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TASK FORCE ON CHILD HEALTH AND MATERNAL HEALTH

Who's got the power? Transforming health systems for women and children

EARTHSCAN

task force

Child Health and Maternal Health

Who's got the power? Transforming health systems for women and children

Achieving the Millennium Development Goals

MillenniumProject

The UN Millennium Project is an independent advisory body commissioned by the UN Secretary-General to propose the best strategies for meeting the Millennium Development Goals (MDGs). The MDGs are the world's targets for dramatically reducing extreme poverty in its many dimensions by 2015—income poverty, hunger, disease, exclusion, lack of infrastructure and shelter—while promoting gender equality, education, health, and environmental sustainability.

The UN Millennium Project is directed by Professor Jeffrey D. Sachs, Special Advisor to the Secretary-General on the Millennium Development Goals. The bulk of its analytical work has been carried out by 10 thematic task forces comprising more than 250 experts from around the world, including scientists, development practitioners, parliamentarians, policymakers, and representatives from civil society, UN agencies, the World Bank, the International Monetary Fund, and the private sector. The UN Millennium Project reports directly to UN Secretary-General Kofi Annan and United Nations Development Programme Administrator Mark Malloch Brown, in his capacity as Chair of the UN Development Group.

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Who's got the power? Transforming health systems for women and children

Lead authors
Lynn P. Freedman
Ronald J. Waldman
Helen de Pinho
Meg E. Wirth
A. Mushtaque R. Chowdhury, Coordinator
Allan Rosenfield, Coordinator

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Earthscan
8–12 Camden High Street
London, NW1 0JH, UK
Tel: +44 (0)20 7387 8558
Fax: +44 (0)20 7387 8998
Email: earthinfo@earthscan.co.uk
Web: www.earthscan.co.uk
22883 Quicksilver Drive, Sterling, VA 20166-2012, USA

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Foreword

The world has an unprecedented opportunity to improve the lives of billions of people by adopting practical approaches to meeting the Millennium Development Goals. At the request of the UN Secretary-General Kofi Annan, the UN Millennium Project has identified practical strategies to eradicate poverty by scaling up investments in infrastructure and human capital while promoting gender equality and environmental sustainability. These strategies are described in the UN Millennium Project's report *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals,* which was coauthored by the coordinators of the UN Millennium Project task forces.

The task forces have identified the interventions and policy measures needed to achieve each of the Goals. In *Who's Got the Power: Transforming Health Systems for Women and Children*, the Task Force on Child Health and Maternal Health responds to the challenges posed by high rates of maternal mortality, continued child deaths due to preventable illnesses, enormous unmet need for sexual and reproductive health services, and weak and fragile health systems. In addition to identifying the technical interventions to address these problems, the report asserts that policymakers must act now to change the fundamental societal dynamics that currently prevent those most in need from accessing quality health care.

Who's Got the Power proposes bold and concrete steps that governments and international agencies can take to ensure that health sector interventions have significant effects on all aspects of development and poverty reduction.

This report has been prepared by a group of leading experts who contributed in their personal capacity and volunteered their time to this important task. I am very grateful for their thorough and skilled efforts and I am sure that the practical options for action in this report will make an important

contribution to achieving the Millennium Development Goals. I strongly recommend this report to all who are interested in transforming health systems to save lives and promote development.

Jeffrey D. Sachs
New York
January 17, 2005

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Task force members

Task force coordinators

A. Mushtaque R. Chowdhury, Bangladesh Rural Advancement Committee (BRAC), Bangladesh

Allan Rosenfield, Mailman School of Public Health, Columbia University, United States

Senior task force advisors

Lynn P. Freedman, Mailman School of Public Health, Columbia University, United States

Ronald J. Waldman, Mailman School of Public Health, Columbia University, United States

Task force members

Carla AbouZahr, World Health Organization, Geneva

Robert Black, Johns Hopkins Bloomberg School of Public Health, United States

Flavia Bustreo, World Bank, United States

France Donnay, United Nations Population Fund, United States

Adrienne Germain, International Women's Health Coalition, United States

Lucy Gilson, University of Witwatersrand, South Africa

Angela Kamara, Regional Prevention of Maternal Mortality Network, Ghana

Betty Kirkwood, London School of Hygiene & Tropical Medicine, United Kingdom

Elizabeth Laura Lule, World Bank, United States

Vinod Paul, World Health Organization Collaborating Centre for Training and Research in Newborn Care, All India Institute of Medical Sciences, India

Robert Scherpbier, World Health Organization, Geneva
Steven Sinding, International Planned Parenthood Federation, United Kingdom
Francisco Songane, Ministry of Health, Mozambique
TK Sundari Ravindran, Sree Chitra Tirunal Institute for Medical Sciences and Technology, India
Cesar Victora, Universidade Federal de Pelotas, Brazil
Pascal Villeneuve, United Nations Children's Fund, United States

Task force associates

Rana E. Barar, Administrative Coordinator, Mailman School of Public Health, Columbia University, United States
Helen de Pinho, Policy Adviser, South Africa
Meg E. Wirth, Consultant, United States

Preface

What will it take to meet the Millennium Development Goals on child health and maternal health by 2015, including the targets of two-thirds reduction in under-five mortality, three-quarters reduction in maternal mortality ratios, and the proposed additional target of universal access to reproductive health services? This report reflects more than two years of discussions and meetings of an extraordinary group of experts in child health, maternal health, and health policy charged with responding to this question.

The task force agreed on several principles from the very start. First, although achieving the Goals depends on increasing access to a range of key technical interventions, simply identifying those interventions and calling for their broad deployment is not enough. Answering "what will it take?" requires wrestling with the dynamics of power that underlie the patterns of population health in the world today.

Second, those patterns reveal deep inequities in health status and access to health care both between and, equally important, within countries. Any strategy for meeting the quantitative targets must address inequity head-on.

Third, although child health and maternal health present very different challenges—indeed, often pull in different directions—they are also inextricably linked. The task force made a clear decision from the start that it would stay together as one task force and build linkages between the two fields. All task force members were convinced that the fundamental recommendation of the joint task force must be that widespread, equitable access to any of these interventions—whether primarily for children or for adults—requires a far stronger health system than currently exists in most poor countries. Moreover, only a profound shift in how the global health and development community thinks about and addresses health systems can have the impact necessary to meet the Goals.

This report seeks to capture the texture of the task force's discussions and major conclusions. It does not review the entire field of child or maternal health; it does not cover every important area of work or express every legitimate viewpoint on every issue. It most certainly does not offer a blueprint for all countries. Instead, it tries to offer a way forward, by posing the question that must be asked, answered, and confronted at every level in any serious strategy to change the state of child health, maternal health, and reproductive health in the world today, namely, "who's got the power?" How can the power to create change be marshaled to transform the structures, including the health systems, that shape the lives of women and children in the world today?

Acknowledgments

The coordination team of the task force extends its deepest thanks to the task force members, who contributed their insight, experience, and wisdom every step of the way. The members served on the task force in their personal capacities.

We are grateful to several colleagues for significant contributions to the report. Eugenia McGill, a task force consultant, wrote the first draft of chapter 6 and provided more detailed analysis in a commissioned paper. Task force member Vinod Paul gave several outstanding presentations on newborn health during task force meetings and wrote parts of the report on neonatal mortality. Giulia Baldi, of Columbia University's Center on Global Health and Economic Development, assisted with sections of the report on nutrition. We also benefited from a series of papers commissioned by the task force. The authors of all of these papers did outstanding work. The authors are Hannah Ashwood-Smith, Patsy Bailey, Deborah Balk, Gregory Booma, John Clements, Mick Creati, Candy Day, Enrique Delamonica, Ermin Erasmus, Walter Flores, Deborah Fry, Lucy Gilson, Wendy Holmes, Julia Kemp, Mandi Larsen, Samantha Lobis, Sunil Maheshwari, Clement Malau, Deborah Maine, Dileep Mavalankar, David McCoy, Eugenia McGill, Alberto Minujin, Chris Morgan, Susan Murray, Antoinette Ntuli, Valeria Oliveira-Cruz, Ashnie Padarath, George Pariyo, Bruce Parnell, Anne Paxton, Steve Pearson, Rajitha Perera, Ester Ratsma, Mike Rowson, Emma Sacks, Bev Snell, Freddie Ssengooba, Adam Storeygard, Mike Toole, Cathy Vaughan, and Meg Wirth.

We are also grateful to the many colleagues from around the world who provided comments and suggestions on the task force's background paper and interim report, on which this report builds. We received useful comments on drafts of this report from many quarters, including Zulficar Bhutta, Jack Bryant, Gary Darmstadt, Petra ten Hoope-Bender, and Joy Lawn, as well as

collective comments from USAID and the World Bank. Three outside reviewers—Marge Berer, Di McIntyre, and Peter Uvin—carefully read and commented extensively on the draft. We are extremely grateful to all of them.

Our task force meetings in Bangladesh and South Africa were enlivened by the presentations and participation of colleagues from NGOs and various multilateral agencies, including Koasar Afsana, Yasmin Ali Haque, Ana-Pilar Betran, Genevieve Begkoyian, Jude Bueno de Mesquita, Marinus Hendrik Gotink, Marian Jacobs, Sunil Maheshwari, Elizabeth Mason, Zoe Matthews, Dileep Mavalankar, Antoinette Ntuli, Yogan Pillay, Ester Ratsma, Meera Shekar, and Wim van Lerberghe. We thank BRAC for hosting our meeting in Bangladesh and the Centre for Health Policy at the University of the Witwatersrand for hosting our meeting in Johannesburg.

The task force had the incredible good fortune to connect its work with several major global health research projects. The child health work drew on the findings of the Bellagio Study Group on Child Survival, the Child Health Epidemiology Research Group, and the Multi-Country Evaluation of Integrated Management of Childhood Illnesses (IMCI). Recent publications by these groups have been highly influential and made the job of summarizing the field infinitely easier. Members of the Global Equity Gauge Alliance (GEGA) prepared a series of commissioned papers and presented at the task force meeting in South Africa. The work of the Rights and Reforms Project, based at the Women's Health Project in South Africa, informed our deliberations on health systems and health financing. Close communication with the Joint Learning Initiative on Human Resources for Health provided important background for our thinking on the health workforce. The Maternal and Neonatal Health and Poverty project of the World Health Organization collaborated with us in jointly commissioning an important review of the literature on obstetric referral and participated in our South Africa meeting. The Special Rapporteur on the Right to Health, Paul Hunt, and his staff consulted on human rights issues and participated in our South Africa meeting as well.

We would also like to acknowledge the following colleagues for providing invaluable input to the report and assistance with tracking down data: Hilary Brown, Mariam Claeson, Mick Creati, Becky Dodd, Caren Grown, Davidson Gwatkin, Piya Hanvoravongchai, Kathy Herschderfer, Pamela Putney, G. N. V. Ramana, Della Sherratt, Joyce Thompson, and Jeanette Vega.

Our colleagues in the UN Millennium Project Secretariat, especially John McArthur, Margaret Kruk, and Stan Bernstein, provided input, support, and guidance throughout. The members of other task forces who joined with us in the cross–task force working groups on health systems and on sexual and reproductive health and rights have helped ensure that the issues that matter for maternal and child health ultimately matter for the entire UN Millennium Project as well.

At Columbia University, we thank our colleagues in the Averting Maternal Death and Disability project for commenting on drafts and providing background data. We also thank graduate research assistants Perry Brothers, Ann Drobnik, and Christal Stone for their administrative and research assistance over the three years of the project.

Finally, here's to our administrative coordinator, Rana Barar. We thank her for her unbelievable efficiency, unfailing good humor, and consistent dedication and support throughout this entire project.

Millennium Development Goals

Goal 1

Eradicate extreme poverty and hunger

Target 1.
Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day

Target 2.
Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Goal 2

Achieve universal primary education

Target 3.
Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Goal 3

Promote gender equality and empower women

Target 4.
Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

Goal 4

Reduce child mortality

Target 5.
Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Goal 5

Improve maternal health

Target 6.
Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Goal 6

Combat HIV/AIDS, malaria, and other diseases

Target 7.
Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Target 8.
Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Goal 7

Ensure environmental sustainability

Target 9.

Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources

Target 10.

Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Target 11.

Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers

Goal 8

Develop a global partnership for development

Target 12.

Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction—both nationally and internationally)

Target 13.

Address the special needs of the Least Developed Countries (includes tariff- and quota-free access for Least Developed Countries' exports, enhanced program of debt relief for heavily indebted poor countries [HIPCs] and cancellation of official bilateral debt, and more generous official development assistance for countries committed to poverty reduction)

Target 14.

Address the special needs of landlocked developing countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and 22nd General Assembly provisions)

Target 15.

Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

Target 16.

In cooperation with developing countries, develop and implement strategies for decent and productive work for youth

Target 17.

In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Target 18.

In cooperation with the private sector, make available the benefits of new technologies, especially information and communications technologies

Executive summary

What kind of world do we want to live in? The Millennium Declaration lays out a vision that links poverty reduction and development, human rights and democracy, protection of the environment, and peace and security. Like many proclamations before it, the Millennium Declaration is cast in soaring, inspirational language. Its goals are lofty. Its hopes are high. But are we serious? Does the global community, particularly those who hold power in countries both rich and poor, have the courage to make the decisions, to challenge the status quo, to guide the transformative change necessary to advance this vision? Will those whose lives and health depend on these actions have the space, the leverage, and the will to demand and ensure that they do?

The state of children's health and women's health in the world today can be described through data and statistics that catalogue death, disability, and suffering. On this score alone the picture is "staggering," to quote the World Bank, "dire," to quote USAID, "a human disaster," to quote the World Health Organization, a "health emergency," to quote the African Union (Konare 2004; USAID 2004; Wagstaff and Claeson 2004; WHO 2003g).

The technical interventions that could prevent or treat the vast majority of conditions that kill children and women of reproductive age and enable all people to protect and promote their health—and so, theoretically, enable all countries to meet the Millennium Development Goals—can be identified. On these points there is strong consensus among health experts: Effective health interventions exist. They are well known and well accepted. They are generally simple and low-tech. They are 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 utilized is in crisis—a crisis ranging

The challenge posed by the Goals is deeply and fundamentally political

from serious dysfunction to total collapse. And behind the failure of health systems lies a deeper, structural crisis, symbolized by a development system that permits its own glowing rhetoric to convert the pressure for real change into a managerial program of technical adjustments.

The result is a terrible disconnect between the dominant development models and prescriptions and the brutal realities that people face in their daily lives. Mainstream development practice is effectively delinked from the broader economic and political forces that have generated a level of inequity, exclusion, divisiveness, and insecurity that will not be bottled up and stashed away. Too many bold attempts have been neutralized: the damage now lies exposed.

The chasm between what we know and what we do, between our ability to end poverty, despair, and destruction and our timid, often contradictory efforts to do so lies at the heart of the problem. The targets and indicators set by the Goals are framed in technical, results-oriented terms. But the response cannot be simply a technical one, for the challenge posed by the Goals is deeply and fundamentally political. It is about access to and the distribution of power and resources within and between countries; in the structures of global governance; and in the intimate spaces of families, households, and communities. Until we face up to the fundamental anchoring of health status, health systems, and health policy in these dynamics, our seriousness about achieving the Goals can be legitimately questioned.

Indeed, some have scoffed at the ambitious targets for child mortality and maternal health set by the Millennium Development Goals. But the Goals are attainable. There are inspiring examples of success. Huge reservoirs of skill and determination exist in every part of the world. The financial costs of meeting the maternal and child health Goals are dwarfed by what the world spends on preparing for and waging war. Indeed, they are dwarfed by the enormous sums already spent on interventions that do not reach those who need them—and by the terrible price being paid in human lives as a result.

The obstacles loom large as well. The impulse to continue business as usual gives way to talk about transcending business as usual. But talk is not action. Sometimes talk delays or deflates action, erects a wall of words that effectively blocks action. The Goals crack open a space in the wall. The task force hopes to help forge a pathway through that wall. But in the end, it is those who hold power and the people who demand their accountability who must take the first steps.

This report assesses progress on Goal 4 (on child mortality) and Goal 5 (on maternal health) and proposes best strategies for reaching them (table 1).

The report builds on a strong foundation of epidemiological data and analysis generated over the past several decades. This evidence base provides an increasingly refined picture of who dies or suffers poor health and why. It provides crucial information about the efficacy and safety of interventions to address those causes. It also generates insights about the effectiveness of different delivery systems for making interventions available, accessible, appropriate, and affordable.

Table 1
Goals, targets, and indicators for child health and maternal health

Goal	Targets	Indicators
Goal 4: Reduce child mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under-five mortality rate Infant mortality rate Proportion of 1-year-old children immunized against measles
Goal 5: Improve maternal health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	Maternal mortality ratio Proportion of births attended by skilled health personnel

This evidence base must be increased and strengthened. But epidemiological data and intervention-specific cost-effectiveness assessments cannot by themselves provide all the answers for achieving the maternal and child health Goals, because they capture only some dimensions of a highly textured problem. In addition to the epidemiology, therefore, this report puts forward a second line of analysis, which focuses on health systems and their unique role in reducing poverty and promoting democratic development. It demonstrates that functioning, responsive health systems are an essential prerequisite for addressing maternal and child health at scale and in a sustainable way—in short, for meeting the Millennium Development Goals.

To address health systems, the report draws on research from multiple disciplines, including epidemiology, economics and political economy, anthropology and the behavioral sciences, law, and policy analysis. Although the task force joins the call for increased health systems research to generate a deeper and stronger evidence base (*Lancet* 2004; Ministerial Summit on Health Research 2004), we explicitly recognize that policy responses to health systems do not just follow automatically from the data. Rather, policymakers face choices. And the choices they make must be fundamentally grounded in the values and principles that members of the global community have agreed should govern the world that we build together.

The report therefore takes its first principles—equity and human rights—from the Millennium Declaration and the long line of international declarations, binding treaties, and national commitments on which it is based. The values captured by these principles can be translated into specific steps, clear priorities, policy directions, and program choices, guided by the scientific evidence. The aim of this report is to set out the broad dimensions of the strategy that results.

A rights-based approach to the child health and maternal health Goals

"Women and children"—a tag line for vulnerability, an SOS for rescue, a trigger for pangs of guilt. Change must begin right there. The Millennium Development Goals are not a charity ball. The women and children who make up the statistics that drive the Goals are citizens of their countries and of the

The women and children who make up the statistics are citizens with rights

world. They are the present and future workers in their economies, caregivers of their families, stewards of the environment, innovators of technology. They are human beings. They have rights—entitlements to the conditions, including access to healthcare, that will enable them to protect and promote their health; to participate meaningfully in the decisions that affect their lives; and to demand accountability from the people and institutions that have the duty to take steps to fulfill those rights.

What should those steps be? Indisputably, poor health is connected to broader social, economic, and environmental conditions, some of which must be addressed from outside the health sector. Meeting other Millennium Development Goals (MDGs), particularly the Goals on gender empowerment, education, water, hunger, and income poverty, can have a powerful effect on the health and survival of all people, including women and children. In some cases, the causation is direct (clean water directly reduces infection, for example). But in many other cases, the impact of factors outside the health sector is mediated through the health sector. For example, advances in women's equality and empowerment mean that women can more readily make the decision to access emergency care when they suffer obstetric complications or their children fall seriously ill.

Hence health sector interventions—ideally in synergy with other MDG strategies outside the health sector—are critical for achieving Goals 4 and 5. Health sector interventions can also have significant effects on many other aspects of development and poverty reduction.[1]

The proximate causes of poor health and mortality in children and in women of reproductive age are known

Approximately 10.8 million children under age five die each year, 4 million of them in their first month of life. While child mortality has steadily declined in the past two decades, progress on key indicators is now slowing, and in parts of Sub-Saharan Africa child mortality is on the rise. The great bulk of the mortality decline since the 1970s is attributable to reduction in deaths from diarrheal diseases and vaccine-preventable conditions in children under five. Other major killers of children, such as acute respiratory infection, have shown far less reduction and malaria mortality has been increasing, especially in Sub-Saharan Africa. Neonatal mortality has remained essentially unchanged. Therefore, as other causes of under-five mortality decline, neonatal mortality accounts for an increasing proportion of all childhood deaths. Malnutrition of children is a contributing factor in more than half of all child mortality, and malnutrition of mothers in a substantial proportion of neonatal mortality.

For maternal mortality—the death of women in pregnancy and childbirth—progress has been even more elusive. Despite 15 years of the global Safe Motherhood Initiative, overall levels of maternal mortality are believed to have remained unchanged, with the latest estimate of deaths standing at about 530,000 a year

Scaling up is not just a process of multiplication

(WHO, UNICEF, and UNFPA 2004). A handful of countries has experienced remarkable drops in the maternal mortality ratio (an indicator of the safety of childbirth and pregnancy)—an inspiring reminder that with the right policies and conditions in place, dramatic and rapid progress is possible. But in the great majority of high-mortality countries, where the great majority of maternal deaths occur, there has been little change. In some countries, where levels of HIV/AIDS and malaria are high and growing, the number of maternal deaths and the maternal mortality ratio are thought to have increased. And the half million maternal deaths are the tip of the iceberg: another 8 million women each year suffer complications from pregnancy and childbirth that result in lifelong health consequences.

Other aspects of maternal health present a mixed picture. While fertility has declined dramatically—from a total fertility rate of 5.0 births per woman in 1960 to 2.7 in 2001—an estimated 201 million women who wish to space or limit their childbearing are not using effective contraception that would enable them to do so. The result is about 70–80 million unintended pregnancies each year in developing countries alone (Singh and others 2003).

Meanwhile, violence continues to shatter the lives of women in every part of the globe. Sexually transmitted infections, including HIV/AIDS, ravage whole communities, with disastrous effects on families and societies. The 13 million "AIDS orphans" around the world—children who have lost one or both parents to AIDS—are testament to this fact.

Full access to and utilization of proven, effective interventions would avert two-thirds of child deaths and three-quarters of maternal deaths

The primary health interventions needed to address most of these conditions are known. The Bellagio Study Group on Child Survival estimated that with 99 percent coverage of proven effective interventions, 63 percent of child mortality would be averted (Jones and others 2003) (figure 1). The World Bank has estimated that if all women had access to the interventions for addressing complications of pregnancy and childbirth, especially emergency obstetric care, 74 percent of maternal deaths could be averted (Wagstaff and Claeson 2004) (figure 2). Moreover, universal access to sexual and reproductive health information and services would have far-reaching effects for both the maternal health and child health Goals and for virtually every other Goal, including those for HIV/AIDS, gender, education, environment, hunger, and income poverty.

If we know the causes of most death and disability and we have the interventions to prevent or treat those causes, then why have the problems of maternal health and child health been so intractable? It is simple enough to call for massive scaling up of these interventions, but scaling up is not just a process of multiplication, of more providers, more drugs, more facilities in more places. Scaling up—ensuring that healthcare is accessible to and used by all those

Figure 1

Full use of existing interventions would dramatically cut child deaths

Millions of deaths, 2000

Source: Adapted from Jones and others 2003; neonatal deaths based on Save the Children 2001.

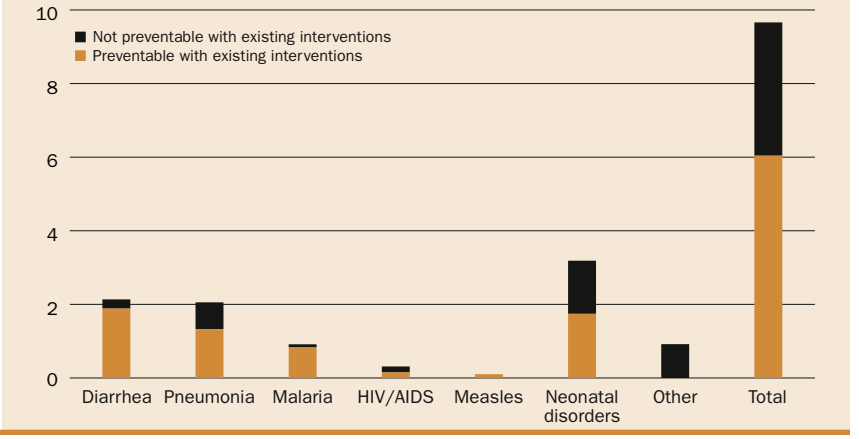
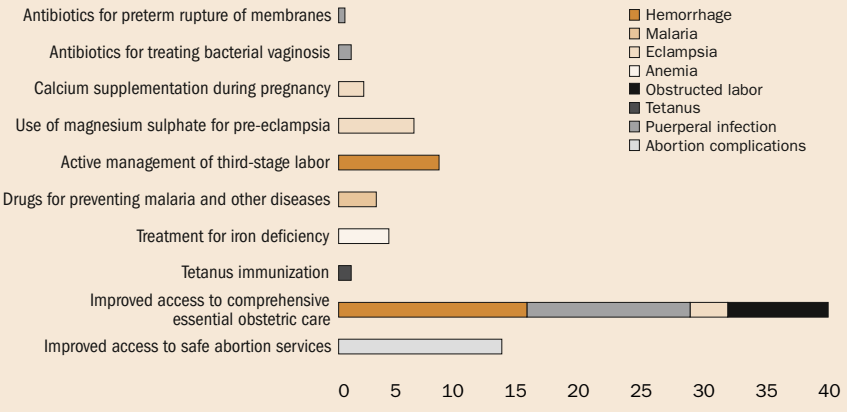


Figure 2

Full use of existing services would dramatically reduce maternal deaths

Share of deaths averted, 2000 (%)

Source: Wagstaff and Claeson 2004.



who need it—also means tackling the social, economic, and political contexts in which people live and in which health institutions are embedded. Both dimensions—concrete operational issues and wider, contextual issues—need sustained attention and investment.

Scaling up has technical dimensions, including priority-setting and sequencing of interventions

The task force recommends that highest priority be given to strengthening the primary healthcare system, from community-based interventions to the first referral-level facility at which emergency obstetric care is available. This implies a focus on the district level where, in many countries, critical planning, budgeting, and implementation decisions are made. There is no single blueprint for how a health system at this level should be organized. In the fields of maternal, child, and reproductive health, multiple scenarios have proven successful. Based on these experiences and on a large body of scientific data, the task force suggests basic principles and guidelines that countries should consider in developing detailed plans for meeting the Goals.

Countries must make hard choices about setting priorities

Strategies for tackling maternal and neonatal mortality should focus on delivery and the immediate postpartum period

The ideal scenario is this: as part of an integrated primary healthcare system, every birth, whether it takes place at home or in a facility, is attended by a skilled birth attendant, backed up by facilities that can provide emergency obstetric care and essential newborn care and by a functioning referral system that ensures timely access to the appropriate level of services in case of a life-threatening complication. On the way to that ideal, countries must make hard choices about setting priorities. One challenge is to determine whether there are immediate interim steps that can address some significant proportion of mortality while simultaneously strengthening the foundations of the health system so that ultimately the optimal level of care is provided for every woman and every newborn.

The most appropriate interim steps for addressing newborn care may well be different from the most appropriate interim steps for addressing maternal mortality. For newborns a substantial proportion of life-threatening conditions can be addressed within the community, by healthcare workers with only a few months of training.

But healthcare providers with this level of skill will not be able to effectively address obstetric complications experienced by the woman giving birth. These are the complications that kill women—and often their babies as well. Such emergencies must be handled by skilled professionals with the supplies, equipment, and healthcare teams that are available only in health facilities that provide emergency obstetric care.

A number of interventions, such as malaria prophylaxis and active management of third-stage labor, can have some impact on maternal mortality by preventing complications. These interventions certainly should be provided as part of routine antenatal and delivery care, and research to improve their safety and effectiveness—research on uniject oxytocin or misoprostol, for example—should be encouraged. Complications of unsafe abortion, which now account for some 13 percent of maternal deaths globally, could also be prevented through access to contraception and safe abortion services.

However, most obstetric complications occur unexpectedly around the time of delivery in women with no known risk factors, striking about 15 percent of all pregnant women. Therefore, to meet the MDG target of reducing the maternal morality ratio by 75 percent by 2015, it is critical for countries now to put priority focus on ensuring that women who experience life-threatening complications can and do access the emergency obstetric care that can save their lives. This necessarily means tackling the facility-based health system and its interaction with the communities and individuals it serves. Both supply-side factors (the availability of high-quality services) and demand-side factors (the barriers to appropriate utilization) are relevant, but initiatives to address them in any given geographic area must be carefully sequenced. A rights-based

Good results are realized only when health systems are strong

approach will pay particular attention to the link between supply and demand, establishing constructive accountability mechanisms that involve the community to ensure consistent 24-hour-a-day, 7-day-a-week functioning, equitable access, and high-quality, responsive care.

Strategies for reducing the under-five mortality rate begin in the community

For children, much can be accomplished without the involvement of the health system. Improved water supplies and sanitation and cleaner sources of energy to reduce indoor air pollution could significantly reduce the incidence of some of the more common diseases of childhood. Exclusive breastfeeding for the first six months and appropriate complementary feeding could prevent almost 20 percent of childhood deaths in the 42 countries where 90 percent of those deaths occur (Jones and others 2003). Teaching mothers and other primary caretakers how to recognize the early signs of potentially fatal illnesses and where to seek care for them is also essential.

Bringing appropriate curative care into the community would help overcome low utilization rates of health facilities. New policies allowing closer-to-client services, such as the use of antibiotics by community-level healthcare workers, recently recommended by the WHO and the United Nations Children's Fund (UNICEF), would be welcome. Development of new and more heat-stable vaccines and new antibiotics and other drugs that can be given in shorter and easier-to-administer courses would also be welcome.

But peripheral workers will always need close supervision and support from higher level health professionals, and both they and mothers will need to be able to access well staffed and supplied facilities for outpatient care. First-level referral hospitals are indispensable for treating severe illnesses. In other words, further reductions in child mortality must rely heavily on an accessible and competent health system that is actively involved through the entire range of primary healthcare services. Recent evaluations of the Integrated Management of Childhood Illness (IMCI) strategy supported by the WHO and UNICEF and implemented widely throughout the world have indicated that good results are obtained only when health systems are strong.

Full access to sexual and reproductive health information and services is critical to the health of women and children

A comprehensive district health system is critical for ensuring full access to sexual and reproductive health information and services which, together with good nutrition, form the foundation of good health for women and for children. It includes access to contraception, since control over the number and spacing of children can have a profound impact on the health and well-being of both women and their children. It also includes safe abortion services, as well as information and services for preventing and treating sexually transmitted

Full access to reproductive health services is critical

infections, including HIV/AIDS. Indeed, for HIV/AIDS interventions to be maximally effective they should be integrated into sexual and reproductive health services, since this is where most women access healthcare.

Adolescents deserve special attention with services tailored to meet their needs, including the differing needs of married and unmarried adolescents. As the largest cohort—1 billion strong—ever to make the transition from childhood to adulthood, today's adolescents are a key to meeting the Goals in a long-term, sustainable way.

Changes in human resource policies are necessary to deliver these interventions at scale

One enormous barrier to providing these interventions is the lack of adequately trained providers deployed at the appropriate levels of the health system and geographic locations—a problem intensified in recent years by massive migration of health professionals from poor countries to rich countries (the so-called "brain drain") and by HIV/AIDS, which has decimated the health workforce in some high-prevalence countries.

To address the crisis in human resources, policymakers should take several key steps:

- Revise laws and practices to enable mid-level providers, such as midwives, surgical technicians, and general medical practitioners, to perform procedures they can be trained to do safely and effectively but that now are restricted to specialist physicians. These procedures include all basic emergency obstetric care functions, as well as anesthesia and even cesarean section.
- Enable community health workers to perform key child and newborn health and reproductive health interventions within the community, with supportive supervision from the health system.
- Substantially increase salaries and improve career paths and working conditions of health providers.

Simply identifying these kinds of technological interventions that must be available at scale to meet the Goals gets us only marginally closer to the kind of functioning health system that is needed to deliver them. The wider context in which health services are delivered and accessed must also be addressed.

Scaling up toward universal access and full utilization requires tackling social, economic, and political conditions

Social, economic and political conditions present complex environments that resist formulaic solutions, particularly when imposed from outside and above. But too often recognition of this fact spells paralysis or, even worse, new rounds of technical solutions designed to dodge the issues altogether.

This report focuses on three kinds of interconnected challenges that can provide meaningful entry points for addressing the broader context and are

A trickle-down approach to addressing disparities will not work

themselves high-priority issues essential to MDG strategies: health inequity and the experience of poverty, health systems as social institutions that are greater than the sum of the medical interventions they deliver, and international aid levels and the development policies and processes through which the levels are determined and the aid distributed.

Trickle-down approaches to health disparities are not good enough; inequities must be explicitly addressed

The disparity between rich and poor countries in maternal mortality is dramatic. In some parts of Sub-Saharan Africa women have a 1 in 6 chance of dying in childbirth, while in parts of North America and Europe, lifetime risk is as low as 1 in 8,700 and maternal mortality has virtually disappeared as a public health problem (WHO, UNICEF, and UNFPA 2001).

Although the disparities in child mortality are less dramatic, nearly all child deaths occur in low- and middle-income countries, 75 percent in Sub-Saharan Africa and South Asia alone. For both maternal and child health, Sub-Saharan Africa (with the highest mortality rates) and South Asia (with the largest number of deaths) form the two epicenters of the crisis.

Less well documented, and far less understood, are the massive disparities that occur within high-mortality countries. Differences in health are not random; a growing body of research demonstrates that the disparities are systematic and track underlying hierarchies of social disadvantage. The magnitude of inequities varies from country to country and across different health conditions and health interventions. Disparities by wealth, geographic area, and gender have been most widely documented, but health disparities often follow other lines of social disadvantage as well, including race and ethnicity, urban or rural location, and linguistic or religious divisions.

To some extent the disparity in health status is due to disparities in living and working conditions that fall outside the health sector. But it is critical to recognize that social and economic disadvantages also directly influence access to and utilization of healthcare, as well as the patterns of health spending. While the health system could and should function as a safety net, providing care to those who need it most, too often the reverse is true: socially excluded groups do not have access to badly needed care, despite their higher burden of disease, and when they are able to access care, it often involves catastrophic costs that deepen their impoverishment.

The implication for MDG strategies is clear: a trickle-down approach to addressing disparities will not work. The fact that a particular health intervention is used to prevent or treat a disease that is more prevalent among the poor does not mean that the poor will be the ones who benefit from increased spending on that intervention. In fact, without specific attention, just the opposite is likely to happen. For strategies to meet the Goals, it is not only the poor and marginalized, but inequity—the gap itself—that must be explicitly addressed.

"Pro-poor" strategies must deal meaningfully with the roots of inequity

Countries—including health authorities at the local and even the facility level—must document and understand disparities in health status and the utilization of healthcare. Although there is enormous room for new work and innovation in health equity research, a wealth of information is now buried in the data generated by current health information systems (Wirth and others 2004). Progress in closing the equity gap can and should be monitored as an intrinsic part of the MDG initiative. The task force therefore recommends that the maternal health and child health targets be modified so that they are equity sensitive. These same monitoring processes can also feed directly into human rights monitoring at the international and national levels, since nondiscrimination is a crosscutting norm codified in human rights law.

A far more complex question is exactly what kinds of interventions will best address inequity. The answer will be context specific, and the process by which the answer is formulated—ideally, a process that includes the marginalized in a meaningful way—will be intrinsic to the solution. The overriding recommendation of the task force is that so-called "pro-poor" strategies should not deal only with the symptoms; they must deal meaningfully with the roots of inequity. Much writing in the international health field in recent years has referred to "pro-poor" interventions, sometimes with little thought about whether such interventions are necessarily "pro-equity" or even "anti-poverty." Sometimes interventions do need to be carefully "targeted" to geographic areas or even populations that are disadvantaged. But if the more basic sources of inequity within the structure of the health system are not acknowledged and addressed, the danger is a targeted intervention that stigmatizes or a superficial equity initiative that breeds little more than cynicism. "Pro-poor" interventions deployed around a deeply inequitable core structure are insufficient.

Equitable, well functioning health systems play a central role in poverty reduction, democratic development, and the fulfillment of human rights

The very structure and functioning of the health system must be considered. One objective of the health system is, of course, to ensure equitable access to the technical interventions necessary to promote health and treat disease. But development planners and government authorities have often failed to grasp the extent to which abusive, marginalizing, or exclusionary treatment by the health system has come to define the experience of being poor. Moreover, they have often failed to grasp that the converse is also true: the health system as a core social institution, part of the fabric of social and civic life, has enormous potential to contribute to democratic development.

Health claims—claims of entitlement to healthcare and enabling conditions—are assets of citizenship. Their effective assertion and vindication through the operation of the health system helps build a human rights culture and a stronger, more democratic society.

Market-based health reforms fail to reach the poor

A fundamental shift in the approach to health systems is needed

Our ability to meet the Millennium Development Goals turns on our ability to think differently and act differently about health systems. The status quo is unacceptable, in multiple respects:

- The fragile and fragmented health systems that now exist are unable to ensure availability, access, and utilization of key health interventions in sufficient volume and quality to meet the Goals.
- The costs individuals incur in managing (or failing to manage) their health are often catastrophic, thus deepening poverty.
- As core social institutions, dysfunctional and abusive health systems intensify exclusion, voicelessness, and inequity while simultaneously defaulting on their potential—and obligation—to fulfill individuals' rights and contribute to the building of equitable, democratic societies.

The approach put forward in this report responds to the dominant policy packages that have been promoted for health sector reform over the past two decades and to the realities that have resulted on the ground. These prescriptions for reform have been based on the fundamental conviction that healthcare is best delivered to populations through competitive markets. To create such markets, the dominant approach converts healthcare into a marketable commodity, that is, into a product or service to be bought and sold; encourages the development of a competition-driven private sector to deliver health services on a for-profit basis (and in practice also encourages private, nonprofit providers, such as nongovernmental organizations and church-owned facilities); and tries to expand the choices available to healthcare consumers, who are assumed to make optimal decisions for themselves in seeking healthcare.

This basic approach to the health sector, championed largely by donors, has been part of a broader strategy for poorly performing public sector institutions—a strategy that is ideologically opposed to a strong state presence. The strategy minimizes the role and, in practice, the legitimacy of the state.

Even the most ardent health sector reformers, however, recognize that market-based reforms based on the commodification of healthcare will end up failing to reach the poor, who simply do not have sufficient cash or other assets to purchase the care they need. They also recognize that such "market failure" means that a segment of the population will continue to suffer poor health, which, especially in the case of infectious disease such as HIV/AIDS and severe acute respiratory syndrome (SARS), has clear "externalities"—that is, effects on the broader society beyond the poor health of the individuals who are unable to purchase healthcare. Thus even strongly market-based health reforms see a role for public sector services. In this model, the central role of the public sector is to "fill the gap" by providing a minimum level of essential services—often formulated as an "essential services package"—for the poor. Government also acts as the "steward" of the system, setting policies, law, and regulations, even if it does not deliver services directly.

Health systems are core social institutions

Health sector reforms were expected to increase both efficiency (through markets) and equity (through the broader reach of an invigorated private sector for those who could pay and a "residual" public sector for those who could not). That was the theory. The reality has been far different and, of course, rather varied as well. But, quite systematically, these reforms have been experienced as deeply unequalizing. Moreover, the theoretical neatness of discrete public and private sectors, each with its own role, pertains almost nowhere. People rich and poor face a pluralistic market with a wide and chaotic array of services of wildly varying quality that in virtually all cases require outlays of cash to access, even in the public sector where fee exemption schemes are in place.

The overall weakening of the state has left it unable to perform the regulatory and governance functions on which a market-based system depends (in many cases it was not strong enough to perform these functions well in the first place). That failure and the chaos and inequity that result intensify the problem: they further delegitimize the state in the eyes of both the people who make up the health system and the people who look to it for managing health and disease—quite often for matters of life and death. Confronting this reality, this report puts forward the outlines of a different approach to health systems (table 2).

The conventional and the proposed approaches are not mutually exclusive. Indeed, many elements of the conventional approach, such as burden of disease assessments, user preferences, or even market operations, are also important elements of the task force approach. But the task force advocates a basic shift in perspective and mindset. That shift begins with the need to understand the nature and functioning of the health system differently, in effect to change the primary unit of analysis from specific diseases to health systems as core social institutions.

The proposed approach also adopts a different view of the role of the state. It does not propose a particular model for state involvement in service delivery, recognizing that there are many different routes to and providers of excellent

Table 2
Task force approach to health systems

Item	Conventional approach	Task force approach
Primary unit of analysis	Specific diseases or health conditions, with focus on individual risk factors	Health system as core social institution
Driving rationale in structuring the health system	Commercialization and creation of markets, seeking financial sustainability and efficiency through the private sector	Inclusion and equity, through cross-subsidization and redistribution across the system
Patients/users	Consumers with preferences	Citizens with entitlements and rights
Role of state	Gap-filler where market failure occurs	Duty-bearer obligated to ensure redistribution and social solidarity rather than segmentation that legitimates exclusion and inequity
Equity strategy	Pro-poor targeting	Structural change to promote inclusion

Many of the steps needed can begin immediately

healthcare. But it does propose a different understanding of state responsibility and obligation in relation to health and a different understanding of the role of health systems in the overall project of democratic development. Among other things, the approach places increased importance on equity, seeing it as a central objective of health policy. This means taking seriously the need for redistribution within the health system.

To do that, the report puts forward three principles to guide context-specific policymaking and offers supporting rationales and specific possible policy interventions that derive from each. These principles are:

- Strengthening the legitimacy of the state.
- Preventing excessive segmentation by enhancing norms of collaboration to improve services in both public and private sectors.
- Strengthening the voice and power of the poor and marginalized to assert claims.

Health spending must increase dramatically if the Goals are to be met

Current levels of expenditure are simply not enough to effect the changes necessary to meet the Goals. In the poorest countries of Sub-Saharan Africa, health expenditures are in the range of $1–$10 per capita, with a substantial proportion coming out of the pockets of users. In many cases the costs of healthcare are catastrophic, pushing already poor people deeper into poverty. In 2001 the Commission on Macroeconomics and Health determined that a basic package of primary healthcare would cost about $34 per capita per year (Commission on Macroeconomics and Health 2001). It is the obligation of national governments and the international community to ensure that such amounts are available and spent to improve and safeguard health.

Development practices must create a policy environment that ensures appropriate policies, expenditures, and accountability for implementation

Many of the steps needed to meet the child health and maternal health Goals can begin immediately, at the national, district, and local levels. For example, inequity can start to be tackled immediately by initiating the local documentation and problem-solving processes. Failures in the provision of emergency obstetric care can often be fixed by focusing attention on the problem and making changes in facility-based management or logistical systems that do not require massive infusions of new money.

But the kind of transformational change required to meet the Goals at the national level will also entail serious revisions in the policy environment, including the processes and practices by which aid is determined and distributed. Far too often, the best laid plans of the health sector are quashed or neutralized when put through the wringer of financing and planning mechanisms that operate at the national and international levels. Finance and planning ministries and the officials of international financial institutions with

Accountability should lie at the heart of the MDG initiative

whom they negotiate need to have a profoundly different appreciation of the importance of health and health systems for economic growth, poverty reduction, and the building of democratic societies.

The UN Millennium Project calls for poverty reduction strategies that are based on the Millennium Development Goals. In the area of health, this requires more than a list of statistics of poor maternal and child health and a statement of determination to address them. It entails making hard decisions about priorities, examining the underlying health system, and ensuring that implementation, monitoring, and accountability processes are in place.

Accountability should lie at the heart of the MDG initiative. In the end, poverty reduction and the strategies to make it happen will require meaningful participation by those whose lives and health depend on it and serious, determined, courageous action from those who have the power to initiate, sustain, and guarantee change.

Goals 4 and 5 are attainable—but not without extraordinary effort

The principal recommendations of the task force for achieving the Goals are as follows:

Health systems. Health systems, particularly at the district level, must be strengthened and prioritized in strategies for reaching the child health and maternal health Goals.

- Health systems are key to sustainable, equitable delivery of technical interventions.
- Health systems should be understood as core social institutions indispensable for reducing poverty and for advancing democratic development and human rights.
- To increase equity, policies should strengthen the legitimacy of well governed states, prevent excessive segmentation of the health system, and enhance the power of the poor and marginalized to make claims for care.

Financing. Strengthening health systems will require considerable additional funding.

- Bilateral donors and international financial institutions should substantially increase aid.
- Countries should increase allocations to the health sector.
- User fees for basic health services should be abolished.

Human resources. The health workforce must be developed according to the goals of the health system, with the rights and livelihoods of the workers addressed.

- Any health workforce plan should include plans for building a cadre of skilled birth attendants.

- "Scope of profession" regulations and practices must be changed to empower mid-level providers to perform life-saving procedures safely and effectively.

Sexual and reproductive health and rights. Sexual and reproductive health and rights are essential to meeting all the Millennium Development Goals, including those on child health and maternal health.

- Universal access to reproductive health services should be ensured.
- HIV/AIDS initiatives should be integrated with sexual and reproductive health and rights programs.
- Adolescents must receive explicit attention with services that are sensitive to their increased vulnerabilities and designed to meet their needs.
- In circumstances where abortion is not against the law, abortion services should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion.
- Governments and other relevant actors should review and revise laws, regulations, and practices, including those on abortion, that jeopardize women's health.

Child mortality. Child health interventions should be scaled up to 100 percent coverage.

- Child health interventions should be increasingly offered within the community, backed up by the facility-based health system.
- Child nutrition should get added attention.
- Interventions to prevent neonatal deaths should get increased investment.

Maternal mortality. Maternal mortality strategies should focus on building a functioning primary healthcare system from first-referral facilities to the community level.

- Emergency obstetric care must be accessible for all women who experience complications.
- Skilled birth attendants, whether based in facilities or in communities, should be the backbone of the system.
- Strategies to ensure skilled attendants at all deliveries must be premised on integrating them into a functioning district health system that supplies, supports, and supervises them adequately.

Global mechanisms. Poverty reduction strategy processes and funding mechanisms should support and promote actions that strengthen equitable access to quality healthcare and not undermine them.

- Global institutions should commit to long-term investments.
- Restrictions on funding of salaries and recurrent costs should be removed.

- Donor funding should be aligned with national health programs.
- Health stakeholders should participate fully in policy development and funding plans.

Information systems. Information systems are an essential element in building equitable health systems.

- Indicators of health system functioning must be developed and integrated into policy and budget cycles.
- Health information systems must provide appropriate, accurate and timely information to inform management and policy decisions.
- Countries must take steps to strengthen vital registration systems.

Targets and indicators. All targets should be framed in equity-sensitive terms.

- Universal access to reproductive health services should be added as a target to Goal 5.
- All targets should have an appropriate set of indicators as shown in table 3, where new indicators and changes to the targets appear in italics.

Table 3

Proposed targets and indicators for the child health and maternal health Goals

Note: Proposed modifications appear in italics.

Goal	Targets	Indicators
Goal 4: Reduce child mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate, *ensuring faster progress among the poor and other marginalized groups*	Under-five mortality rate Infant mortality rate Proportion of 1-year-old children immunized against measles *Neonatal mortality rate* *Prevalence of underweight children under 5 (see Goal 1 indicator)*
Goal 5: Improve maternal health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio, *ensuring faster progress among the poor and other marginalized groups* *Universal access to reproductive health services by 2015 through the primary health-care system, ensuring faster progress among the poor and other marginalized groups*	Maternal mortality ratio Proportion of births attended by skilled health personnel *Coverage of emergency obstetric care* *Proportion of desire for family planning satisfied* *Adolescent fertility rate* *Contraceptive prevalence rate* *HIV prevalence among 15- to 24-year-old pregnant women (see Goal 6 indicator)*