

Delivering for women

20 years ago the global health community came together to highlight the most striking inequity in public health: half a million women, 99% of them in the developing world, were dying every year in pregnancy and childbirth. High fertility, inadequate and inaccessible health services, and women's low status meant that women in the poorest regions of the world were 500 times more likely to die from pregnancy-related complications (one in 20 risk) than women in northern Europe (one in 10 000 risk).¹ The global Safe Motherhood Initiative was launched to generate political will, identify effective interventions, and mobilise resources that would rectify this horrifying injustice.

Today, 20 years into the initiative, maternal mortality has declined in some regions, especially in middle-income countries in Latin America and northern Africa, as documented by Ken Hill and colleagues in today's *Lancet*.² But dismally, we are nowhere near the goals of reduction of global maternal mortality by 50% (the target set in 1987) or 75% (the target set by Millennium Development Goal [MDG] 5, accepted by the UN and heads of state in 2000). Progress has been achieved in other areas, including much greater awareness of the issue and an enormous increase in knowledge about what works and what does not. But without substantial decreases in maternal mortality, what is there to celebrate in 2007? As the 20th anniversary approached, this dilemma was faced by the agencies, organisations, donors, and individuals who helped launch the initiative.

After many years of sometimes heated debate about what strategies should have priority, over the past 18–24 months a broad consensus has emerged within the maternal health community about the core health-sector strategies for reduction of maternal mortality. First, comprehensive reproductive health care, including family planning and safe abortion, or where necessary, postabortion care. Second, skilled care for all pregnant women by a qualified midwife, nurse, or doctor during pregnancy and especially during childbirth. Third, emergency care for all women and infants with life-threatening complications. These strategies are the basic elements that must be in place if a country with high maternal mortality is to bring its rate down significantly, but are by no means exclusive. There is growing attention to the need for

timely postnatal care for both mothers and newborn babies, preferably within the first 2–3 days after birth. And although research has not shown that antenatal care directly reduces maternal mortality, good quality antenatal care is linked with greater use of skilled care during childbirth. Generally, we know what to do to save the lives of women and mothers—and, in 2007, we do not need another technical conference to debate the issue of basic strategy.

The Saving Newborn Lives project, launched in 2000, has brought particular attention to the problem of neonatal mortality. Newborn babies account for almost 40% of child deaths,³ and this percentage has been increasing as child mortality has declined. Most deaths of newborn babies are directly related to the mother's poor health or to inadequate care during and after pregnancy and childbirth. The 20th anniversary of the Safe Motherhood Initiative therefore gave an opportunity to recognise the inextricable links between maternal and newborn health, and revitalise action for both, in the context of the continuum of maternal, newborn, and child health, as discussed by Kate Kerber and colleagues in *The Lancet* today.⁴

Recent global developments offer an unprecedented opportunity to refocus on maternal health, to change the terms of the discussion and debate, and to convert goodwill into resources and focused action. These developments include: the adoption of the MDGs in 2000, with a specific MDG on maternal health; the launching of

See [Editorial](#) page 1283

See [Articles](#) page 1311

See [Review](#) pages 1347 and 1358

See [Public Health](#) page 1383



UNICEF/Michael Kember

the Partnership for Maternal, Newborn and Child Health in 2005; the recognition that vertical disease-specific funding initiatives have often not contributed to strengthening health systems;⁵ and more recently, major shifts in the discourse around global health issues and in the structure of aid packages. Specifically, a range of new initiatives, led mainly by donor governments and UN agencies, have been brought together under the umbrella of the Global Campaign for the Health Millennium Development Goals, with selected initiatives (such as Deliver Now for Women and Children, led by Norway) focusing specifically on maternal and child health.⁶

Perhaps more than any other factor, the realisation that we need to fundamentally change the way maternal mortality is viewed shaped plans for marking the Safe Motherhood Initiative's 20th anniversary. Addressing the problem is essential for the social and economic development of families, communities, and nations. This point is the central principle for the Women Deliver conference, on Oct 18–20, in London, UK.

The title for the safe motherhood 20th anniversary conference carries, quite deliberately, multiple meanings—women deliver babies, certainly, and that is a central theme of the conference. But women also deliver in many other ways: food, goods, and income for their families; education, affection, and care for their children; and energy, creativity, and inspiration for their communities. The Women Deliver conference is a celebration and acknowledgment of the many ways in which women are the backbone of society—and a vigorous call for that role to be recognised and supported, not only because women deserve it, but also because societies need it. As Kirrin Gill and co-workers⁷ show in today's *Lancet*, the economic and social cost of maternal and newborn mortality is enormous, at around US\$15 billion a year in lost productivity. Preventing these deaths would cost only about a third of this amount: estimates vary, but are in the range of \$4–6 billion a year for a basic package of maternal and neonatal interventions in the 75 countries with highest mortality. We need more research and data to document the costs of both inaction and action, but the core message is clear, and is articulated in the conference theme: invest in women—it pays. The Women Deliver conference, and this special issue of *The Lancet*, aims to achieve four major outcomes.

First, as outlined above, we need to establish maternal health as an essential contributor to economic and social

development. The 1500 participants at the conference therefore include not just health policymakers, medical professionals, and public-health experts, but also those working on education, human rights, micro-enterprise, HIV, child health, and a range of other development sectors. Featured speakers include not only the heads of WHO and UNFPA, agencies with longstanding commitment to maternal health, but also the heads of the International Labour Organization and UNAIDS, the President of the Global Fund for Women, the UN Special Rapporteur for Human Rights, and of course, the conference co-chairs, the Deputy Secretary-General of the UN and the former UN Commissioner for Human Rights. This broad participation is intended to forge and strengthen programmatic and advocacy links to other sectors that are crucial for improvement of women's status and women's health.

Second, we need to get both donor and developing country governments to allocate sufficient resources, financial and otherwise, to achieve MDG 5, as well as the related MDGs for poverty eradication (MDG 1), education (MDG 2), gender equality (MDG 3), child survival (MDG 4), and HIV (MDG 6). At the country level, we need to reach out not only to ministers and ministries of health, but also to ministers and ministries of planning, finance, and local government. And we also need to ensure that the maternal health community, especially at local and national levels, understands how and when budgeting decisions are made, and has the evidence and the arguments it needs to show how improved maternal health affects national development. As noted by Lynn Freedman and others in *The Lancet* today,⁸ for maternal death to be prevented, health systems must meet a minimum level of functionality in terms of human resources, infrastructure, supplies, and management. As such, monitoring indicators of maternal health is a highly effective way for countries to monitor the basic capacity of their health systems.

Third, we need to activate and re-energise civil society, both to challenge donors and governments to invest in maternal health, and to hold them accountable for the promises they have made or implied. Women deliver, but they must demand too; and unfortunately women's groups and women's rights activists have historically not made the issue of maternal health a priority. By recognising the links between maternal health and other aspects of women's status and roles, Women Deliver aims

to redress this gap. The term safe motherhood served an important political purpose 20 years ago, allowing sensitive issues relating to reproduction to be raised at high-level policymaking. But by implying that women's value was based on their maternal roles only, the term was also a liability. It is time to put it to rest, to talk instead about maternal health, and to focus on the more positive vision inherent in the phrase women deliver.

Fourth, the maternal health community needs to overcome the perception that there is no agreement on effective interventions for reducing maternal mortality. As outlined above, a broad consensus has emerged. Specific elements of these strategies, such as how much to focus on facility-level versus community-based interventions, can and should still be discussed, and will of course vary depending on the national context. But we can no longer allow the excuse "we don't know what to do" to be used as a way to avoid action—and the maternal-health community itself needs to coalesce behind the three core strategies of comprehensive reproductive health services, skilled care, and emergency obstetric care. Since the human race began, women

have delivered for society. It is time now for the world to deliver for women.

Ann M Starrs

Family Care International, New York, NY 10012, USA; and
Partnership for Maternal, Newborn and Child Health, Geneva,
Switzerland
astarrs@familycareintl.org

I declare that I have no conflict of interest.

- 1 Starrs A. Preventing the tragedy of maternal deaths: a report on the International Safe Motherhood Conference, Nairobi, Kenya, February 1987. Washington, DC: World Bank, 1987.
- 2 Hill K, Thomas K, AbouZahr C, on behalf of the Maternal Mortality Working Group. Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data. *Lancet* 2007; **370**: 1311–19.
- 3 Lawn JE, Cousens S, Zupan J, for the Lancet Neonatal Survival Steering Team. 4 million neonatal deaths: When? Where? Why? *Lancet* 2005; **365**: 891–900.
- 4 Kerber KJ, de Graft-Johnson JE, Bhutta ZA, Okong P, Starrs A, Lawn JE. Continuum of care for maternal, neonatal, and child health: from slogan to service delivery. *Lancet* 2007; **370**: 1358–69.
- 5 Garrett L. The challenge of global health. *Foreign Aff* 2007; **1**: 14–38.
- 6 The global campaign for the health Millennium Development Goals. <http://www.norad.no/default.asp?FILE=items/9244/108/GlobalCampaignHealthMDGs.pdf> (accessed Oct 2, 2007).
- 7 Gill K, Pande R, Malhotra A. Women deliver for development. *Lancet* 2007; **370**: 1347–57.
- 8 Freedman LP, Graham WJ, Brazier E, et al. Practical lessons from global safe motherhood initiatives: time for a new focus on implementation. *Lancet* 2007; **370**: 1383–91.

No woman should die giving life

Of all health indicators, maternal mortality reveals the greatest gap between rich and poor women, both between and within countries. Each year, 536 000 women die from complications of pregnancy and childbirth—99% in the developing world—and another 10–20 million women have severe health problems, including obstetric fistula. In 2005, women in developed countries had a one in 7300 lifetime risk of dying from pregnancy-related causes, compared with a one in 75 risk in developing countries.¹ In Africa, the lifetime risk is one in 26.¹ Little change has been seen in the hardest hit areas and the gap is widening.

At the midpoint in the timeline to achieve the Millennium Development Goals (MDG), the absence of progress in reduction of maternal mortality and morbidity is unacceptable. The urgent and life-threatening circumstances of millions of women call for quick, concerted, and decisive actions to be taken now and sustained through 2015 and beyond. The new MDG 5 target to achieve universal access to reproductive health,² in line with the International

Conference on Population and Development,³ paves the way for faster progress.

After decades of experience, we know what works. We can irreversibly and significantly reduce maternal mortality by simply making sure that all women everywhere have access to essential reproductive health

The printed journal
includes an image merely
for illustration