

Perspectives on Maternal and Child Health: The Need to Revisit Primary Health Care

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ABSTRACT

Maternal morbidity and mortality remain major global concerns in developing and underdeveloped countries. Various international interventions have been made over the last 50 years but with essentially the same targets and indicators. This review traced the development of programs on maternal and child health based on major global policies, from the 1978 Declaration on Primary Health Care to the Millennium and Sustainable Development Goals, and related the approach they engendered to the Philippine experience. Health outcomes have not significantly improved despite adherence to recommended goals and programs. New strategies purportedly propose novel and innovative methods, but are burdened by essentially the same old presumptions: government resources are limited, and interventions need to be supported by whatever funds are available. Preference for low-cost and measurable programs providing minimal essential care persists with the current socio-economic conditions characterized by neoliberal and conservative policies. There is a need to return to the fundamentals of the Comprehensive Primary Health Care, linking the health of vulnerable groups, like women and children, to social and economic development. Inter-agency and multi-sectoral approach, community participation and empowerment, real political commitment and major rethinking are needed in national and international discourses on health not just to attain better maternal and child health but to achieve health for all.

Keywords: maternal health, child health, primary health care, development goals

INTRODUCTION

Maternal and child health remain global concerns, especially among developing and underdeveloped countries. The United Nations International Children's Emergency Fund (UNICEF) estimates that every day, some 6,500 babies die in the first month of life and 810 women die from complications related to pregnancy or childbirth. These are unacceptably large numbers from preventable and treatable causes.¹

From the comprehensive Alma Ata Declaration on Primary Health Care (PHC)² in 1978 to the Millennium Development Goals³ (MDGs) in 2000 and Sustainable Development Goals⁴ (SDGs) in 2015, numerous commitments to addressing maternal and child health problems have been made in the last five decades, but often with less success in the very areas where these are most needed. Majority of the 75 priority countries failed to achieve MDGs 4 and 5. Among the 81 countries accounting for 95% of maternal and 90% of all child deaths worldwide, many are still a long way from universal coverage of essential interventions with notable inequalities among and within countries, aggravated by weak health systems and non-health sector drivers.^{5,6}

Many programs focused on growth monitoring, oral rehydration, breast-feeding, immunization, female education, family spacing and food supplementation as posited by the

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GOBI FFF package⁷ of selective PHC, which emphasized low-cost and measurable interventions as essential. Maternal and child health services are often provided through vertical programs or as minimal essential care packages to be integrated within the continuum of care.⁸ Implementation is usually monitored in terms of coverage and evaluated based on cost-effectiveness. To date, “finite resources,” “sustainability,” and “attainable goals” continue to be the buzzwords within health, financial and government institutions. These remain as the foundations of policy formulation in low- and middle-income countries (LMICs).^{9,10} These also serve as restrictions because interventions need to be supported by the limited funds available and should be measurable by global standards. Yet programs based on this paradigm continue to short-change mothers and children everywhere. Unfortunately, often unaddressed are factors beyond the confines of the health sector, particularly the structural and social determinants of health.

If the health outcomes have not substantially improved despite adherence to the programs recommended by international bodies, are these measures really the right areas of intervention? If countries are to attain better health outcomes for mothers and children, what needs to change? This paper aims to revisit the major global policies that served as basis in the development of international and local programs, and their attendant metrics of success or failure. This review analyzes the approach used in identifying and targeting maternal and child health issues, and presents recommendations on how to tackle the health concerns of mothers and children.

PRIMARY HEALTH CARE: FROM COMPREHENSIVE TO SELECTIVE

The Declaration of Alma Ata from the International Conference on Primary Health Care (PHC) held in 1978 presented a very radical approach to health in consonance with the holistic definition of health as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity”. It posited the progressive view of health as a human right and as a social goal. Consequently, it emphasized economic and social development as requisites to the fullest attainment of health, as well as the importance of peoples’ participation and government responsibility. Intended to be comprehensive, PHC covered a broad range of concerns, including food supply, proper nutrition, adequate safe water and basic sanitation, health education, maternal and child health, immunization, prevention and control of endemic and common diseases, and essential drugs. It was a stark contrast from widespread vertical disease-specific programs which were implemented before its advent.

However, PHC was immediately criticized. Both conservatives and progressives regarded PHC as being too idealistic, unrealistic and unachievable. Conservatives criticized the Alma Ata goal as “unattainable in terms of

its prohibitive cost and the numbers of trained personnel required.”¹¹ Comprehensive PHC is faulted for being vague and replete with difficulties in financing, implementation, and monitoring. On the left side of the political spectrum, Navarro¹² critiqued that despite listing different types of interventions outside and within the healthcare system, the declaration’s avoidance of recognizing the structures and power relations between these elements makes the recommendations “not so much limited as they are incorrect.” For him, the Alma Ata declaration represents the perspective of the dominant classes of the world and fails to view health as primarily an outcome of politically determined structural economic and social changes.

In 1979, Walsh and Warren proposed selective PHC as a more attainable, less costly approach. Their paper “Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries,”¹¹ which was anchored on the challenge of diminishing resources and emphasized the attainability of goals, suggested that selective programs should target main infectious diseases affecting the developing countries with low-cost technical interventions as the most cost-effective form of medical intervention.

Governments soon followed and interventions were reduced to four main areas of growth monitoring, oral rehydration techniques, breastfeeding, and immunization, collectively known as GOBI. In the next few years, food supplementation, female literacy, and family planning were added, creating GOBI-FFF. These interventions were promoted as short-term technical programs with clear budgets and easy monitoring and evaluation rather than broadly defined health programs.¹³ As a result, more international agencies like the UNICEF supported them.¹⁴

Comprehensive PHC was downplayed and health reforms that followed merely built up on the premise that selective PHC interventions just needed funds and better implementation. This opened the doors to a greater role of the private sector in three key aspects: 1) filling gaps in health service delivery; 2) providing additional fund sources; and 3) presenting as models for efficiency. But despite the ability to deliver care to segments of the population, the private sector can never guarantee access to the poorest since it is neither their role nor business.¹⁵

There was significant reduction in under-five mortality and morbidity rates, and increase in breastfeeding. However, these are frequently achieved at the expense of other sectors of health, with resources being largely restricted to these programs. Selective PHC failed to solve malnutrition, acute respiratory infection, and diarrhea. Aggressive family planning programs did not yield results especially in societies of high inequity and low female education. It did not address health in a holistic manner and failed to solve health infrastructure issues.¹⁶ Overall, selective PHC turned out to be more expensive than previously anticipated since each vertical program had to set up their own organizational structure, infrastructure, system for service delivery and monitoring.¹⁷

FROM MDGs TO SDGs: ARE THE GOALS BEING MET?

When the Millennium Development Goals (MDGs) were established in 2000, two of the eight goals focused specifically on maternal and child health. MDG 4 sought to reduce under-five mortality by two thirds while MDG 5 aimed to reduce maternal mortality by three quarters. Based on the Countdown to 2015 for Maternal, Newborn and Child Survival Initiative,⁵ under-five mortality has dropped by 53% with a marked acceleration in global rate of decline – from 1.2% per annum during 1990–1995 to 4.0% during 2005–2013.¹⁸ Global maternal mortality ratio decreased by around 45% over two decades.⁴ However, very few countries reached their MDG targets and global parameters were not achieved. In line with MDG 4, 62 out of 195 countries with available data achieved a two-thirds reduction of under-five mortality rate (U5MR),¹⁹ but only 6 of the 75 priority countries achieved their respective MDG 5 target for maternal mortality ratio (MMR).

Priority countries had problems and were unable to significantly improve their situation despite efforts at implementing recommendations. Recommended essential interventions were graded and selected based on their 1) expected impact on maternal, newborn and child survival, 2) suitability for implementation in LMICs and 3) delivery strategies through the different levels of the health sector.⁸ Among these, the second criterion usually trumps the other two, and suitability for implementation practically translates to affordability. Thus, programs utilizing low-cost minimal essential care packages with measurable coverage dominates as the favored strategies of funding agencies, global institutions and even governments. Such interventions across the continuum of care include family planning, antenatal care, neonatal tetanus protection, skilled attendant at delivery, postnatal visits for mothers, breastfeeding, child immunization, proper child nutrition, improved water sources and sanitation facilities. Monitoring showed that coverage of different interventions varied widely both between and within countries. Some interventions have poorer coverage such as malaria interventions, postnatal visits for babies, exclusive breastfeeding, care-seeking for pneumonia and use of oral rehydration salts. Routinely scheduled interventions based on simple technologies like immunization had higher coverage than those that relied on functional health systems and 24-hour availability of clinical services. It was also reported that “programmatically links between different elements of the continuum of care for maternal, newborn, and child health are often not being promoted or provided.”^{25,20}

The MDGs correctly aimed at reducing deaths as the first priority, but reducing non-fatal diseases and improving quality of life are equally important.²¹ The goals set by 2015 were not met without substantial acceleration of PHC. Primary health care requires community empowerment and participation in identifying their health needs and addressing

these. But these have been replaced by tailored programs and projects funded by global agencies and donors being implemented in identified sites. Paul Farmer described the importance of combining “proximal” preventive interventions such as education, basic sanitation, land reform, sovereignty, and an end to political oppression with “distal” curative interventions when the patients are already sick. He also recognized the importance of “re-socializing” our understanding of disease and incorporating structural interventions to combat structural violence.¹⁵

In the eighth paper in the Alma-Ata Series, the idea of creating a further set of goals after 2015 which would go beyond mortality reduction and help to sustain action for health was presented.²¹ This opportunity came with the crafting of the Sustainable Development Goals. However, the targets listed in the SDGs still focus mainly on reducing mortality and morbidity.

In the Countdown to 2030⁶ it was shown that the 81 priority countries accounting for 95% of maternal and 90% of child deaths worldwide have made progress, but are still a long way from universal coverage of essential interventions, reducing inequalities, and addressing major impediments (weak country health systems and conflict settings) to delivery of services to all populations.

THE PHILIPPINE EXPERIENCE

Two basic strategies that underpinned efforts to address high maternal mortality in the Philippines from the 1980s to 2000s were the training of traditional birth attendants (TBAs) and the application of the risk approach through ante-natal clinics.²² However, these strategies barely lowered MMR. In 2006, MMR in the Philippines remained high at 162 (Family Planning Survey)²³ and 104.15 (computed using Philippine Statistics Authority 2006 data)²⁴ deaths per 100,000 live births.

The DOH Administrative Order (AO) 2008-0029 “Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality” officially gave birth to the integrated Maternal, Newborn and Child Health and Nutrition (MNCHN) Strategy.²⁵ This approach highlighted the importance of having committed skilled health professionals in appropriate health facilities and a well-coordinated referral system. It also recognized the province- or city-wide health system as the basic unit for planning, organizing, and implementation.²⁶ This strategy served as the main framework for addressing maternal and child health concerns. The Philippine Health Insurance Corporation (PhilHealth) also offered “Maternity Care Packages for Normal Spontaneous Delivery” in hospital and non-hospital facilities.^{27,28}

By 2015, the Philippines still failed to achieve its MDG 5 target of decreasing MMR to 52 deaths per 100,000 live births. Numbers varied across different sources: 73.63 (FHSIS),²⁹ 98.64 (computed using Philippine Statistics

Authority 2015 data),³⁰ and 114 (UN Estimates).³¹ This implied the lack of precision and questionable accuracy of data collection. Nonetheless, all available sources were way above the target. Despite certain failures in achieving the global MDG targets, the SDGs were created as a continuity and expansion of such targets. Under the SDG 3, MMR should be less than 70 deaths per 100,000 live births by 2030 globally. However, 2019 data show that the Philippines is still way off from achieving this new goal: 96.84 (computed using Philippine Statistics Authority 2019 data).³²

Though local interventions recognize the role of local health systems and aim to bring healthcare closer to the people through service delivery networks, the general framework still manifests the dominance of vertical programs and the selective approach to health. The functions and services provided by delivery networks under the MNCHN strategy are essentially a checklist of the essential family planning, prenatal, childbirth, postnatal, neonatal and childhood interventions. The corresponding PhilHealth packages for mothers and babies are local adaptations of the minimal essential care packages recommended globally. The focus on facility-based and technology-dependent maternal and child services (such as immunization and food supplementation); the emphasis on skilled birth attendance but with very weak integration of traditional community healers; and the fixation on metrics of coverage, morbidity, and mortality, which do not automatically translate to better health for the people – all of these are mere reflections of the failure to comprehensively address maternal and child health.

NEW GOALS AND TARGETS, SAME PROBLEMS: WHAT IS THE ISSUE?

New goals and targets are set locally and globally. But without radical changes in the framework and absolute consideration of the complexity of maternal and child health, these are just iterations of the same old problems. It is more than a health systems problem of finite resources, inappropriate technology, shortage of skilled health human resources, poor health governance, fragmented delivery networks, and lack of information to guide action. It is not just a technical or programmatic problem but a deep and fundamental issue of employing a wrong approach which inadequately recognizes and addresses existing socio-economic conditions.

The socio-economic conditions imposed by inflation, recession, economic adjustment policies, and foreign debt on underdeveloped and developing countries since the 1980s not only persist but are aggravated by neoliberal policies of austerity and privatization. Neoliberalism translated in the health sector as 1) decline of public expenditures in health care, 2) privatization of health care services, 3) impoverishing and dismantling of public health infrastructures, 4) full mobility of health professionals from developing to developed countries, 5) full mobility of medical equipment and drugs from developed countries, and 6) full recovery of the

biological and behavioral-centric view of medicine.³³ The World Bank, which has solidified its role in global maternal and child health, promotes privatization and the reduced role of the state in financing and service provision, which undermines the access, availability and quality of health services for women and children, especially from socio-economically vulnerable communities.³⁴ The emergence of conservative populist regimes sustained the conservative and selective PHC approach.³⁵ To date, countries that are pushed to implement austerity measures experience compromised budget of social policies, setbacks, and even reversal of gains in reducing health inequities such as in Brazil.¹⁰

Selective PHC is also criticized of being a narrow, techno-centric approach that diverted attention away from basic health and socio-economic structures. Even if cost-effective interventions have been promoted, these still fail to reach the populations that need them. Interventions are often delivered independent of each other, utilizing separate infrastructures and mechanisms. These are symptoms of the ills of vertical programs that persisted with selective PHC.

Addressing health and socio-economic structures could not be overemphasized since inequities between and within countries are still very prominent. And social inequities translate to inequities in health. In 2005, the World Health Organization (WHO) established the Commission on the Social Determinants of Health (CSDH) to support countries in “addressing the social factors leading to ill health and health inequities.” The Commission’s report, which came out in 2008, advanced a five-point agenda highlighting the need for health equity, human rights and social justice, the quality and distribution of health as basis of the success of a society, and the centrality of empowerment.³⁶ Similarly, the WHO 2008 World Health Report called for PHC “now more than ever.”³⁷ It reiterated the continuing relevance of PHC as a means of attaining better health and the social imperative among governments to institute measures that promote the basic principles of PHC. However, shortly thereafter, the 2011 Rio Political Declaration on the Social Determinants of Health barely mentioned the essence of the CSDH report and did not advance its agenda.³⁸ In practice, socio-economic structures remain inadequately recognized and addressed.

QUO VADIS? PRIMARY HEALTH CARE IS THE WAY TO GO

Health outcomes have not substantially improved despite adherence to global goals and programs recommended by international bodies like the WHO and the World Bank. This supports the thesis that current measures of maternal and child health are not the right areas of intervention.

Even in the 1978 Alma Ata Declaration, gaps between and within countries are identified as the root of poor health, including vulnerable populations like women and children. Such gaps persist today. One way to address these is to return to the PHC and acknowledge the prevailing “social, econo-

mic, and political inequalities as unacceptable.” Calls for more comprehensive approaches have been re-echoed time and again. In 2018, the Astana Declaration³⁹ reaffirmed the need to strengthen primary health care for the health and well-being of all.

But due to challenges in evaluating primary health care programs, evidence for their effectiveness is limited. More than five decades of experience has shown the complexity of translating PHC into practice due to the intersectionality of issues. Nonetheless, there are countries with established strong community-based primary health care (CBPHC) that have made achievements in improving maternal and child health. Experts recommend that CBPHC be prioritized for strengthening health systems and that resources and funding should be devoted by policy makers and political leaders to primary health care.⁴⁰ Rather than look for a blueprint for the implementation of PHC, it should be regarded as a work in progress, a practice that develops over time and with experience, and therefore, must be assessed within frameworks designed to investigate complex health interventions.⁴¹

The basic principles of PHC, including economic and social development, an inter-agency and multi-sectoral approach, and community participation must again be put front and center of national and international discourses on health. There is also a need to return to the basics: the relevant voice of mothers and women across the globe must be heard. They have been speaking, but the world is still not listening. Women empowerment is proven to improve uptake of child health services, while low empowerment aggravates maternal undernutrition and low birth weight of babies.^{42,43} A more rights-based approach should be the driver of health reform, not health financing schemes. Doctor-centered and hospital/tertiary care-based health care systems should give way to more public health and preventive care. Health promotion is not only an important tool against the proliferation of disinformation but also serves as the foundation for higher health literacy.

CONCLUSION

There is no one-size-fits-all solution or an easy way to attain the highest level of maternal and child health. Real political commitment is needed to avoid repeating the same mistakes or worse, implementing basically the same things but hoping for a different result. This was already done in the last half century and should not be done again in the next.

Moreover, there is a need for a lot of rethinking and reconstruction. A return to the fundamentals of Comprehensive Primary Health Care will refocus attention on the broader view: that the health of mothers and children will be improved only by reducing inequities, by promoting the social and economic development of the marginalized, and by dismantling structures that hinder the attainment of health for all.

Statement of Authorship

Both authors contributed in the conceptualization of work, acquisition and analysis of data, drafting and revising, and approved the final version submitted.

Author Disclosure

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