

Where is maternal and child health now?



21 years ago, Rosenfield and Maine¹⁻³ posed the question “where is the M in MCH?”, conceiving the safe motherhood movement. What has happened to maternal and child health (MCH) since? Mothers are the cornerstone of families; their health and wellbeing is fundamental to the health of newborn babies and children, topics which have already been the focus of series in *The Lancet*.^{4,5} *The Lancet* now focuses on maternal health, providing an opportunity to assess progress, to review epidemiology⁶ and evidence to guide priority setting,⁷ and to analyse programmatic⁸ and financing options.⁹ The ultimate goal is to accelerate efforts to save lives.¹⁰

Where is the progress for the M in MCH in this 21 years? International commitment to maternal health is evident in Millennium Development Goal 5 (MDG-5), which is arguably the heart of the MDGs. MDG 5 aims for a three-quarters reduction in the maternal mortality ratio (MMR) As emphasised throughout *The Lancet* maternal series, progress in reducing maternal deaths has been slow and difficult to measure.⁶ Maternal mortality ratio estimates for 1990 and 2005 are 428 and 400 maternal deaths per 100 000 births, respectively. Both estimates carry enormous uncertainty,¹¹⁻¹³ and are far from the MDG-5 target of 141 per 100 000 births by 2015.

The other indicator for tracking MDG-5 is the proportion of births with a skilled attendant. Just over half the world’s mothers deliver with a skilled attendant, leaving more than 60 million women giving birth without skilled care every year, mostly at home. Three regions (southeast and east Asia, north Africa, and Latin America) have progressed, but the last decade has seen no progress in sub-Saharan Africa, where risks of maternal and neonatal death are highest.¹⁴ Postnatal care coverage is even lower than skilled attendance, despite the fact that at least half of maternal deaths¹⁵ and 4 million neonatal deaths occur in the first days after birth.⁵

Inadequate focus and funding is certainly one of many reasons for this slow progress. Additionally, progress has been impeded at times by competition, conflicts, and changes of direction in global policy.³ We consider two such competitions—the mother versus the child, and community versus clinical care—and how these become obsolete with a shift to a continuum of care approach.

How did mother versus child become a competition? Despite the name, in the 1980s most MCH programmes

focused on the child, with maternal care mainly limited to family planning. The justifiable need for more attention for women contributed to the downplaying of links between maternal and child health to such an extent that the ten action points for safe motherhood in 1997³ did not mention the purpose of motherhood—a live, healthy newborn baby. Meanwhile child health programmes focused primarily on infectious diseases, largely ignoring the causes of 4 million neonatal deaths every year.⁵ The separation of maternal health and child health programmes contributed to inaction for newborn health.¹⁶

Setting mothers against children is a false and damaging dichotomy. Mothers, newborn babies, and children all benefit from a functioning health system providing interventions throughout the continuum of care from pre-pregnancy through pregnancy, childbirth, and the postnatal period, into infancy and childhood.¹⁴ Recent recognition of this mutual benefit has prompted a shift from MCH to MNCH (maternal, newborn, and child health),^{14,17} highlighting previously neglected newborn deaths though yet to recognise fully at least 3 million stillbirths.¹⁸

Disparate competing voices, focusing separately on outcomes for the mother, newborn baby, and child, have contributed to a situation in which, although 11 million of them die each year, funding for maternal, newborn baby, and child health is much lower than for other high-profile health issues with fewer deaths. Unfortunately, the structures of many funding agencies have the unintended effect of setting maternal and child health in competition, rather than prioritising long-term investment that benefits both. A united voice to call for investment in MNCH within health systems would be more effective than internally competing voices and this is the founding principle of the Partnership for Maternal Newborn and Child Health.¹⁹

Competition between policies for clinical or community care in safe motherhood also has a history. Global interest has swung between facility-based and community-based care, slowing progress in building integrated health systems. As independence dawned in the 1950s and 1960s, most countries in Africa and Asia invested in facility-based care for rich people in urban settings. The 1970s and 1980s saw a reaction to this with subsequent emphasis placed on primary health care for all through training of community health workers

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(CHWs) and traditional birth attendants (TBAs). In many cases CHWs and TBAs were trained only briefly and then left unsupervised, without a functional referral system.

By the end of the 1990s, interest in community health systems waned and global focus shifted to vertical approaches epitomised by global funds for vaccines and specific infectious diseases. In safe motherhood programmes the need for skilled attendance and emergency obstetric care was strongly emphasised, often without parallel efforts to promote demand for care. Governments were advised to stop training TBAs.¹⁴ However, even in countries working hard to increase skilled care there is an inevitable time lag—filling the global gap of 330 000 midwives requires new midwifery schools and teachers and takes time, especially to reach poorer rural communities.¹⁴

Conflict between policies for skilled care and community care is another false dichotomy. Both are important for an effective health system. Indeed WHO's model of health systems includes the community as a key component. Strong community services promote demand for skilled care. Assessments of the integrated management of childhood illness (IMCI)²⁰ suggest that either clinical system strengthening or community activities alone have limited effect—the greatest success comes when both are linked. Preclusion of community care leaves the most vulnerable women and babies without options for many years to come.²¹ By applying a phased approach, family-community services can save up

to 37% of neonatal deaths now²² and most child deaths,²³ and may also benefit maternal health, even if mortality impact is low.²⁴

In Nepal, empowering community-based women's groups and simultaneous strengthening of the health system resulted in an increase in healthy behaviours and uptake of antenatal and skilled delivery care, and in a significant reduction in both neonatal and maternal deaths.²⁵ Several studies have shown the effectiveness of well-trained and supported CHWs in reduction of neonatal mortality, especially late neonatal mortality.^{26,27} Although a meta-analysis of training of TBAs indicates a small but significant decrease in perinatal mortality (8%) and neonatal mortality due to birth asphyxia (11%),²⁸ no effect of training TBAs on maternal mortality has been identified.⁷ The failure to detect an effect might be related to the absence of any result or the formidable measurement challenges faced in showing a modest effect on a rare event.^{6,7} Whichever is the case, attempts to exclude TBAs from any role in communities where they have long been responsible for childbirth might be counterproductive. Roles for TBAs can be redefined—eg, in Burundi the involvement of TBAs to promote skilled attendance has increased facility deliveries in one district.²⁹ Malaysia has successfully used TBA training as a step towards skilled care.⁸

Focus on the continuum of care replaces competing calls for mother or child, with a focus is on high coverage of effective interventions and packages, on integrating

| Where have we been? | Where are we heading? |
|---|---|
| Maternal and child health (MCH) Mothers competing with children for little attention and funding Newborn babies lost inbetween | Maternal, newborn, and child health (MNCH) Mothers, newborn babies and children all benefit from essential packages in a continuum of care MDG-4 (child survival) and MDG-5 (maternal survival) are intimately linked with newborn health bridging the two MNCH is receiving more attention, but MNCH interventions are yet to receive adequate investment |
| Facility-based care, with focus on vertical solutions, patchy community approaches, competition between various programmes and packages | Systematic phased strengthening of health systems with focus on universal coverage of essential MNCH packages (pregnancy spacing, focused antenatal care, intrapartum skilled care, and postnatal/newborn care, and IMCI and nutrition promotion) and interventions to address HIV, malaria, and vaccine-preventable conditions Integration between essential MNCH packages and with other programmes such as HIV, malaria, and vaccine-preventable conditions. Strengthening newborn health interventions is a catalyst for integration. Community-based approaches to promote healthy behaviours and demand for skilled care, and to deliver selected essential interventions to under-reached populations while skill-based care is being strengthened |
| Monitoring and assessment with global level indicators led by UN agencies and donors | Tracking of MDGs, deaths, and coverage of essential interventions with an equity lens Tracking financial flows for health Promoting accountability of governments and partners |
| Competing interests of many partners and donors | Country-led action with support from donors harmonised to accelerate progress, and broader partner inputs, such as professional and non-governmental organisations |

Table: Shifts in maternal, newborn, and child health

MNCH services as well as with other key programmes such as HIV/AIDS and malaria (table). Although the highest risk of death for mother and child is during birth and the 24 h after birth, saving of the maximum number of lives requires a continuum of care from pre-pregnancy, pregnancy, through birth and into the postnatal period and on to child health services, and promotion of effective links between communities and health facilities.¹⁷ The effect in each period is dependent on the foundation set in the preceding period—eg, intrapartum care is more likely to be accessed and save lives if this follows effective antenatal care. The cost-effectiveness of essential interventions of antenatal and postnatal care is very high because cost is low and the number of lives saved is high, especially if newborn as well as maternal deaths are included.^{22,30} Furthermore, antenatal care achieves relatively high coverage (68% of African women attend an antenatal clinic at least once) and provides a platform for addition of evidence-based interventions, including those for malaria and HIV.

Companies that focus only on long-term or short-term priorities have high bankruptcy rates, and the same is true for health systems. We need to achieve a balance between investments in community approaches and clinical care, between simple packages that will enable early success, thereby reducing deaths for poor communities at fairly low cost,²² while working to achieve the higher coverage with more complex care, including skilled delivery care in the longer term. Without both we cannot achieve the substantial reductions in mortality to achieve the MDGs, especially for reduction of maternal mortality.

There is progress. In Africa, over the past 3 years, 35 countries have started their own national roadmap to reduce maternal and newborn deaths.²⁹ Countries such as Colombia, Mexico, Honduras, and Vietnam are making good progress in reducing maternal, neonatal and child mortality, despite small resources.³¹ Allan Rosenfield and colleagues' Comment² on MDG-5 draws attention to inspirations both in facilities and communities, but these remain patchy; will the global community work to make these inspirations the norm?

This series in *The Lancet* and the coming of age of safe motherhood provide an opportunity to mark a shift from unhelpful dichotomies that slow action in countries, stifle funding, and ultimately cost lives—mother versus child, skilled care versus community approaches, intrapartum versus the rest of the continuum of care, short term versus

long term (table). The series team call for accelerated progress in scaling up skilled childbirth care⁸ and we echo that call, linking skilled care with empowered communities. Sustained investment in systematic phased scaling-up of essential MNCH interventions integrated in the continuum of care is required—this will save the most maternal, newborn, and child lives. As Cameroonians say, "When the elephant and the rhino fight, it is the grass that suffers".

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