

Women and children first

To make a stable world, we need to recognize the powerful link between maternal health and the well-being of children. The author tells why.

by Paul Farmer

These days, everyone in my line of work (medicine and public health) wants to have straightforward and attainable goals, clear standards of measurement, and an obvious- to use the most common parlance, these days - return on investment. For over a century, in medicine and public health, this was called "the search for the magic bullet." By the late 19th century, effective vaccines were looking like magic bullets, and as efficacy increased and adverse effects decreased, hundreds of millions of lives were saved, and untold misery prevented. One scourge, smallpox, was driven from the earth. Even without using concepts such as grief or sorrow, concepts worthy of respect in public health, that was certainly a handsome return on investment. It's one of the reasons that Rotary chose to devote so much time and energy to making sure that the world's children do not die of vaccine-preventable illness.

But there is no magic bullet for child survival if we hope to meet the aspirations laid out in the United Nations' Millennium Development Goals, which are meant to complement each other. Goal 4 is to reduce child mortality, but all eight are meant to "recognize explicitly the interdependence between growth, poverty reduction and sustainable development." If a child survives measles only to succumb later to a waterborne disease like typhoid, then surely this must be tallied as a loss. One might say that waterborne Diseases render certain vaccines less effective, since the desired rate of return is that every child live a healthy life, go to school, enjoy her (or his) family, and one day have a job and a family of her own. We don't yet have sophisticated and agreed-upon standards for these sorts of dignified aspirations, but that doesn't mean we shouldn't try to develop them and marshal efforts to meet these goals.

One of the ways to do this is to reduce the tendency, now registered in many global health efforts, to have overly focused interventions in the quest to have defined outcomes. Modesty about metrics is warranted. This is especially true in the rural regions of the developing world, where the quest must be to forge comprehensive primary health care systems that can offer children and their families a series of key services.

As an example, the story of child survival gets messier when we contemplate maternal mortality. Goal 5 is to "improve maternal health," but it's hard to separate maternal and child health. It has been almost 25 years since I first witnessed death in childbirth. On one occasion, in a rural hospital in Haiti where I was working as a volunteer (I was a student at Harvard Medical School at the time), a woman near term was admitted in a coma. She had cerebral malaria. She needed a blood transfusion and a Cesarean section, but there was no blood available, and surgeries of all sorts were associated with what are called "user fees," cash co-payments by the sick in order to receive care. Her sister was desperately seeking the funds necessary to go back to the capital city, acquire the blood, and return. I'll never forget what she said, weeping: "But she has five children! Everyone is a human being!" Her sister and unborn niece died as the medical staff stood by, since without the tools of the trade - surgical equipment, blood, et cetera - there was nothing they could do.

A common expression in Haiti - everyone is human (*tout moun se moun*) - is usually invoked to describe the inhumane conditions to which the poor are so often exposed. I was shocked at these two deaths and don't know what became of the woman's surviving children, but some regional statistics could have predicted the outcome: A 1985 community survey in southern Haiti pegged rural maternal mortality at 1,400 deaths per 100,000 live births. In comparison, maternal mortality in the United States in 2005 was 14 per 100,000. (Zero maternal deaths were registered in 2005 in Iceland.) Other studies from Haiti, including more recent ones, reveal the unsurprising fact that among the poor, maternal survival often determines child survival. In a study designed to determine the odds of child survival when a mother dies, conducted in rural southern Haiti between 1997 and 1999, it was concluded that "if a family experiences a maternal death, that family has

a 55.0% increased odds of experiencing the loss of a child under 12, whereas when a non maternal death occurs, no increased odds exists." Similar studies conducted in rural Africa, from Uganda to Gambia, show similar results.

But as public health initiatives have become more "vertical," seeking to focus on only one outcome (whether AIDS prevention or child survival or eradication of river blindness), it has been harder to find funding for comprehensive primary care. And user fees remain a curse for the poorest and most vulnerable. Including safe motherhood in child-survival efforts remains an urgent task in much of the world, and these services should be considered "public goods for public health" rather than commodities to be bought and sold.

Worldwide, over 500,000 women die of pregnancy related causes every year - more than 90 percent live in Africa or Asia, and almost all are poor by any standard. Obscene though it is, death during childbirth isn't the end of the story. In the poorest parts of the world, a mother's death often means destitution for her surviving children. Within a few years, many orphaned children wind up in terrible straits, sometimes resorting to desperate or criminal measures for food, shelter, clothes, or school fees. This is a familiar scenario to doctors working in rural Haiti or rural Africa. But even in less impoverished settings, such as Palestine, studies have shown that motherless children, especially girls, are much more likely to suffer from malnutrition. They are less likely to attend school - again barred by user fees they cannot afford.

One aspect of Goal 5 is to reduce maternal mortality by 75 percent by the year 2015. According to the UN, we are moving too slowly to meet this goal. To speed up progress, we need to do several things that we know, based on our experience working with the nonprofit organization Partners In Health, are all eminently feasible and highly effective. Today, the maternal mortality ratio in Haiti stands at less than half what it was in 1985. Across the broad swath of central Haiti where we work, we estimate the number to be well below 100 - not good enough, but a vast improvement, most of it occurring in the past decade and for three reasons.

First, Partners In Health has worked in close collaboration with the Haitian Ministry of Health to strengthen public health infrastructure. We have rebuilt, equipped, staffed, and stocked hospitals and clinics; trained nurse-midwives and other personnel, including more than 2,000 community health workers; linked villages and health centers to district hospitals by modern telecommunications and ambulance service; and established the full panoply of modern surgical services for obstetrical emergencies, including antihemorrhagics and blood-banking.

We also have broken the rule that says that high-quality health services are a privilege (i.e., must be bought) and not a right. Initially, the case was made for affordable essential medicines, and now it is being made for emergency Cesarean sections - an essential tool to reduce maternal mortality. Faced with local inequalities in maternal mortality that correlated closely with fee structures (higher fees in a region meant greater mortality), the district health commissioner for central Haiti announced in September 2007 that all prenatal care and emergency obstetrical services would, from then on, be available free of charge to all patients.

Finally, we have linked prenatal and obstetric care to an all-out effort to improve access to primary health care, which includes focusing on child survival. The presence of functional, accessible public clinics and hospitals restores faith in the health system, motivates people to seek care before they are critically ill, and allows for preventive interventions such as prenatal care and family planning. Even money for vertical programs, such as AIDS treatment, can be used in a manner that strengthens health systems in general. These positive interactions are only now being studied by public-health experts, but our experience allows us to conclude that well-designed programs, including those funded through the major disease-specific programs like the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) or the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), can end up improving the health services available to the poor in rural areas, where the balkanization of programs makes no sense.

In rural Rwanda, a country that is rising from the ashes of genocide scarcely a dozen years later, Partners In Health, at the invitation of and in partnership with the government, launched efforts to strengthen AIDS treatment and primary health services in one region in 2005. Mindful of the lessons learned during two decades of work in rural Haiti, women's health and child survival have been a high priority.

By helping to train and, importantly, pay community health workers, the Rwandan Ministry of Health hopes to link rural villages to health centers with the capacity to make routine labor safe. Rwanda is also seeking to make family planning available to its citizens and to increase access to preventive and primary care through basic health insurance. Maternal mortality has dropped sharply from an average of 1,071 deaths per 100,000 live births between 1995 and 2000, to less than 600 today - still terrible, but well below the average of 900 reported for sub-Saharan Africa. As programs for child survival are integrated with such efforts, families will remain intact, more children will be able to go to school, and a more virtuous social cycle will ensue.

Promoting basic health care, including women's health, requires resources and political will, as we have seen in Haiti and Rwanda. Addressing maternal mortality can and should be made a top priority, both to put an end to the obscenity of half a million needless deaths each year and to drive forward the broader public health (and surgical) agendas. Linking safe motherhood to child-survival efforts is an important challenge for all those who hope to see children survive to adulthood.

School fees are another challenge in the divided world of public health for the poor. Stephen Lewis, formerly of UNICEF, has described the pitched battles that took place in Africa and elsewhere as policymakers argued about fees for primary school.

Although achieving universal primary education is another Millennium Development Goal, abolishing school fees still generates much ambivalence among experts, including those working in the giant international financial institutions that have held great sway in Africa. Should we not link child-survival efforts to the right to attend school as well? In

some public health circles, this is regarded as "mission creep," but a more seamless approach to health care, education, clean water, and freedom from want would offer a sensible way forward.

Although there are no magic bullets that would allow us to meet all the Millennium Development Goals, making sure there are more comprehensive views on child survival, and more comprehensive programs available to poor families, is the best way to promote a broader agenda of social justice and sustainable development. Are such ambitious goals realistic during a global financial crisis? Recently, a lot of us have been thinking back to the New Deal. The Great Depression ushered in progressive legislation; more important, there was clarity of vision that we need to recapture. In his 1944 State of the Union Address, FDR outlined his "Second bill of rights":

The right to a useful and remunerative job in the industries or shops or farms or mines of the nation;

The right to earn enough to provide adequate food and clothing and recreation; The right of every farmer to raise and sell his products at a return which will give him and his family a decent living;

The right of every businessman, large and small, to trade in an atmosphere of freedom from unfair competition and domination by monopolies at home or abroad; The right of every family to a decent home;

The right to adequate medical care and the opportunity to achieve and enjoy good health;

The right to adequate protection from the economic fears of old age, sickness, accident, and unemployment;

The right to a good education.

FDR insisted that the connection between peace and economic security, "regardless of station, race, or creed," was self-evident, but a recent biography, *Traitor to His Class*, by historian H.W. Brands, calls this statement the most radical he ever uttered - and indeed more radical than any president before or after has ever uttered.

The ideas may be visionary, but now more than ever we must pursue many of the very projects that are often dismissed as unreasonable, naive, unsustainable, or not cost-effective. We need to take heart from such instances and conclude that it is precisely in times of economic downturn that social safety nets must be expanded and strengthened. Child-survival programs, like efforts to lessen maternal mortality, need to be embedded in broader efforts to promote the basic rights of all to freedom from want. Utopian, yes. But this should be the ultimate goal of the global health movement that links so many of us, in the public and private sectors, and the return on investment that we all demand.

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