

Safe motherhood initiative: 20 years and counting

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The global campaign to reduce maternal mortality was launched in February, 1987, when three UN agencies—UNFPA, the World Bank, and WHO—sponsored the international Safe Motherhood Conference in Nairobi, Kenya. The event aimed to raise awareness about the numbers of women dying each year from complications of pregnancy and childbirth, and to challenge the world to do something.

The origins of the conference dated from 1985, when two critical events focused the attention of public-health specialists on the horrific risks pregnancy posed for women in developing countries. In that year, Allan Rosenfield and Deborah Maine pointed out that maternal and child health programmes in developing countries were almost exclusively for the benefit of the child, with almost no attention to the factors that were causing women to die.¹ That same year, during the conference marking the end of the UN Decade for Women, women's advocates from around the world heard WHO announce that half a million women were dying each year from obstetric complications.

These two events began a groundswell of concern for key players, both institutional and individual, who came together to plan the Nairobi Safe Motherhood Conference and to launch the global Safe Motherhood Initiative. The 1987 Nairobi conference led to the formal establishment of the Safe Motherhood Inter-Agency Group (which included the three sponsors of the conference plus

UNICEF, UNDP, and two international non-governmental organisations, IPPF and the Population Council), and to a series of regional and national conferences that made safe motherhood an accepted and understood term in the public-health realm. By the time of the International Conference on Population and Development in 1994, every region of the world had held a safe motherhood conference,² and safe motherhood was firmly enshrined as a core component of reproductive health.³ The importance of maternal survival was reinforced in 2000, when it was included as one of the eight Millennium Development Goals.⁴

The Safe Motherhood Initiative has learned important lessons during the past 20 years. At the Nairobi conference, the framework for action in Fred Sai's closing statement encompassed the need to improve women's status, educate communities, and strengthen and expand core elements of maternal health—antenatal care, delivery care, and postpartum care—at the community and referral levels. The conference proceedings echoed these recommendations,⁵ but they were not always taken up by key actors. During this period, less than 10 years after the Alma Ata conference and the global commitment to primary health care, the public-health community was prioritising community-based preventive interventions. Donors, UN agencies, and governments therefore seized on two elements of the safe motherhood strategy discussed at the Nairobi conference—antenatal care, with a focus on screening women to identify those at risk of complications, and training of traditional birth attendants to improve delivery care at the community level—and poured their funding and support into these strategies.

A decade later, at the conference marking the Initiative's 10th anniversary, two of the key action messages about safe motherhood implicitly acknowledged the failure of these approaches (panel).⁶ The two messages helped shift the focus of the Safe Motherhood Initiative; many donors and governments began de-emphasising large-scale training programmes for traditional birth attendants and prioritising health-sector interventions designed to increase women's access to professional medical care, especially for life-threatening complications.

There were other strategic decisions in the Initiative's early years that had unforeseen negative consequences,

Panel: Key action messages on safe motherhood, 1997

- "Every pregnancy faces risks" emphasised that any pregnant woman can develop life-threatening complications with little or no advance warning, so all women need access to quality maternal health services that can detect and manage life-threatening complications
- "Ensure skilled attendance at delivery" acknowledged the importance of having a health-worker with midwifery skills present during childbirth, backed up by transport in case of emergency referral as required. Traditional birth attendants, trained or untrained, were excluded from the definition of skilled attendants, because they lacked the clinical skills, drugs and equipment, or infrastructure to manage complications such as haemorrhage, eclampsia, or severe infection. Another action message, "improve access to quality maternal health services", also emphasised the importance of both clinical and interpersonal aspects of care, including the capacity to provide emergency obstetric care



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however well-intentioned they might have been. One of these was the focus on maternal death as a multisectoral problem, with equal emphasis on the range of direct and indirect problems that contribute to poor maternal health. Women's rights advocates—and many medical professionals⁷—noted that maternal deaths are not just the result of poor or inaccessible medical care, but indicated a long chain of problems: lack of education for girls; early marriage; lack of access to contraception; poor nutrition; and women's low social, economic, and legal status. These factors, individually and collectively, contributed to women's poor health before and during pregnancy, increasing their vulnerability to life-threatening complications and limiting their ability to seek and receive good quality care.

However, attempting to address all these complex and deeply rooted factors frequently resulted in large national action plans for safe motherhood that were complicated and expensive. Donors were unwilling to support these massive undertakings, and there was often no clear leadership within countries. Ministries of health, education, and women's affairs were all expected to play a role, as were a range of civil society groups, but the reality was that rivalries over funding, visibility, and control mitigated against the development and implementation of clear, focused, realistic strategies for reducing maternal mortality.

These rivalries were sometimes echoed at the international level. Unlike child survival or family planning, issues which fell clearly within the mandates of specific UN agencies, safe motherhood was a cross-cutting issue: WHO, UNFPA, UNICEF, UNDP, and the World Bank all felt ownership and included it within their institutional mandates. This multiple ownership of safe motherhood should have been, and sometimes was, a benefit: all the agencies addressed the issue through their country programmes, and all worked together, especially at the global level through the Safe Motherhood Inter-Agency Group, to articulate strategic priorities and advocacy messages. The Initiative's 10th anniversary in 1997–98 was probably the period when this group worked most effectively together, developing the ten action messages for safe motherhood,⁶ and collaborating on a large-scale comprehensive advocacy campaign that substantially increased the visibility of and support for maternal health.

But despite these achievements, the Initiative did not generate the large-scale effect that was hoped for, and that had been implied by the grand goal articulated in 1987: "reduce maternal mortality by 50% by the year 2000". A range of rationalisations have been put forth: the technical difficulty of estimating maternal mortality, which makes it problematic to measure progress and evaluate programme impact; the lack of a high-visibility global champion and advocate, as Jim Grant was for child

survival; the lack of a clear universal consensus around a set of technical interventions; political sensitivities around key components of safe motherhood, especially unsafe abortion and adolescent pregnancy; and lack of commitment among political leaders (often attributed to the fact that maternal death is a “women’s issue”). In addition, however, the women’s rights movement at the global and national levels never fully mobilised in support of safe motherhood; while they welcomed the focus on the root causes of poor maternal health, most were never comfortable with the term safe motherhood, with its implied focus on women’s childbearing role.

The perception that the Safe Motherhood Initiative failed is perhaps understandable from a superficial perspective, given that the global figure of maternal deaths has remained relatively constant since the Initiative was launched. But that perception is nevertheless unfounded and unacceptable, and needs to be challenged, persistently and loudly. While mistakes might have been made, there is much greater clarity and consensus today about effective strategies for reducing maternal mortality, and greater recognition of the benefits to health systems, to families, and to communities of investing in maternal health. The costs of inaction are devastating.

The next 12–18 months will be critical for safe motherhood advocacy, offering an unprecedented chance to redress errors of the past and take advantage of new opportunities. These arise from the publication of the current *Lancet* series on maternal health; the 20th anniversary (in 2007) of the launching of the Safe Motherhood Initiative, the reaffirmation in 2005 of the Millennium Development Goals, including MDG-5 on improving maternal health, and also in 2005, the launching of the Partnership for Maternal, Newborn and Child Health, a new global consortium that will take on the goal of reducing maternal mortality and integrate it with the closely linked issues of newborn and child mortality in a continuum of care.

The Partnership faces a range of challenges, some of which have existed since the Initiative was launched and some of which are new. But it has the advantage of the past 20 years of achievements and lessons to build on. Key lessons for moving forward include:

- Tailor messages for different audiences, focusing on equity and human rights, as well as the economic and social benefits of saving women’s lives (including the benefits for infants and children)

- Encourage participation by all interested parties and ensure buy-in from key partners, and at all levels—members of the Partnership need to support the core messages and strategies, from the agency heads to staff in country offices
- Link with other key health and development issues, such as HIV/AIDS and poverty reduction, to ensure that maternal, newborn, and child health stays on the agenda and that strategies receive the support they need
- Confront technical disagreements head on, and hammer out a consensus—not every agency needs to implement the same exact interventions, but if governments are to address the issue and if donors are to fund the programmes, a core set of recommendations must be endorsed by the key institutional players, including UN agencies, donors, health professional associations, non-governmental organisations, and academic and research institutions
- Invest in getting the necessary data, and be careful how it is used—imprecise estimates should not be used to rank countries or assess interventions, and more efforts are needed to develop assessment methodologies that are cost-effective
- Harmonise efforts at the country and regional levels, with national governments taking the lead in setting priorities; collaboration among agencies within countries is essential for implementation at the scale of the needed interventions.

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