

Cautious Champions: International Agency Efforts to Get Safe Motherhood onto the Agenda

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Summary

Successful advocacy requires clear messages and effective dissemination. The international health and development agencies have an important role to play in advocacy because of their visibility and access to resources. Yet advocacy for maternal health by the UN and other international agencies efforts has been relatively ineffectual because the messages have not always been clear and unambiguous and the dissemination strategies have been small-scale and sporadic. Messages have focused largely on the size of the problem of maternal mortality and its human rights dimensions. What has been missing until very recently, has been clarity about the interventions that work to reduce unsafe motherhood along with a way of measuring their impact. Dissemination strategies have included major international meetings, involvement of women's health advocates, mobilisation of health care professionals and donor support. Yet on the whole these efforts have lacked conviction. Political commitment has been cautious, ambivalent, and at too low a level to make an impact either nationally or internationally. Alliances have been shifting and unstable and even "natural" allies have lacked conviction. Neither women's advocacy groups nor health care professionals have invested in maternal health with the full force of their numbers or power. Real progress in improving maternal health will require outspoken and determined champions from within the health system and the medical community, particularly the obstetricians and gynaecologists, and from among decision-makers and politicians. But in addition, substantial and long-term funding - by governments and by donor agencies - is an essential and still missing component.

Introduction

In this paper, I started out with the intention of reviewing what strategies have been successful in getting safe motherhood onto the political agenda at global and national levels. But in trying to get together the documentation, one thing soon became apparent, namely, that very little has been documented. There is plenty of evidence of advocacy efforts - conferences, posters, newsletter etc. But little evidence of any attempt to evaluate their impact. Did the global advocacy efforts result in greater visibility for and commitment to safe motherhood at national level? Conversely, how was it that in some countries sustained safe motherhood programmes were put into place? What was the key motivating factor? There are no simple answers to either of these questions. There are, however, lessons to be learned about factors that may have helped to get safe motherhood on to the agenda and those that have been a hindrance. In this paper I try to summarise some of these lessons and make some suggestions about what is needed if future advocacy for safe motherhood is to be more successful than in the past. I argue that hitherto advocacy by international health and development agencies has focused on a limited range of messages and vehicles for getting the messages across. What is needed now is new, forward looking messages combined with a wider range of vehicles for disseminating them.

The Awakening

In February 1987, Hafdan Mahler, the Director-General of the World Health Organization (WHO) in his statement to the Nairobi Safe Motherhood conference, called for the creation of "...an awareness that something can, should - indeed must - be done, starting with the commitment of heads of states and governments" (Mahler 1987). The conference, sponsored by The World Bank and UNFPA along with WHO, represented the starting point of what came to be known as the Safe Motherhood Initiative (SMI). The three original Cosponsors were later joined in the SMI Inter-Agency Group (IAG) by UNDP, UNICEF, IPPF and The Population Council with Family Care International (FCI) serving as an informal secretariat.

The fledgling Safe Motherhood Initiative had two parents and a somewhat disparate set of genes. On the one hand, it was very much a product of the growing confidence of the international women's movement, galvanised by the United Nations Decade for Women, 1976-1985, which helped focus attention on women's rights and health. The Decade culminated in the formulation of the "Forward Looking Strategies" which called for a reduction in maternal mortality by the year 2000. A key perception to emerge over this period was the relative neglect of women's health compared with the attention then being given to child survival and health, a point most forcefully made by Allan Rosenfield and Deborah Maine in their seminal article "Where is the M in MCH?" (Rosenfield & Maine 1987).

The other parent was more mathematically oriented. The figure of half a million deaths each year, the first attempt to come to grips with the dimensions of the problem, was produced thanks to the unsung efforts of the late Dr Robert Cook, Deputy Director of WHO's Division of Family Health. He provided modest funding for the first community studies on levels of maternal mortality in developing countries (WHO 1985). The results of these studies were fed into an indicator database maintained by WHO which produced global and regional estimates on a range of maternal health issues including maternal mortality, coverage of maternity care, perinatal mortality and low birth weight (WHO).

These two strands - women's health and rights and the dimensions of the problem - continued to provide the underpinning for maternal health advocacy messages by the international community throughout the 1990s. While both have been of inestimable value in raising safe motherhood to a higher position in international and national consciousness, neither is sufficient as the point of leverage.

Playing the Numbers Game

In 1987, Dr Mahler asked why maternal mortality had only recently become a cause for concern. His own answer was that the dimensions of the problem had previously remained unknown. "Sound estimates based on new data are ... the foundation of our current understanding and concern" (Mahler 1987). With the perspective of another decade of experience in collecting data on levels and trends in maternal mortality, his confidence seems remarkable. After all, the "sound estimates" were generated on the basis of a mere handful of community studies in developing countries. For many years WHO tabulations of available information were heavily dependent on hospital-based data, known to be problematic because of bias. (WHO 1986, 1991, 1996). Because of this, WHO did not venture into making estimates of the level of maternal mortality for individual countries but confined its estimation activities to regional and global totals.

The global totals served to draw attention to the overall dimensions of the problem but there are limits to such general advocacy. Countries with high levels of maternal mortality could hide with impunity behind relatively lower regional averages. Conversely, countries with maternal mortality levels lower than the regional average - Cuba and Sri Lanka being notable examples - resented being lumped together with countries whose performance in this area was so much inferior to their own. Furthermore, and this is particularly important in the area of advocacy where today's news is tomorrow's history, the constant repetition of the same global totals became self-defeating. It became increasingly difficult to keep maternal health in the public eye when there was nothing new to report.

This changed in 1996 with the publication by WHO and UNICEF of the revised estimates for 1990 which included, for the first time, not only regional and global totals but also the individual country estimates from which they were derived (WHO/UNICEF 1996). These estimates were developed using a variety of adjustment factors designed to account for well-documented problems of underreporting and misclassification. They were in almost all cases, considerably higher than those previously published.

The new numbers were issued with great fanfare, including a joint press release. The powerful UNICEF publicity machine was brought into play with the publication of the estimates in the 1996 *Progress of Nations*, complete with individual country rankings and a leading article by Peter Adamson (UNICEF 1996). Other flagship publications started using the same data set including UNFPA's *State of the World Population* and UNDP's *Human Development Report*.

Nothing before had had such an explosive impact on the awareness of the problem. Reactions of national authorities were frequently critical and questions were asked in the governing bodies of UN agencies. Agency regional and country offices became involved in efforts to explain the origin of the numbers and limit the political fallout (WHO/Regional Office for South East Asia 1997).

As the saying goes, no publicity is bad publicity. The debate provoked by the new estimates was instrumental in ensuring that the issue of maternal mortality was given greater visibility and attention both at the national level and in international fora. Maternal mortality became a key indicator for assessing country eligibility for donor support.

The shock wave produced by the publication of country estimates of maternal mortality had a number of positive outcomes in terms of drawing attention to the issue². But the numbers game can be a double-edged sword. In order to ensure that the issue remains at the forefront of people's consciousness, it is necessary to keep producing updated numbers or new variations on

² UNAIDS had a similar experience with the publication of the first country estimates of prevalence in 1998.

the numerical analysis. The Safe Motherhood Initiative proved adept at using the numbers for advocacy - “the equivalent of one jumbo jet full of pregnant women crashing every four hours” (WHO 1986); “every minute of every day a woman dies” (InterAgency Group for Safe Motherhood 1990). But other conditions, HIV/AIDS, malaria or tuberculosis, for example, cause more deaths and provide more compelling press copy than maternal mortality. Epidemic diseases subject to global surveillance have a new story to tell on a regular basis. Maternal mortality is neither an emerging epidemic nor one of the world’s major killers. Maternal deaths remain singular, individual and silent tragedies.

There are also technical reasons why it is hard to make a case for maternal health using the numbers of deaths alone. Maternal mortality is a difficult to measure outcome. Currently available measurement techniques have wide margins of uncertainty and it is impossible to be certain that observed trends are real rather than artefacts of the data collection methodology (UNICEF/WHO/UNFPA 1997). The most commonly used indicator, the maternal mortality ratio, is technically complex and intuitively hard to grasp. These factors combine to render it difficult to make a convincing and unambiguous case for safe motherhood programmes. Policy-makers and donors are likely to be wary of putting resources into programmes where the baseline point of departure is unknown and where there is no certainty about the direction of change.

Not Just Another Disease

Recognising that reliance on the size of the problem would be inadequate for advocacy purposes, safe motherhood advocates argue that maternal deaths are unlike other deaths. Pregnancy is not a disease but a normal physiological process that women must engage in for the sake of humanity (Fathalla 1997). Whereas the elimination or eradication of disease is a rational and laudable endeavour, the same strategy cannot be applied to maternal mortality. There is no pathogen to control, no vector to eradicate. Women will continue to need care during pregnancy and childbirth as long as humanity continues to reproduce itself. Failure to take action to prevent maternal death amounts to discrimination because only women face the risk. This perception of the different nature of maternal mortality within the general context of illness and disease, has stimulated renewed interest in a rights-based approach to stimulating action.

Defining maternal death as a “social injustice” as well as a “health disadvantage” obligates governments to address the causes of poor maternal death through their political, health and legal systems. This raises the option of using international treaties and national constitutions that address basic human rights to advocate for safe motherhood and to hold governments accountable for their actions - or inaction (Cook 1997). A rights-based approach has proved hugely influential in increasing accountability in the area of child health. The Convention on the Rights of the Child has become a powerful tool for monitoring progress and has been integrated into international human rights machinery as the standard to which all should aspire. The Convention is the most universally accepted human rights instrument in history - it has been ratified by every country in the world except two. By ratifying this instrument, national governments have committed themselves to protecting and ensuring children's rights and they have agreed to hold themselves accountable for this commitment before the international community.

Efforts to resolve the practical challenges of doing the same for maternal health have gathered momentum in recent years but they remain stymied by the difficulty of defining indicators for monitoring progress.

Telling the Story

If a rights-based approach is to be useful for getting safe motherhood on to the agenda, clear and unambiguous indicators are needed against which to assess where countries stand and judge progress (Yamin & Maine 1999). This need for measurable process indicators was absorbed early on by UNICEF in drawing attention to the rights of the child. UNICEF's regular analysis of country progress towards the goals and the World Summit for Children is founded on a systematic review and analysis of key monitoring indicators³. UNICEF has not only worked on the conceptual development of such indicators, but has also invested considerable funding into generating the data, through, for example, its Multi-Indicator Cluster Surveys (MICS).

Unfortunately, we have not reached an equivalent stage in safe motherhood. Although some process indicators have been identified and are currently being promoted for monitoring progress (see for example, UNICEF/WHO/UNFPA 1997), more experience is needed with generating them in diverse country settings and with using them over sustained periods of time. Moreover, whereas there is a clear and unambiguous link between vaccination against measles, for example, and the decline in measles-related mortality, no such link has been scientifically demonstrated between maternal mortality and the most commonly advocated process indicators such as skilled attendant at delivery or access to emergency obstetric care.

The challenge is well illustrated by the example of the skilled attendant at delivery indicator. The indicator is intuitively easy to understand and readily available for many countries. The source of the information is generally the Demographic and Health Surveys, which have the advantage of providing a standardised methodology and sampling framework along with strict criteria regarding the maintenance of data quality. Although efforts are made to standardise definitions of skilled birth attendant, there remain doubts about the comparability of some of the results across countries and within countries at different time periods. One source of potential confusion is the differing interpretations as to who is a skilled attendant, particularly in settings where traditional birth attendants have been trained and where many of them work within a health setting. But more critically, while there is ecological evidence in support of a link between skilled attendant at delivery and reduced maternal mortality, and sound clinical reasons for assuming that the link is real, unequivocal evidence is lacking (AbouZahr & Wardlaw 2000).

This problem is not simply of academic interest. It means that it is hard to make a convincing advocacy case for maternal health and for investment in the needed interventions. Decision-makers, whether among governments or donor agencies, want to be able to demonstrate to a sceptical public that their investments are bearing fruit. The need to be able to "tell the story" has been underestimated by many working in the area of safe motherhood and it is a failure that has cost the issue dear in terms of keeping it at the forefront of the health and development agenda.

³ These are largely process rather than impact indicators. Rather than measuring the incidence of specific vaccine-preventable diseases such as measles, attention is directed into monitoring vaccination coverage. Similarly, UNICEF focuses on monitoring access to and use of oral rehydration therapy rather than monitoring mortality due to diarrhoeal diseases.

Getting the Message Out

So far we have examined the two main messages that have provided the basis for maternal health advocacy - the extent and nature of the problem and its human right dimensions. Let us turn now to the main vehicle for disseminating these messages, the highly mediatised, high level, international meeting.

The 1987 Nairobi Safe Motherhood Conference was the first high level international meeting on the theme of maternal mortality. It was also the last⁴. That is not to say that safe motherhood no longer appeared on the agenda at international conferences, far from it. But its appearance in such gatherings has been part of a broader agenda for children's, women's or reproductive health and rights. This has had important implications for the visibility of safe motherhood within the international context.

High level conferences such as the International Conference on Population and Development in Cairo in 1994, the Fourth World Conference for Women in Beijing in 1995, and the Social Summit in Copenhagen in 1995, have included safe motherhood within a broader reproductive or women's health context. While this has obvious advantages, it also raises questions about the extent to which safe motherhood can survive and prosper in the absence of a focused and well-financed effort, an issue that is taken up again below.

The contrast between international meetings for child health and maternal health is telling. Shortly after Nairobi, the World Summit for Children took place in New York in 1989. Unlike the Safe Motherhood Conference, the Children's Summit was attended by heads of state, executive heads of UN agencies, and high level representatives of countries, NGOs and the international development community. The Summit was the culmination of a series of meetings that regularly brought together international development agencies, political leaders from developed and developing countries, key NGOs such as Save the Children, and funding agencies from both the multilateral and bilateral community and the private sector (such as Rotary International). These had been organised by the Task Force for Child Survival, a high level secretariat body created in 1984 with substantial financial and human resources at its disposal and bringing together WHO, UNICEF, The World Bank, UNDP and the Rockefeller Foundation.

The Safe Motherhood Initiative has yet to achieve such a level of visibility and sustained impact, or to identify such vocal and powerful partners. The Initiative's secretariat, unlike the Child Survival Task Force, informally brings together technical staff from the agencies with Family Care International providing administrative support. The group exchanges information and organises meetings of partners to review progress in the initiative. However, it has always lacked decision-making power and access to the kinds of resources needed to sustain high level visibility for the Initiative on a par with those available for children's health.

⁴ A number of regional conferences had safe motherhood as the principal theme but they were largely replicas of the Nairobi meeting and neither attended at a higher level nor intended to go beyond what had already been achieved in Nairobi.

A New Beginning

Awareness of the need to raise the level of discourse on maternal health grew during the late 1990s and in 1996 the SMI Inter-Agency Group embarked upon a two-year effort to bring maternal health to a wider audience and to a higher level of decision-makers. The preparatory phase culminated in an international technical consultation in Colombo, Sri Lanka in October 1997. The consultation brought together safe motherhood specialists, programme planners and decision-makers from international and national agencies. The consensus that emerged from the Colombo meeting helped to forge greater consensus on the interventions needed to reduce maternal mortality. This was extremely valuable in developing a communications campaign on the theme of safe motherhood and in mobilising UN agencies and high level decision-makers and political advocates on World Health Day on 7 April 1998, designated for safe motherhood by WHO. Around the world, street parties, theatrical presentations, marches, media events and poster campaigns, focused on safe motherhood. In Washington D.C., executive heads of major international agencies came together with high level politicians from the developing world and the US first lady to issue a Call to Action for safe motherhood.

There is no question that the 1998 Call to Action represented a significant upgrading of efforts for maternal health. In the years following the Call to Action, a number of new entrants to the safe motherhood field have come to add their weight to the growing movement. These include the White Ribbon Alliance for Safe Motherhood and Safe Motherhood Initiatives USA. Others, already involved in safe motherhood, such as Columbia University, PATH, AVSC and Marie Stopes have increased their existing commitment. UN agencies have promised greater resources and visibility, for example, through WHO's Making Pregnancy Safer Initiative, UNICEF's Women-Friendly Health Services strategy, UNFPA's Programme Advisory Note for Reducing Maternal Mortality and Morbidity, and The World Bank's Safe Motherhood Action Plan. Four agencies - WHO, UNFPA, UNICEF and the World Bank - issued a joint statement on the essential strategies needed to reduce maternal mortality and affirming their collective engagement in support of safe motherhood (WHO/UNFPA/UNICEF/ World Bank 1999). Reduction of maternal mortality: a joint WHO/ UNFPA/UNICEF/World Bank statement.

It is impossible to estimate the extent to which the increased interest in safe motherhood was a direct result of this advocacy campaign or simply the outcome of a gradual increase in interest stimulated by other events such as ICPD. However the activities leading up to the Call to Action, known generically under the title of *Safe Motherhood at 10*, had two important strengths which had not previously characterised international safe motherhood advocacy efforts, namely, focus on effectiveness and high level involvement, particularly among UN agencies. Although by no means on a par with the 1990 Children's Summit, this represented as major step forward in terms of visibility.

At the same time, the success of the 1998 campaign led to questioning among safe motherhood activists. To what extent is appropriate to keep a specific Safe Motherhood Initiative alive at a time when the move in international health and development circles is towards horizontal approaches and integration into broader concepts such as reproductive health? It has been suggested that there is a continuing need to focus on safe motherhood because the issue is often under-emphasised or omitted from "reproductive health" programmes. This raises a more general concern about safe motherhood -that of brand recognition, to use a marketing term.

Alphabet Soup

Question: What do PHC, MCH, SMI, MMR, MBP, MSM, SRH, MNH, PMM and MPS have in common (apart from being letters of the English alphabet)?

Answer: They are all acronyms for projects and programmes designed to help alleviate women's suffering and death in the cause of pregnancy and childbirth.

These acronyms fall into two classes. Some represent umbrella concepts within which maternal health and safe motherhood issues should be addressed - PHC (Primary Health Care), MCH (Maternal and Child Health Care) and SRH (Sexual and Reproductive Health). Others relate in a vertical, focused way to maternal mortality reduction - SMI (Safe Motherhood Initiative), MSM (Maternal Health and Safe Motherhood Programme), MBP (Mother-Baby Package), MNH (Maternal and Neonatal Health), PMMN (Prevention of Maternal Mortality Network) and MPS (Making Pregnancy Safer Initiative).

Alternating waves of broad, inclusive approaches and the more narrow focused ones have succeeded one another with predictable regularity. From the establishment of WHO to the late 1980s the strategy was to incorporate maternal health under a broader framework for basic health care for women and children. Starting in 1987 a different strategy was preferred and throughout the late 1980s and early 1990s there was a preference for "vertical" focused programmes, perceived (often correctly) to be more effective in reaching their target audiences and in delivering their promises (Werner & Saunders 1997).

In 1991, concerned about the continuing lack of progress in safe motherhood, several major donors pressed for the establishment of WHO Special Programme for Safe Motherhood, analogous to the Special Programmes for Research, Development and Research Training in Human Reproduction (HRP), the Special Programme for Research on Tropical Diseases (TDR) and the Special Programme on HIV/AIDS (GPA) (WHO 1991b). The WHO administration of the time resisted such pressures for "verticalisation" and by the time of the International Conference on Population and Development in 1994, the pendulum had swung back again to favour the inclusive or "horizontal" approach. Safe motherhood programmes were presented as part of the overall concept of sexual and reproductive health (UNFPA 1994), or within a broader agenda of health sector reform (The World Bank 1999). At the start of the new century, concern that safe motherhood tended to disappear within these broad inclusive agendas resurfaced and interest in focusing more specifically on safe motherhood has waxed, for example, under the titles of Making Pregnancy Safer and Maternal and Neonatal Health.

None of this would matter were it not for the confusion it creates in countries. No sooner have the international health and development agencies managed to create brand recognition for one strategy, than the fashion changes and a new approach, new strategy and new set of acronyms is foisted upon the world.

Small wonder, therefore, that so many observers concur that getting safe motherhood onto the agenda and keeping it there has been a difficult challenge.

Ambivalent Allies

The frequent name changing that has characterised the recent history of safe motherhood has been symptomatic of another problem, that of weak alliances. The linkages between women's health and rights and safe motherhood would appear to be natural and unquestioned. But in practice, things are not so simple. Some perceive that attention to maternal health derives more from concern about the impact on children than from the risk to women themselves. In this paradigm, women are seen simply as the vehicles for making children, their own health and rights subsumed to that of their infants. In part, this perception is due to fact that safe motherhood was born in the shadow of child survival. Indeed, during the 1990 Children's Summit, the issue of maternal mortality was an item for discussion, but almost entirely within the context of ensuring the survival and health of children. As James Grant himself noted, "...the emphasis on goals for maternal mortality is largely a by-product of child survival efforts" (Grant 1990).

At the start of the Initiative, women's health activists had the issue of maternal mortality high on their agenda and were working to promote solidarity among women around the world. The Women's Global Network for Reproductive Rights and the Latin American & Caribbean Women's Health Network/ISIS International, issued at Call to Action on 28 May 1990, declared International Day of Action for Women's Health (Women's Global Network for Reproductive Rights and the Latin American & Caribbean Women's Health Network/ISIS International 1990). This campaign was instrumental in drawing attention to the issue of maternal mortality, particularly in Latin America. The campaign focused particular attention on unsafe abortion and on the poor quality of care meted out to women (particularly poor or indigenous women) by the formal health care system. Maternal mortality was presented as a political challenge with responsibility firmly attributed to high level decision-makers: "To cure the health problems of women is to acknowledge that oppression - and health problems - are not determined by biology but by a social system based on the power of sex and class" (Araujo and Diniz 1990).

At the same time, NGOs around the world were working in the area of reproductive health and safe motherhood, often at a very local level, engaging in community-based research, participating in awareness-raising or public education campaigns, promoting workshops, meetings or media events, and even delivering care (WHO 1992). The breadth and extent of the types of activities is such that it is impossible to evaluate their impact, particularly at the international level. While they undoubtedly make a contribution, its extent is likely to be limited by the availability of resources - human and material - to sustain a long-term effort.

More recently, the energies of many NGOs have been absorbed by the broadening of the women's health agenda to address previously neglected problems such as female genital mutilation, violence and trafficking. And among some activists, ambivalence about safe motherhood has strengthened. Even the title is suspect because it draws attention to the outcome of the pregnancy rather than to the choice to become pregnant in the first place.

The women's movement recognised early on that the abortion issue would be the most contentious aspect of efforts to reduce maternal mortality. Almost universally, they identified societal reluctance to endorse the right of women to decide whether and when to have children and to provide both contraceptive and abortion services to enable them to do so safely. The "abortion issue" complicated efforts to draw attention to safe motherhood. Among anti-abortionists, safe motherhood was seen as the trojan horse for the introduction of legal abortion. Funders interested in supporting safe motherhood programmes became wary and to this day certain donors cannot be approached for support to projects or programmes that include an abortion-related component.

Problems such as these have added to the ambivalence and hesitation of policy-makers. In some countries, for example, although national plans for the reduction of maternal mortality exist,

government officials have an ambivalent attitude towards reproductive health which has hampered implementation (UNFPA 1999).

The complexities of this debate may account for the difficulties that safe motherhood has faced in bringing new partners into the effort, notably the private sector. During the preparations for *Safe Motherhood at 10*, the IAG created a pilot project to attract the support of global business (Safe Motherhood Inter-Agency Group 1999). The project's goals were modest and did not include fund-raising, focusing instead on raising awareness about the Safe Motherhood Initiative and the issues among an elite group and encouraging businesses to support safer motherhood among their employees and within the communities in which they work.

As a result of the project, 12 businesses publicly endorsed a corporate "charter" and became founding members of the Corporate Council for Safe Motherhood. However, since the 1998 World Health Day event, follow-up activities have been sporadic and there remains much to be done in terms of identifying feasible and appropriate activities for the private sector. Despite its potential benefits, the potential pitfalls of working with the private sector and the strict criteria for corporate involvement imposed by the UN organizations in particular, have put a brake on any major attempt to involve corporations more fully in safe motherhood.

Professional Partnerships

Of all the allies that safe motherhood needs, none is as crucial as the medical community and this group has done much to advocate for attention to the issue and to promote strategies to address it. But although many committed individuals have been active in safe motherhood, the mobilisation of doctors, and especially obstetricians and gynaecologists, midwives and nurses as professional groupings, has been slower in the making, particularly as concerns the professionals at the apex of the maternal health care system, the ObGyns.

International midwifery and nursing professional associations recognised early the potential role of midwifery in safe motherhood. International Nurses Day 1988 was on the theme of safe motherhood. The International Confederation of Midwives has taken on an even more active role, organising pre-congress workshops on different aspects of safe motherhood midwifery prior to the triennial congress since 1987. The 1990 pre-congress workshop was instrumental in opening up debate among midwifery associations about delegation of responsibility and the need for training of midwives to deal with emergency obstetric complications. Later workshops addressed issues of monitoring, quality, abortion and HIV/AIDS.

The WHO and the International Federation of Obstetricians and Gynaecologists (FIGO) Task Force was established in 1982 to draw attention to safe motherhood at both global and regional levels. Pre-congress workshops have tackled a range of reproductive health issues including safe motherhood. But the fine sentiments voiced at such meetings were rarely followed by practical action. A 1998 article in the *Lancet* took the profession to task for failing to assume its responsibilities and leaving Safe Motherhood “an orphan initiative” (Weil & Fernandez 1999).

It was not until 1997 that FIGO moved from words to specific action with the establishment of the FIGO Save the Mothers Fund, a north-south partnership to support direct training projects between ObGyn associations. In addition to support from UNFPA and the World Bank, the Fund receives funds from Pharmacia-Upjohn, a rare instance of private involvement in safe motherhood. This initiative is illustrative of the increasing role of the ObGyn which has grown with the emerging consensus that effectively addressing the challenge of maternal mortality implies doing something to ensure that all women with complications - whether emergency or not - can access the needed medical care. This implies that all labouring women must have the assistance of a skilled health care worker who can manage deliveries in such a way as to minimise the numbers of complications while also being able to recognise and deal with complications before they become life-threatening emergencies. These new directions in safe motherhood programming focussing on the indispensability of obstetric care have major implications for health care professionals at all levels and in particular for health care professionals at the apex of the system - obstetrician/gynaecologists and senior physicians.

At the same time, the medical profession has to contend with frank mistrust on the part of some women's advocacy groups who have sensed tendency for doctors to overmedicalise a natural process, a diagnosis supported by the inexorably rising rates of caesarean delivery around the world.

Caesarean delivery can be convenient and lucrative for physicians but carries risks for the woman, particularly when conducted in less than optimal conditions. It also imposes additional costs for the woman and her family.

Alternative Pathways

Despite all these apparent difficulties, there are a number of countries where safe motherhood has been raised high on the agenda - Bolivia, Ghana, Egypt, Indonesia, Mexico, Morocco, Uganda - to name but a few. And in several countries - China, Cuba, Jamaica, Malaysia, Sri Lanka, Tunisia and Thailand - relatively low levels of maternal mortality have been achieved with little fanfare or international conferences and donor driven incentives. What was the motivating factor in this second group of countries, and can we learn from them how to promote safe motherhood more effectively elsewhere? And looking further back in time, are there lessons to be drawn from the developed countries that achieved remarkable reductions in maternal mortality at the beginning of the last century - Japan, the Netherlands, Sweden, UK?

If we take the group of developed countries first, two factors predominate: the societal recognition that female social, economic and political emancipation was a prerequisite for social development (and its corollary, social peace) and the involvement of medical professionals in promoting that emancipation (De Brouwere *et al.* 1997). In the UK, for example, concern among the medical profession about continuing high levels of maternal mortality resulted in setting up of enquiries into the subject by the Ministry of Health in 1928. These enquiries continued and were eventually turned into the system of Confidential Enquiries into Maternal Deaths which continues to this day. During the same period, government committees of enquiry were set up to “investigate the general conditions of health among women ... in view of indications that ill-health is more widespread and more serious than generally known” (Spring Rice 1939). Representatives of women’s organizations were included in the Committee “on an entirely non-political basis”.

This combination of the energies of the women’s movement and high level medical professionals, ensured that no government could afford to ignore women’s health particularly during pregnancy and childbirth.

It is difficult to know the precise origins of concern about maternal mortality in the group of developing country success stories but from what one can discern the pattern is similar. In China, Cuba, Jamaica, Malaysia, Sri Lanka, Tunisia and Thailand, maternal health care programmes were part and parcel of a broader movement towards the provision of basic services -health, education, sanitation - for all. Very often, this accompanied profound political changes, the aimed for social objectives being encompassed within the wider political ones. A similar phenomenon emerged more recently in South Africa, where safe motherhood, and safe abortion in particular, was seen as a necessary part of the post-apartheid transformation.

Particularly noteworthy in all countries that have achieved low levels of maternal mortality is the fact that high level political commitment to the issue is sustained over time. Effective safe motherhood programming requires incremental changes over a long period, with the needed infrastructure and skills being gradually extended to cover a broader geographic and social spread (Pathmanathan & Shanti 1990). One of the challenges facing the international community is how to support this sustained level of commitment. What safe motherhood needs is not so much advocacy campaigns, but a long-term social movement.

Countries that have started more recently down the road to safer motherhood have generally followed a different path and it remains to be seen to what extent their current levels of commitment can be maintained in a context of continuous resource constraints. In Bolivia, Egypt, Ghana, Indonesia, Mexico, Morocco, Nepal and Uganda the stimulus for action has come from high level political leadership on the part of the elite allied in some cases (Bolivia, Ghana, Nepal) with strong grassroots support expressed through women’s advocacy groups.

Key decision-makers can make the difference between a safe motherhood programme that falters and one that moves from strength to strength. There is a risk, of course, that the

programme will be subject to political changes that are beyond its control, such as the removal of a key political leader from office. Where there is long term stability, on the other hand, political leaders can be powerful advocates for safe motherhood. The support of President Museveni and the First Lady of Uganda, Jerry Rawlings of Ghana and Pascal Mocumbi of Mozambique nurtured the social and economic conditions for sustained progress. By contrast, where such leadership is absent, neither active NGO groups nor high profile actions of international agencies can create the level of sustained interest and commitment that safe motherhood requires. A clear example of this is Kenya, host to the first safe motherhood conference and home to many active women's health groups, but where the absence of high level national political commitment has resulted in relative stagnation of safe motherhood efforts.

To what extent the support of political leaders for safe motherhood has been influenced by the communication campaigns of the Safe Motherhood Initiative and the advocacy activities of international agencies is impossible to say. But experience shows that alongside political commitment, two other factors are determinant. One is the translation of political support into clear and focused national policies and plans which address clearly defined problems and are based on a local analysis of needs and priorities. The other is long term financial inputs, both external and more significantly in the long term, internally generated.

Follow the Money

It is often said that if you want to know what is really going on, follow the money. To what extent has funding for safe motherhood projects and programmes grown over recent years and can this increase - if there is one - be attributed to the advocacy efforts of the international health and development community? Answering this turns out to be a difficult task. Back in 1987, WHO estimated that less than US\$2 out of every US\$10 of international resources devoted to health was spent on maternal-child health and family planning (WHO 1987). During the preparations for the 1994 Cairo conference, a similar exercise produced rather similar results (SIDA 1993). But the work was criticised on the grounds that it failed adequately to distinguish funds directed specifically to safe motherhood activities and those which fell under a broader umbrella of MCH, reproductive health or women's health.

The problem of tracking funding remains as difficult today. The most comprehensive attempt to do so to date, sponsored by UNFPA, categorises population programmes and activities into broad groups, with safe motherhood activities grouped under 'basic reproductive health services given at primary health care level' along with training of traditional birth attendant (TBA's), antenatal care and eradicating female genital mutilation (NIDI 2000). Moreover, there is no attempt to identify funding directed towards the elements of safe motherhood programming known to be most effective, such as skilled attendance at delivery or care for obstetric emergencies.

Several major donors, USAID among them, do not have a separate budget for maternal health. For many years, the MotherCare project was virtually alone among USAID-supported projects in focusing on safe motherhood. This is beginning to change and several USAID-funded projects that hitherto concentrated almost entirely on family planning, including JHPIEGO and Measure, now include a large component of safe motherhood programming. The JHPIEGO supported Maternal and Neonatal Health project, established in 1999, has access to up to US\$50 million over the first five years.

Of the UN agencies, only the World Bank has carried out a systematic analysis of its funding for safe motherhood activities. The Bank is now the largest source of external assistance for safe motherhood. In 1987, it supported only 10 projects dealing with maternal and child health and family planning. In the years since then, there have been 150 such projects. In recent years, the Bank has been instrumental in promulgating a shift from programmes focused almost entirely on child health or family planning activities to programmes comprising activities related to safe delivery and management of obstetric complications, as Figure 1 shows (The World Bank 1999).

Despite such progress, there remains a long way to go in terms of translating the global advocacy effort into sustained programming for safe motherhood at national level. Whereas there are many programmes with the title safe motherhood, only a few focus on the interventions known to be effective in reducing maternal mortality.

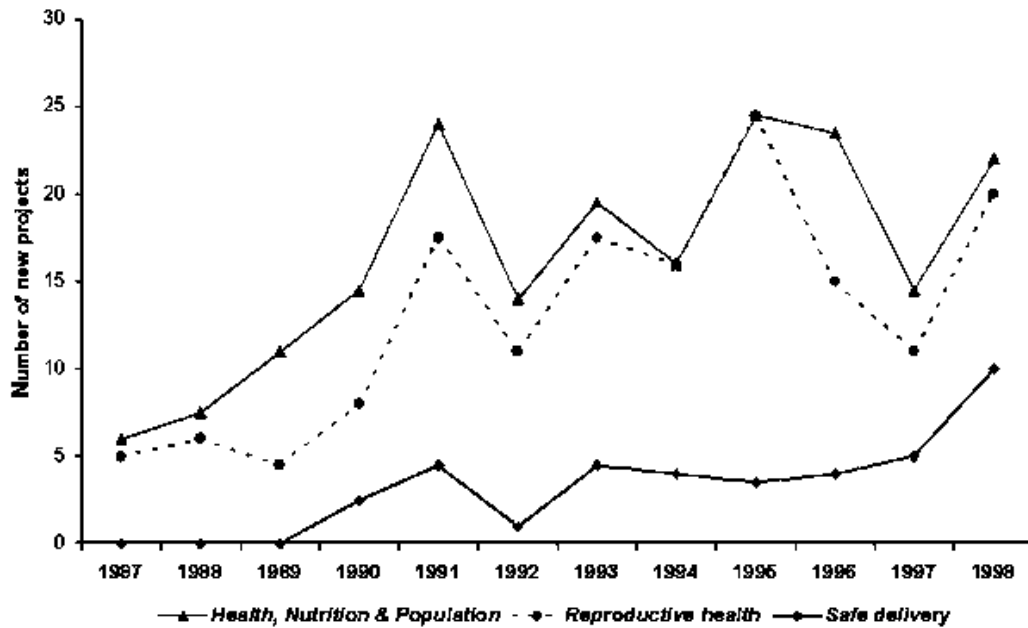


Figure 1. World bank - Number of new projects with reproductive health, safe delivery and health, nutrition and population activities, 1987-98

SOURCE: The World Bank 1999

In the Bank's review, of 29 countries with high levels of maternal mortality (600 maternal deaths per 100,000 live births or higher) The Bank supported family planning or general maternal health care activities in 22 of them, but safe delivery activities only in seven. Even in countries with the most serious maternal mortality problems, only nine of 24 country-assistance strategies made explicit mention of the issue (The World Bank 1999). UNFPA's evaluation of its own safe motherhood efforts came up with similar findings. Priorities were neither clearly defined nor necessarily those known to be effective (UNFPA 1999).

Addressing this problem has become one of the major challenges that governments and external donors need to address and has been one of the main preoccupation of a number of safe motherhood advocates. The evidence indicates that clearly focused and evidence-based strategies will succeed in generating the needed resources. For example, significant new funding for safe motherhood has recently been generated through Columbia University's Joseph L. Mailman School of Public Health with resources from the Bill and Melinda Gates Foundation. For example, UNFPA and Columbia University have signed a pact through which US\$8 million will be allocated to improving the availability of emergency obstetric care in developing countries.

Funding Solutions not Problems

One of the most striking recent developments in safe motherhood has been the frank admission that many of the strategies originally put forward were ineffectual, despite the proclamation that “the interventions are known”. This was coupled with a failure to prioritise. Diagnosis of the underlying causes of maternal mortality led to the justifiable conclusion that action was needed on a wide variety of fronts, including strengthening the health system, improving women’s status and education, and addressing gender issues. But it also resulted in a tendency to load safe motherhood programmes with the responsibility for managing primary health care in its entirety.

Not until the 1997 Sri Lanka technical consultation was there greater clarity among international agencies about what works and what doesn’t and even today discussions continue around the expectations of TBA training, the role of risk assessment and the contribution of antenatal care. This poses problems from an advocacy perspective because donors (whether international or national) do not want to fund problems, they want to fund solutions, and they want to fund the kinds of solutions that can be monitored and around which it is possible to tell a story of success. The kind of question that a national level decision-maker, Minister of Finance or Minister of Health want an answer to is “What will be achieved if we invest in this programme? How many lives will be saved?” International donor agencies have much the same concerns. The single most important breakthrough achieved by the Task Force for Child Survival was in developing good responses to these kinds of questions and ensuring that all concerned agencies promoted the same kinds of interventions. Although there has been progress in doing the same in the safe motherhood arena, there is still some way to go and some needless conflicts that need to be resolved (such as the primacy of emergency obstetric care versus essential obstetric care, the role of the skilled attendant).

Conclusions

The success of any advocacy effort depends on achieving the right mix of messages and disseminating them through the most effective means. Recent efforts to get safe motherhood on to the agenda have been sporadic and have had to face many challenges, including lack of high level commitment, mixed messages, lack of prioritisation and focus, frequent changes in direction, absence of strong partnerships or a sufficiently diverse and vocal set of allies. The international agencies have not always been the source of such problems, but there is little doubt that they have contributed to their persistence.

Maternal health messages have focused largely on the size of the problem of maternal mortality and its human rights dimensions. What has been missing has been clarity about the interventions that work to reduce unsafe motherhood. Too many programmes try to do too much while simultaneously failing to focus on the interventions known to be effective. Solutions lie at the heart of any successful advocacy effort. There is today a much greater degree of clarity about what works but there remain many areas of uncertainty about how to implement the interventions successfully and in a sustained manner. The ongoing areas of disagreement need to be resolved as a matter of urgency or they risk distracting attention away from the issue. The positive energies created by the availability of unequivocal solutions have been critical to the success of child survival. Safe motherhood needs to promote such positive messages more aggressively in the future. The international health and development agencies can play a critical role in doing so.

In addition, ways need to be found to monitor progress towards the goal of safe motherhood. Because of the difficulty of measuring maternal mortality, attention has been directed in recent years to using process indicators. However, there is as yet no consensus on which process indicators are most feasible and appropriate for such monitoring. Nor is it clear that the process indicators currently under investigation are unambiguously related to the outcome of interest. Until this issue is resolved, decision-makers and funders will remain unconvinced that their money is being invested wisely. Again, international agencies should put greater energies into the kind of research and programme evaluation that will contribute to solving this conundrum.

Safe motherhood dissemination strategies have included major international meetings, involvement of women's health advocates, mobilising health care professionals and incorporating specific safe motherhood interventions in donor-funded support. Yet on the whole these efforts have lacked conviction. Safe motherhood meetings tend not to attract the most senior decision-makers.

Political commitment has been cautious, sporadic rather than sustained, and generally not placed at a high enough level either nationally or internationally.

Alliances have been shifting and unstable. Safe motherhood's "natural" allies, women's advocacy groups, have had to contend with a large and ever growing agenda and have had misgivings about focusing on maternal health because of an understandable wish to avoid seeing women only in terms of their reproductive roles. This conflict needs to be resolved if safe motherhood is to be able to count on the support of this key constituency. Maternal health needs outspoken and determined champions from within the health system and the medical community, particularly the ObGyns. The obstetrician has responsibilities not only towards the women to whom they provide clinical care but also to those many millions of women who are beyond their reach. Obstetricians and gynaecologists must become the voices of the voiceless, the champions of the neglected, the militants for the poor.

Their leadership and their social and economic clout are necessary to shift resources at the national level on planning and investing to improve the non-functioning, non-performing health systems. International agencies can help promote and support the forging of such alliances.

For the future, safe motherhood needs greater visibility, at a higher level and more often. We need to harness the energies of well-organised, vocal and powerful advocates who can help mobilise a 'massive effort' of the kind now being directed towards the trio of diseases which so excited the Group of Eight of G8 Summit in Japan - malaria, tuberculosis and HIV/AIDS. The premise underlying WHO's new 'massive effort' strategy to follow-up the G8 is that malaria, TB and HIV/AIDS are responsible for a significant proportion of the global burden of disease, that they particularly affect the poor, that they exacerbate the cycle of poverty and that cost-effective interventions are available for dealing with them. Exactly the same kind of rationale can be used to justify a 'massive effort' for safe motherhood. Indeed, in terms of total loss of healthy years of life (Disability Adjusted Life Years or DALY's), maternal and perinatal conditions account for more of the total burden than malaria or TB and only a little less than HIV/AIDS (Figure 2). The fact that to date maternal mortality continues to be excluded from the 'massive effort' speaks volumes.

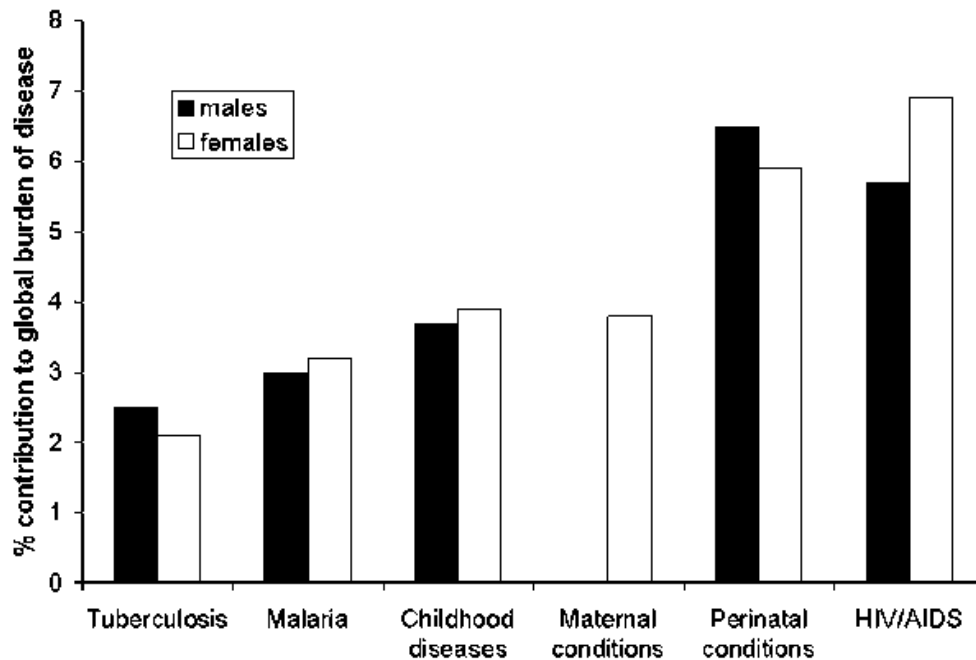


Figure 2. Contribution of maternal and perinatal conditions to the global burden of disease, 1999

Finally, substantive and long-term funding - by governments and by donor agencies - is needed to oil the wheels of the advocacy effort. Although it is difficult to track the level of funding for maternal health programmes over the past few years, it is clear that the resources available have not been enough to make a difference. The grant of US\$50 million to Columbia University represented the single largest donation to maternal health yet in comparison to the needs, the sum is paltry. Safe motherhood seems to have been afflicted by a problem of underfunding since the start of the Initiative. Only US\$5 million was available for operations research in safe motherhood at the start of the Initiative. WHO's newly established Making Pregnancy Safer Initiative has a mere US\$3 million at its disposal. With resources at these kinds of levels, progress towards safer motherhood will inevitably be limited.

Inadequate resources, lukewarm political commitment, failure to articulate evidence-based interventions, and the inability to tell a story of progress are all aspects of the same mutually reinforcing problem cycle. Maternal health finds itself in a spiral of uncertainty and under-investment from which it is difficult to extricate itself. Yet progress has been made and much more is known today about what works than was the case a few years ago. The time has come for key actors - governments, civil society and health care workers - to come together in order to

break the logjam and permit the implementation and evaluation of meaningful and significant interventions.

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