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Saving Mothers, Giving Life: Attainable or Simply Aspirational?

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Each day, nearly 800 women die around the world from complications in pregnancy or childbirth. That's one woman losing her life, every 100 seconds, every day. And while, from 1990 to 2010, global maternal mortality rates declined by roughly 47%, from about 546,000 to 287,000, the regional disparities are enormous: 85% of all maternal deaths occur in sub-Saharan Africa and South Asia—and more than half of these occur in sub-Saharan Africa. These deaths are largely preventable with interventions and training to address complications such as hemorrhage, infection, and obstructed labor, and more broadly with increased access to reproductive health services.

On June 1 in Oslo, U.S. Secretary of State Hillary Clinton announced the “Saving Mothers, Giving Life” project—an ambitious, dynamic effort by the U.S. government with a new public private partnership to drive efficiencies, spur innovation, and ensure impact in this fundamental area of global health. Maternal mortality is the ultimate health indicator, reflecting both a health system's strength and how accessible it is to women and girls of reproductive age. If successful, “Saving Mothers” will be an important dimension of Clinton's legacy as Secretary, lifting the lives of women, families, and communities around the world.

Yet the program's success is far from assured. The question that inevitably arises is whether these big ideas and much-needed goals for reducing maternal mortality can be translated into building the long-term support necessary to address maternal and child health – the core of health systems in developing countries -- while reformulating long-standing and sometimes difficult relationships between multiple U.S. agencies that each have a piece of the U.S. global health agenda, all at a time of shrinking U.S. foreign assistance budgets?

“Saving Mothers” is rooted in the Obama Administration's Global Health Initiative (GHI), announced by President Obama in May 2009 as a six-year, \$63 billion program, and the Administration's signature foray in the global health arena. Until now, GHI has been more of an approach than a program, which has made it difficult to quantify; it seeks to solve global health problems by building on existing health programs and

focusing on seven core principles. The first principle is women, girls, and gender equality, and is intended to increase attention to these areas throughout U.S. global health programs. In many respects, this principle reflects and reinforces Secretary Clinton's core areas of interest in women's health and empowerment, which have been central to her approach to foreign policy, health, development, and security. GHI's focus on reducing maternal mortality and increasing access to health services for women and girls, including family planning and reproductive health, has elevated those issues in U.S. global health policy.

The "Saving Mothers" project is the first concrete expression of how GHI can change the way the US government operates in the global health arena. It stemmed from a visit Secretary Clinton's made to Zambia in June 2011 for the Africa Growth and Opportunity Act (AGOA) forum, after which the USG agencies were encouraged to develop a proposal to address maternal mortality. What ensued was a fast-tracked initiative—"We started at a sprint," one USG analyst explained—to put in place activities to dramatically reduce the number of deaths associated with pregnancy, using the GHI approach of gaining greater synergies, efficiencies, and outcomes by leveraging existing U.S. health programs.

"Saving Mothers" is a five-year, concentrated pilot in a targeted geographic area—four districts of Zambia and four in Uganda. It aims to demonstrate what is possible if the range of U.S. health investments, as well as new public-private partners, are pulled together to target a narrow set of issues in a specific geographic area, and thus to advance a new way of reducing maternal mortality. The program focuses on a limited time window—the first 24 hours around labor, delivery, and the immediate post-partum period—because two-thirds of maternal deaths and 45 percent of neonatal deaths occur in that crucial span of time. The aim of "Saving Mothers" is to bring the players from the national health system, the community workers who try to reach women where they live, and the various U.S. agencies together to implement targeted maternal mortality interventions to achieve rapid, dramatic impact: to reduce maternal deaths by 50% within 12 months – by June 2013.

I traveled to Zambia as "Saving Mothers" was being developed in late 2011, seeking to understand how these enormous challenges can be addressed. I spoke with U.S. government officials, nongovernmental experts, and health care professionals about the potential benefits of the GHI approach and the synergies it encourages, as well as the hazards of overpromising measurable results. The "Saving Mothers" program's success in achieving its ambitious goals may serve as an indicator for GHI overall, and whether the U.S. agencies themselves can transform the way they work together to support health systems. This is no small task, especially without significant, sustainable funding – although some \$200 million has been pledged as part of a public-private partnership, "Saving Mothers" is designed to build on programs already put in place by the President's Emergency Plan for AIDS Relief (PEPFAR), the U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC), as well as Peace Corps and Department of Defense.

Over a 12-month period, “Saving Mothers” plans to introduce high impact interventions to address this critical 24-hour period, to train health care workers to provide maternal health services, and to support community mobilization to re-orient the focus of deliveries from homes to health facilities, including district hospitals. Much of this program will build off of the infrastructure that PEPFAR has built for HIV prevention, care, and treatment. Through this GHI approach, “Saving Mothers” would add value to U.S. health investments in HIV and in maternal child health by leveraging the range of U.S. health programs: PEPFAR’s significant investments in refurbishing health facilities and strengthening provincial centers for collecting safe blood (essential for blood transfusions), as well as prevention of mother-to-child transmission (PMTCT) sites that are also supporting antenatal care and deliveries; USAID’s work on maternal and neonatal health; and CDC’s expertise in surveillance and monitoring. U.S. officials say this illustrates how GHI can make U.S. resources work in a new way, better coordinating U.S. investments while building skills, services, and infrastructure to provide comprehensive services focused on women’s needs.

Whether these goals are attainable and sustainable, or simply aspirational, remains to be seen, but GHI officials contend, “We have to make sure women count and that they are counted.”

To define what it will mean to reduce maternal mortality by 50%, the “Saving Mothers” team had to develop a baseline by which to measure progress; since it will not be easy to measure the maternal mortality ratio, the idea is at least to count every pregnancy and every mother’s death. Using the 2010 census, the program is working with the Zambian Central Statistics Office (CSO), to ask details about all deaths of adult females—whether she was pregnant, and whether she died around childbirth, or in the first six weeks. The plan is to assemble a national count by district, which is being undertaken by the CSO with technical support from CDC.

Since maternal deaths are not routinely reported in Zambia, this strengthened reporting system might make it “look like the deaths are going up,” one GHI official readily admitted. “We’ll uncover things, but you have to understand the scope of the problem to fix it.” Similarly, a USG health analyst in Zambia noted, “These are tough, aspirational goals and challenges. We hope to learn from this to transform the situation of maternal mortality and to get closer to achieving the Millennium Development Goals.”

Yet, the hurdles are enormous—including an extremely weak health system in Zambia, with severe human resource constraints. As one international NGO representative put it: “They are lousy facilities, with too little space, too many people in need—the systems are at a breaking point.” Moreover, even when there is a health facility, there is often no nurse or health professional to staff it. “The system is handicapped,” the NGO representative observed, “because there are few service providers.”

The pilot phase of “Saving Mothers” is being built with expectations of eventual scale-up and sustainability through strengthened systems to address maternal mortality in the two target countries, and several more countries are likely to be added. GHI officials know that aiming for scale and sustainability sets the bar quite high, but they draw parallels to the skepticism in many quarters that greeted PEPFAR’s launch, and note that it took political will to accept those risks, and that PEPFAR has since saved millions of lives. While GHI officials do not claim that “Saving Mothers” will save the lives of millions women and their babies, they contend that it will greatly impact maternal and neonatal mortality by helping the district and ultimately the national health systems gain greater efficiencies and capacity.

In Oslo, Secretary Clinton announced that the U.S. would contribute \$75 million over five years to the project. Most of the funding comes from existing USG resources—notably USAID, CDC, and PEPFAR. According to GHI officials, \$60 million is from PEPFAR, and is all previously notified funding, and \$15M is part of the USAID FY13 funding request. GHI officials say that to realize this new program, they are pulling largely from existing resources and using only staff temporarily assigned from a range of USG agencies, but that “GHI is a way of doing business—it’s not a pot of money.” They argue that “Saving Mothers” builds on previous U.S. investments but in a more accelerated, concentrated effort.

Secretary Clinton’s speech in Oslo also emphasized the new public-private partnerships that are being established to help build sustainable financing for “Saving Mothers.” This includes \$80 million from the government of Norway, \$53 million from Merck for Mothers (plus \$5 million in-kind), technical support from the American College of Obstetricians and Gynecologists, and public outreach from the Every Mother Counts campaign. These partners will contribute their specific expertise -- ranging from technical support to implementation science, from supporting a rigorous evaluation to galvanizing public outreach campaigns and fundraising in the U.S. -- as well as providing links to professional societies, academic institutions, research pipelines, and policy and advocacy opportunities.

The addition of such alternative funding and support is critical, given this time of austerity in international assistance budgets. This is especially acute since, as of the President’s World AIDS Day speech last December 1, the USG is committed, to raise the numbers of HIV-infected people who receive antiretroviral therapy (ART) from the current 4 million to 6 million by 2015, on a flat budget. This obviously implies reallocation of resources and concentration on ART as the top line priority in U.S. global health funding. That, in turn, would seem to imply fewer resources for add-on initiatives that leverage existing platforms as well as other long-term financial commitments. Here is where the public-private partnerships could be key, and might help give the program the necessary lift and sustainability. It will be important for this program to show quick results in order to sustain confidence, while building realism about the need for long-term transformation of health systems.

To achieve its goals, “Saving Mothers” will need reliable blood banks, surgical capacity, supply chains, data systems, and transportation networks. “It’s the two hour question,” a USAID analyst explained. “If you have obstructed labor, you have two hours to get help.” A comprehensive and sustainable program has to include equipment, renovations, and communications, which could add a few million dollars more to the program costs.

“Saving Mothers” is also looking for innovative ways to address the barriers that women face in accessing health services. For example, to address the challenge of transporting pregnant women to health facilities, plans are being developed in Zambia to use SMS technology to transfer funds to cover the costs of transportation. Another project is looking to purchase locally made motorcycles with extended side carts that can travel on rough terrain. More broadly, the program will also focus on more frequent risk assessments for individual pregnant women and pre-positioning of women with high-risk pregnancies to places close to where they can access emergency services if required.

Part of the challenge is that women in Zambia, as in other developing countries, often have little confidence that needed services and trained health care providers will be available at health facilities, which often dissuades them from planning to deliver their babies there, given the risks and costs involved in what can be long and difficult travel. To encourage higher demand for services during the critical hours surrounding labor and delivery, “Saving Mothers”—and ultimately the health system overall—will have to demonstrate that it can live up to its name and actually save women’s lives. Encouraging demand without ensuring an adequate supply of services could undermine whatever gains will have been made in community mobilization efforts.

Country ownership is another core GHI principle, meaning that the national governments should be investing in country-led plans, and this is essential to the success of “Saving Mothers.” Indeed, Zambia and Uganda were selected as the first countries due partly to the expressed commitment of those governments to tackle maternal mortality. In Oslo, Secretary Clinton emphasized that country ownership goes beyond a country funding its health plans, that “a country’s political leaders must set priorities and develop national plans to accomplish them in concert with their citizens, which means including women as well as men in the planning process.” She continued: “We are well aware that moving to full country ownership will take considerable time, patience, investment, and persistence. But I think there are grounds for optimism.”

In Zambia, government is expected to help drive the “Saving Mothers” process. The Ministry of Health is planning to deploy trained health workers to the sites, which will also require ensuring them a place to live, means of transportation, and even access to solar chargers for their cellphones and laptops. In some cases, the Ministry plans to call retired health care workers back into service to fill these spots. The goal is for each facility to have at least one staff member who is trained in emergency obstetric care and neonatal resuscitation

techniques, if not a doctor and nurse-midwife at each site. As one USAID analyst noted, even with just one trained staff member, “we’d be far ahead of where we are now.”

For “Saving Mothers” to work, it will require all the pieces to function – from the community to the facility to the commodity supply chain – and for all the partners focused on HIV and MNCH to think collectively. This means ensuring appropriate numbers of skilled health personnel, safe places for women to deliver and where quality services are available, adequate supplies and procurement systems, systems for speed (referrals from communities and facilities, transportation, communications systems), as well as surveillance systems and response mechanisms. It means strengthening the district health systems and ensuring that implementing partners collaborate across the district. It means mobilizing the community, and getting services close enough or transportation available enough so that the pregnant woman receives the level of services she needs, especially in remote areas.

When evaluating “Saving Mothers,” some observers are skeptical—even cynical. One implementing partner called it “an unrealistic set of expectations, magical thinking,” saying,

[Saving Mothers] gets high marks on the spirit of this, but low marks on reality checks...this is a health systems issue—there’s no magic bullet. Pregnancy isn’t an infectious disease—they’re using the wrong model. It needs to be a long-term, sustainable effort to address the system. It won’t happen in 12 months, but hopefully we’ll get out ahead on maternal mortality. We’ve got to build a system. There’s no pill.

Another analyst pointed out that it will take 4-6 months just to get the infrastructure in place, and that the expected impact won’t be achievable in one year. “We all know it’s impossible—it’s aspirational.”

Others pointed to the challenges of working across USG agencies – especially USAID and CDC -- with different funding streams, which could present potential problems in standardizing procurement and evaluation mechanisms, and in some countries these problems have led to considerable tension and in-fighting. Some observers also expressed concern about sustainability, especially if the Ministry of Health deploys its best personnel for this program, thus giving a tremendous health advantage to just four districts and handicapping other parts of the country. Still others note that the focus of the initiative around labor and delivery does not address other critical drivers of maternal mortality, such as refusal of husbands or other family members to allow women to travel or access to family planning information and services. Nevertheless, most agree that the services being put in place will serve the broader population, especially the improvements relating to infrastructure, transportation, and communications.

GHI officials acknowledge the challenges, but see “Saving Mothers” as a risk worth taking. As one official explained,

Is it feasible? Is it the right thing to do? Do we have the courage and the will to make it happen? There is an element of risk, but we can do nothing or we can do something. The world hasn't met the Millennium goals, has not stepped up on maternal mortality. If we lead the way and show that we can do it and that we can make a difference, show that we are committed to do business in a different way, they'll join us... donors will come. This is a bellwether issue—if we can't save mothers at birth, how can we move up the chain of progress? We have to break the cycle.

And, despite the implicit urgency of the “Saving Mothers” one-year timeline, its greatest impact may be as a catalyst rather than a milestone. As one observer put it: “If these sites have trained staff, transportation networks, and a new initiative with the SMS companies, everything will be in place so that the following year, we could reduce maternal mortality by 50%. We need the lead time.”

In Oslo, Secretary Clinton acknowledged that the world risks failing in its collective promise to cut maternal mortality by three-quarters by 2015, and outlined how new partnerships can help meet those commitments. That's a tall order, especially in these tough economic times, but that's the challenge and the opportunity of this new approach to tackling maternal mortality. In Secretary Clinton's words, “we need to do things differently.”

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