

Since the start of 2015, Save the Children, in partnership with the White Ribbon Alliance, IPPF, World Vision International and local partners, have been working together to support Citizens' Hearings[30] on women's, children's and adolescents' health, bringing the voices of communities to leaders and policy-makers, and strengthening accountability for the commitments made in the *Global Strategy* and the SDGs. These open dialogues have enabled communities and civil society to voice their views on improving health services. Around 100 such hearings have taken place in 19 countries. Citizens' voices from the hearings were taken to the 68th World Health Assembly where citizens, NGOs, health ministers, and government delegates came together for the Assembly's first ever Global Citizens' Dialogue. This provided a global platform for citizens to share the lessons and recommendations of the Hearings – held at national and local levels – with health ministers and government delegates, and to call for these lessons to be integrated into the SDGs and updated Global Strategy frameworks.

Across these hearings, there have been calls for health providers, local authorities, governments and the international community to ensure stronger and more accessible health systems that can deliver good-quality services for women, children and adolescents, removing financial barriers and improving access for young people and marginalised groups. Recommendations highlighted the need for more skilled and trained health workers, for integrated health systems that provide the full range of sexual, reproductive, maternal, newborn, child and adolescent health services, for functioning facilities with effective equipment, supplies, medicines, piped water and electricity, and for effective referral systems. They have also included calls for mechanisms to ensure inclusive and participatory systems of accountability at local, national and international levels for citizens and communities.

In Tanzania, for example, partners held a series of consultative meetings leading to a Citizens' Hearing with women, men and children from five districts of Tanga region. Participants were able to identify maternal, newborn and child health priorities that would bring about change and reduce maternal and newborn mortality. They called government representatives to action on access to good-quality health services, community empowerment, engagement and accountability. They also emphasised that citizens should be involved in setting priorities and targets, and have an active role in monitoring maternal and child health services, and in planning and budgeting, and they recognised the role of community involvement in monitoring progress at all levels. Issues raised by participants included the long distances to health posts as one of the key barriers for women delivering in health facilities. They also raised the costs for transport and of medical supplies, the shortage of qualified health personnel, of medicines and supplies, rudeness of staff, as well as insufficient awareness by communities of existing policies and structures, and limited involvement of citizens in decision-making in relation to health provision.

For more information, go to:
http://www.citizens-post.org/

6 Conclusions and recommendations

The movement to end preventable maternal, newborn and child deaths and the movement for Universal Health Coverage (UHC) have often been separate and sometimes competing forces. But advocates for different health priorities – such as malaria, tuberculosis, HIV and immunisation – are increasingly recognising that achieving results at scale depends on having a health service that can provide essential healthcare for everyone, without discrimination or exclusion.

Maternal and child health advocacy may focus on specific neglected interventions. Immunisation is highly cost-effective, and initiatives such as the Global Vaccine Action Plan and Gavi are helping to make progress. Newborn care was previously neglected in child health debates – something the Every Newborn Action Plan sought to galvanise action on. Sexual and reproductive health and rights, often subject to restrictions that harm women's and girls' health and autonomy, always need to be protected and championed. Deaths of women in childbirth have all too often been tolerated as inevitable and of little concern in societies that are highly unequal, and insufficient attention has been given to poor quality care experienced by the poorest and most disadvantaged women.

Drawing attention and resources to these injustices is clearly very important. Increasingly, it is being recognised that these services are most efficiently approached as a continuum of care, usually delivered in the same settings by the same staff, thereby providing a more integrated pathway for service users. Advocates for sexual, reproductive, maternal, newborn, child and adolescent health often call for universal coverage of particular services but rarely engage with the debate about how governments should fund and structure their health systems.

On the other hand, advocates for UHC are rightly challenged for failing to articulate what universal coverage would mean for health outcomes or particular services. The desire to support national ownership of decisions about health priorities often seems free of values about what should be included in the package of services. The myth that UHC would mean all health services – at primary, secondary or tertiary levels – being available instantly to everyone fuels accusations of a utopian fantasy. Instead, UHC advocates need to articulate clear principles for how national health priorities should be set, recognising that health impact, quality-adjusted life years (QALY) and equity would mean essential services needed by all communities should be the priority. The proposed multi-stakeholder 2030 Alliance for UHC has the potential to galvanise political momentum for a shared vision of UHC, to strengthen accountability for progress on the SDG health targets and for the delivery of the right to health, and to improve coordination of investments in health systems strengthening.

Joining forces would mean promoting and strengthening primary care services – especially sexual, reproductive, maternal, newborn, child and adolescent health services – as the priority for UHC. This means articulating a vision of UHC that puts these services at the centre – free at the point of use – as a national and global priority.

Bringing together these two movements towards a common cause has the potential to make the dream of ending all preventable maternal, newborn and child deaths a reality by the target date of 2030. Failing to join forces will continue to allow fragmented and inadequate health services that do not meet population health needs, and instead drive continued inequality and exclusion. In this first year of implementation of the SDGs, now is the time to bring together these two health movements to realise the right to health for *all* women, children and adolescents.

RECOMMENDATIONS

Save the Children calls on those working on maternal and child health and those who are championing UHC to come together in support of a shared ambition to ensure that all women, children and adolescents have access to essential health services that enable them to survive and thrive.

Save the Children calls on governments, donors, development partners and other stakeholders to make the following commitments and take the necessary action:

Prioritise women's, children's and adolescents' health

- Make a clear commitment to prioritise essential services for women's, children's and adolescents' health as fundamental to achieving UHC.
- Guarantee an essential package of good-quality sexual, reproductive, maternal, newborn, child and adolescent health services, accessible to their whole population and free at the point of use, with a strong focus on primary healthcare. No one should be denied essential healthcare due to an inability to pay.

Leave no one behind

- Develop policies and plans to ensure universal access to sexual, reproductive, maternal, newborn, children's and adolescents' health services. There should be time-bound equity targets to ensure accelerated progress among the poorest and most marginalised sections of the population.
- Make specific efforts to guarantee age-appropriate sexual and reproductive health information, goods and services to adolescents, including comprehensive sexuality education. Services must be tailored to adolescents' needs and be free from stigma, discrimination and bias.

Increase public investment in health

- Governments should assess the level of financial investment needed to ensure universal access to the continuum of care, and develop a strategy for increasing public spending on healthcare as needed. This includes:
  - increasing fiscal space by reforming the tax system and improving tax compliance so as to collect 20% of GDP in taxes
  - increasing health spending to at least 5% of GDP, and ensuring this is spent equitably and efficiently.
- Donors should increase or maintain the target of at least 0.1% of gross national income as official development assistance for health. Their technical and financial assistance should support countries' efforts to guarantee a package of essential services for the continuum of care, as part of UHC, and strengthen health systems.

Improve quality of care

- In collaboration with health professionals, women's groups and other stakeholders, commit to improving quality of care in women's, children's and adolescents' health services. Governments and partners should adopt specific strategies (eg, strengthening regulatory bodies, supportive supervision, staff training and remuneration) to improve quality of clinical care as well as measures to promote respectful and dignified care in health facilities.
- Nutrition interventions must be fully integrated in the reproductive, maternal, newborn, child and adolescent health continuum of care, including with an emphasis on addressing the nutritional needs of adolescent girls.

Endnotes

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A COMMON CAUSE

Reaching every woman and child through Universal Health Coverage

Countries around the world have committed to a historic ambition: to end preventable child and maternal deaths within a generation.

A Common Cause shows why two key movements in global health – maternal and child health, and Universal Health Coverage – need to join forces to make that ambition a reality.

The report argues for universal access to an integrated continuum of care for women's, children's and adolescents' health, provided through strengthened primary healthcare and referral systems.

Country 'spotlights' on Ethiopia, Indonesia and Nigeria set out the challenge, highlighting disparities in access to essential healthcare and in maternal and child health outcomes.

The report goes on to make the case for Universal Health Coverage as the framework for countries to build a health system capable of providing essential services for all their people.

Finally, the report makes recommendations to all stakeholders in health – including governments and donors – urging them to unite around a common cause in order to make their shared ambition a reality.

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