

Transforming health systems to improve the lives of women and children

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Ambitious quantitative goals for reducing mortality and increasing access to health interventions are nothing new to the areas of child, maternal, and reproductive health. They are the standard fare of global declarations and national 5-year plans. They come. They go. What makes the Millennium Development Goals (MDGs) different? With health firmly embedded in this wider poverty-reduction initiative, which has garnered unprecedented consensus and support from governments and multilateral organisations, the global health community has a rare opportunity to break through to new ways of thinking about the obstacles now blocking improvements in the health of women and children and to translate that thinking into bold new steps to meet goals 4 and 5 (table).

For the UN Millennium Project Task Force on Child Health and Maternal Health, the potential breakthrough lies in putting health systems at the centre of MDG strategies and in addressing these systems, not only as delivery mechanisms for technical interventions but also as core social institutions—as part of the very fabric of social and civic life. In high-mortality countries today, especially for the poorest populations, health systems are frequently the source of catastrophic costs, humiliating treatment, and deepening social exclusion. But a different way is possible. Health systems can be a vehicle for fulfilling rights, for active citizenship, and for true democratic development—poverty reduction in its fullest sense.¹

Effective interventions exist

The Task Force began its work with broad consensus on the technical interventions to prevent or treat most conditions that kill children and women of reproductive age. The *Lancet* series by the Bellagio Study Group on Child Survival² elegantly mapped the epidemiological picture of child mortality, highlighting the growing importance of neonatal deaths as a proportion of child deaths—of the 10.8 million children who die every year, nearly 4 million are younger than 1 month—and giving new recognition to the pervasive effects of malnutrition, a contributing factor in more than half of all child deaths. The Bellagio Group concluded that full use of existing health interventions would reduce child deaths by at least 63% (figure 1).³

The picture for maternal mortality, while not yet benefiting from as carefully calibrated an epidemiological mapping, was similarly clear: skilled care in delivery and particularly access to emergency obstetric care in the case of complications would greatly reduce maternal deaths—indeed, by about 74% according to World Bank estimates (figure 2).⁴ With full use of proven interventions, the

number of deaths in pregnancy and childbirth every year would drop from more than 0.5 million⁵ to less than 140 000.

Sexual and reproductive health services and rights, if genuinely fulfilled, would also have substantial effects on both women and children. Women's ability to control their fertility could, by itself, reduce the number of maternal deaths by as much as 20–35% simply by reducing pregnancies to the number desired.^{6,7} Moreover, birth spacing has a substantial effect on child mortality, potentially reducing child deaths by as much as 20% in some cases.³ With the full complement of sexual and reproductive health services, including particular attention to the 1 billion adolescents now transitioning to adulthood, the effect on health (including HIV prevention), wellbeing, and poverty-reduction would be far greater than with the level of coverage and selected interventions that currently exist.⁸ The Task Force therefore agreed that interventions to protect and promote sexual and reproductive health and rights must be an integral part of MDG strategies.

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Goal	Target	Indicators
Goal 4: reduce child mortality	Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate	<ul style="list-style-type: none"> Under-5 mortality rate Infant mortality rate Proportion of 1-year-old children immunised against measles
Goal 5: improve maternal health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	<ul style="list-style-type: none"> Maternal mortality ratio Proportion of births attended by skilled health personnel

Table: MDGs for maternal and child health

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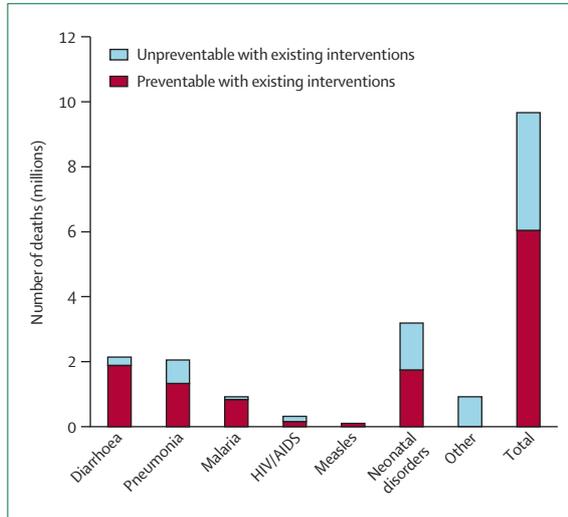


Figure 1: Child deaths in relation to use of existing interventions
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In sum, the basic interventions exist. They are well known and well accepted. They are fairly simple and even cost effective. Yet, vast swathes of the world's population do not benefit from them. For hundreds of millions of people, a huge proportion of whom live in sub-Saharan Africa and south Asia, the health system that could and should make effective interventions available, accessible, and used is in crisis, ranging from serious dysfunction to total collapse.

Health systems as core social institutions

Neglect, abuse, and marginalisation by the health system are part of the very experience of what it means to be poor in high-mortality countries today.⁹⁻¹²

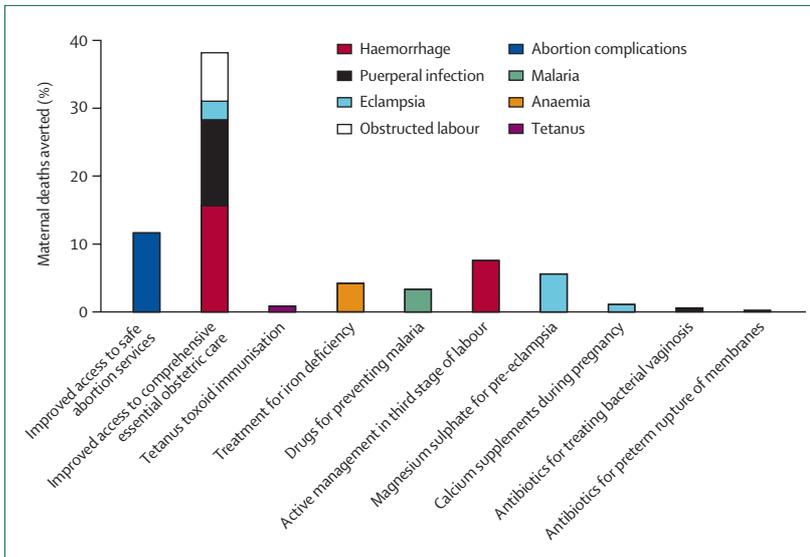


Figure 2: Maternal deaths in relation to use of existing services
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Disparities between highest and lowest wealth quintiles in access to health care are usually enormous, with skilled attendants at delivery being the most inequitably distributed of major maternal and child health interventions for which data are available.¹³ Even within poor communities, distinctions between poor and the very poorest people translate into disparities in access to care, as reported for child-health interventions in rural Tanzania.¹⁴ And wealth is not the only dividing line; inequities in child and maternal health track multiple social divisions including sex, race and ethnic origin, maternal education, and urban or rural residence, with overlapping forms of marginalisation conferring even greater health risk.¹⁵

Conversely, health claims—legitimate claims of entitlement to the services and other conditions necessary to promote health—can be understood as assets of citizens in a democratic society.¹² An accountability-oriented health system functioning in a way that promotes the ability of all people, including poor and marginalised populations, to assert and satisfy such claims can potentially have profound effects on social development and economic growth—a lesson yet to be heeded in some rich countries as well.

The health system as a system, and not simply the aggregation of individual interventions, is therefore a fundamental building block of an integrated poverty-reduction strategy. Both health ministries and finance ministries must come to see the health system in this light and invest in it as such—because the citizens of their countries who struggle to manage life and death through its operation surely do.

By proposing and pursuing disease-specific, seemingly cost-effective programmes that may or may not accord with national priorities, donors have sometimes distorted and deformed—or simply ignored—health systems. Their unhealthy fixation on what are usually short-term and short-lived successes has, at times, sidetracked human rights considerations. Both national governments and donors must revise their approach and invest substantially in more systemic, contextualised strategies that result in longer term, sustainable capacity-building.¹⁶ Only then will we see results that both meet the quantitative targets of the MDGs and respect their spirit.

Implications for operational strategies

This vision of the health system must be translated into operational strategies. Equity is a core concern. At the policy level, this concern demands deeper analysis and reflection on what is meant by a genuinely pro-poor strategy. Targeting in ways that leave the poorest population further stigmatised and marginalised is not necessarily pro-equity or ultimately even antipoverty. Pro-poor interventions deployed around the core of a structurally inequitable system can breed cynicism and despair. The roots of the problem must be addressed by

fundamental rethinking of the market-based strategies that have turned health care into a commodity to be bought and sold. A strong, market-based economy requires a healthy population and, therefore, a functioning health system. But that fact does not mean that health care itself should—or can—be delivered on a purely market-driven basis. The theoretical neatness of discrete public and private sectors with exemption schemes to protect the poorest communities prevails almost nowhere. Irrespective of whether services are nominally public or private and whether fees are formal or informal, poor people have been systematically priced out of good quality care.¹⁷ Policymakers must take redistribution within the health system seriously, implementing policies that move towards cross-subsidisation and inclusion rather than segmentation and market-based incentives that ultimately legitimate exclusion.

If strengthening of systems is set as a genuine priority, then the goal of an integrated primary health-care system with a focus on the district level—ie, from community up through first referral facility level—should frame decision making. With that perspective, the calculus around disease-specific interventions will change. For example, in addressing maternal mortality, initiatives to ensure availability and use of emergency obstetric care necessarily force attention to wider systemic problems, making such initiatives effective and valuable beyond just the number of mothers and newborns they will save. The training and deployment of skilled birth attendants would be done with careful attention to their integration with and support by the broader system. In the child-health arena, even efforts to move interventions such as administration of antibiotics out of facilities and closer to the community would proceed with sustained linkage to the facility-based health system. Efforts to track and monitor disparities would be implemented in ways that strengthen health information systems overall.

Systemic operational issues must be confronted directly.¹⁸ Most urgently, human-resource strategies need to address not only the absolute shortage of skilled workers but also the neglect of their basic human rights. Unfair geographic deployment, unconscionably low wages, and other manifestations of poor human resource management have led to widespread demoralisation and demotivation of health-care workers. For maternal health and child health, changing the scope-of-profession rules and practices that disempower the non-doctor health-care provider is a first important step. Professionally trained midwives are likely to be the backbone of a rights-based strategy for tackling both maternal and neonatal mortality, and the building of this cadre of workers must be an explicit part of any human resource plan.

All these strategies require a new mindset. Building on fundamental commitments to equity and human rights, child health and maternal health can be approached systemically, with the linkages between them

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strengthened at every level, from community interventions to global advocacy.

Investment is critical

Great improvements will not happen without substantial new investment.¹⁹ But deeper, more profound change is also needed. The distribution of power and resources between countries, and within households, communities, and health systems, lies at the heart of the problem. It is a question of money, but even more, it is a question of how we shape the world in which we want to live. We know how to achieve the child health and maternal health MDGs technically and we know what it will take financially. But a clear and strong moral and political commitment will also be needed to bring about a genuine reduction of poverty in all its many forms. Is the world willing to make that commitment?

Contributors

A M R Chowdhury and A Rosenfield were co-coordinators on the Task Force. L P Freedman and R J Waldman were senior Task Force advisers. H de Pinho was policy adviser for the Task Force. M E Wirth was a consultant on the Task Force.

Conflict of interest statement

We declare that we have no conflict of interest.

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