Ensuring accountability for maternal, child health and new born care

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Millennium Development Goals

In September 2000, the largest–ever gathering of Heads of State agreed upon the Millennium Declaration. The Declaration was endorsed by 189 countries and a roadmap was set with eight critical development goals to be reached by 2015. Of those eight goals, two of them (Millennium Development Goals 4 and 5) relate directly to improvement in maternal and child health. Other goals on poverty and hunger (MDG 1), gender equality (Goal 3) malaria and HIV (Goal 6) are also linked to achievement of maternal and child health. In fact, achieving our goals in this area requires input from all aspects of development set out in the MDG.

So what do we want to achieve in the area of maternal and child health? The target for Goal Four is to reduce the under-five mortality rate by two-thirds between 1990 and 2015. The target for Goal 5 is to reduce maternal mortality by three-quarters, in that same time period. We are far from achieving either of these targets.

In fact, according to the Millennium Development Goals report (2009) published by the UN, we are unlikely to achieve many of the goals, despite major gains. The success is threatened by the global economic crisis that affected the world at large in 2009. There is also major geographical variation in the achievement of goals. For example, while the under-five mortality rate has steadily declined globally, the rates remain unacceptably high in Sub Saharan Africa and South Asia. In Sub-Saharan Africa, I in 7 children do not reach their fifth birthday. In addition very little progress has been made globally in reducing neonatal mortality (deaths within 28 days after birth) which accounts for 38% of the child deaths. Likewise, maternal mortality has seen very little improvement in most regions of the developing world. Data showing country averages mask the realities on the ground. Gains in maternal and child health and new born care are mostly because of the achievements among people who are affluent. Little positive change has been achieved among the poor and those living in difficult circumstances. In order to meet the MDG goals, targeted efforts and investment are needed among those population who are left behind: the poorest, the rural communities, ethnic minorities (MDG report 2009).

Despite the lack of progress in maternal, neonatal and child health, investment has not been made where it is needed most, and it has not kept pace with the increasing population in the poor countries. Contrary to popular belief, achieving reductions in maternal, neonatal and child mortality does not require expensive health care. There is evidence to show that significant progress can be made through the delivery of cost-effective, proven interventions at the community level. These low-cost responses have been in existence for decades; however, due to a lack of funding and political will, these integrated community-based interventions are not being delivered to those who need them most. Millions of mothers and children can be saved through essential low cost health care (State of the World's Mothers 2008) designed based on the realities of the

communities where the services are being provided. Investment in front-line health workers and support systems is critical, yet health budgets are heavily invested in tertiary care – a level of care that the majority of women and children never reach.

Accountability in health care

It is clear we are not serving the health care needs of poor women and children. In order to reach this group, innovative ideas are needed. According to author Robert Chambers (*Whose reality counts?: Putting the first last*) development professionals need new approaches and methods for interacting, learning and knowing. Chambers argues that personal, professional and institutional change is essential if the realities of the poor are to receive greater recognition. Self-critical awareness and changes in concepts, values, methods and behavior must be developed to explore the new high ground of participation and empowerment. Chambers presents a radical challenge to all concerned with development, whether practitioners, researchers or policy-makers, from field workers to senior executives. Development practitioners need to be accountable to the poor communities they serve.

Chambers ideas and theories have been put into practice by Plan International with a new methodology we call "child- centered community development" (CCCD). It is a participatory, rural appraisal technique that enables people to take ownership of their own development through a process that empowers them to take action on the barriers to improving their own lives. This methodology has been at the centre of how our community-managed health care model has evolved. CCCD is based on concepts of equity and empowerment of poor children, women and their families. Plan's role is to create opportunities for the poor to effectively act on their issues and influence reform in relationships with elites and institutions like the health systems. CCCD supports the strengthening of poor people's capacities for human and social development, especially for children and women. Through participation, the poor learn how to effect changes in their lives and work in collective action to influence reforms in the power structure of the elites. Fundamental to human rights is the right to participate in society and the right to chose for oneself.

Community managed health care: a model for providing maternal and child health care

Community-based health care involves the provision of maternal and child health services at the primary health care level, situated in and easily accessible to communities. But the traditional management and provision of services is dependent on people external to the community, meaning that program targets and priorities are most often set by the national health services. This means that local people are passive beneficiaries and do not have a chance to be active participants in their own health care. By contrast, the Community-Managed Health Care concept is based on grass-roots community participation to improve the quality of primary health care services, improve access for the hard-core poor, improve accountability of service providers, and to increase health

service utilization rates. This concept was tested in Bangladesh from 2001 to 2007 with funding from the Canadian International Development Agency (CIDA).

The purpose of the pilot in Bangladesh was to improve the sustainability and the effectiveness of the primary health care system in 11 target areas through a community-managed approach to reach the disadvantaged community members, including those in the lower economic quintiles, especially poor women and children. A package of essential maternal and child health services were provided in the poor rural communities. Over 660,000 people, of which 244,200 were women and 325,600 children, accessed the heath care services. A major emphasis of this project was on building community capacity to actively participate and demand services though community management health committees. Over 250 community-based organizations (CBOs) were formed and participated actively in the decisions for running the community clinics. These community management committees were there to ensure that high quality, integrated maternal and child health services reached those who need them most. The availability of trained health care workers on the front line is critical. Accordingly, the project invested heavily in getting trained personnel in the communities. Over 2,500 health workers were trained (paramedics, front line health workers) and another 3,600 volunteers were trained, including traditional birth attendants. The health care staff were trained on the essentials of providing integrated maternal, child health and new born care. They were also provided with training on gender and on community facilitation techniques using participatory rural appraisal tools.

The five year pilot shows that this approach is successful in many ways. It increased health service utilization by women and gave them a much-needed voice in decision-making about health care services. It also improved accountability within the health system and information sharing between health care providers and communities. Communities need to know what services are being offered, when they are offered and how much they cost. This pilot project made investments in improving the quality of maternal and child health services based on demands to do so from the communities, as represented by the health committees. An evaluation of the health outcomes and results of this pilot program ((Chowdhury et al 2006) showed that within the project sites maternal mortality ratio reduced over time to 186 per 100,000 live births when the national average was 320 per 100,000 live births. Many of the women who were trained to participate in the health committees become elected members in the local government bodies (known as *Union Parishad*) which are local governance structure linked to district and national level governance bodies.

The evaluation of the CMHC model in Bangladesh showed that there are five prerequisites for its success: Firstly, there must be high level of national commitment to the decentralization of the health care system with well organized governance structure at the grass roots. Secondly, accountability needs to be established upwards to the managers and downwards to the communities. Thirdly, trained health care workers must be available and linked to the larger national system. Fourthly, the child and maternal health care strategy requires integration with other development interventions, such as education (both formal and informal) and livelihood support. It is a multi-sectoral approach which

requires the involvement of other stakeholders and partners. Finally, plans that are simple and come about from the community itself are always easier to establish. These should be the starting point for any community-managed health care system.

Conclusion: As the 2015 date for achieving the MDG targets looms closer, we need to review our strategies for getting there. When it comes to the goals set for maternal and child health, increased investment is needed to reach the target, especially for poor and vulnerable women and children who are currently not being served.

Various accountability models exist in heath care. But very rarely do we see accountability models that involve the disadvantaged groups of a population who are in most need of health care. In order to provide maternal and child health care to the vulnerable and poor women and children living in difficult situations, we need to emphasize community accountability. This can only be achieved through a devolved health care system where women and children can participate in their own health decisions and are empowered to voice their opinion. This accountability mechanism backed by staff trained to provide essential, integrated maternal and child care services can help save lives in a cost effective manner. The model builds capacity of poor women and communities to participate in strengthening and building functioning health systems. It also enables them to participate in strengthening other fundamental systems and institutions that are critical to addressing issues of poor and fragile states– in particular, building democratic institutions.

As we head closer to 2015, we need to scale up such an innovative mechanism for achieving the MDG targets for maternal and child health and new born care.