The Safe Motherhood Initiative and beyond

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In 2007, the Safe Motherhood Initiative is celebrating its 20th anniversary. Many countries have been able to improve the health and well-being of mothers and newborns over the last 20 years. However, countries with the highest burdens of mortality and illness have made the least progress, and inequalities between countries are increasing. In many places, inequalities within countries are increasing too, between those who live in better conditions and have access to care, and those who for a variety of reasons are excluded.

Globally, the numbers remain staggering: each year there are at least 3.2 million stillborn babies, 4 million neonatal deaths and more than half a million maternal deaths. The majority of these deaths are avoidable. HIV/AIDS and malaria in pregnancy are having an impact on maternal mortality and could reverse the progress that has been made.

A total of 11–17% of maternal deaths occur during childbirth itself; 50–71% occur in the post-partum period. The time spent in labour and giving birth, the critical moments when a joyful event can suddenly turn into an unforeseen crisis, needs more attention, as does the often-neglected post-partum period. These periods account not only for the high burden of post-partum maternal deaths, but also for the associated large number of stillbirths and early newborn deaths.

A total of 98% of stillbirths and newborn deaths occur in low- and middle-income countries: obstetric complications, particularly in labour, are responsible for perhaps 58% of them. The care that can reduce maternal deaths and improve women's health is also crucial for newborns' survival and health.

During the early years of the 20th century, standard maternity care in Europe, North America and Japan consisted of a home delivery with regular, frequent visits by an obstetric specialist. The advent of modern obstetric care in the late 1930s did not alter this practice, but gradually moved the process to institutional settings, with post-partum follow-up and care by a skilled health-care provider. Antenatal care is a relatively new concept, and pregnant women in most developed countries now receive an integrated package of antenatal, childbirth and post-partum care.

This contrasts with the situation in developing countries, where antenatal care tends to be the first service to receive resources and is commonly widely implemented within maternal health programmes. Most pregnant women in developing countries visit antenatal care services at least once. Far less available and accessible is provision of professional childbirth care, either institutional or at home, and of emergency obstetric and newborn care services. In many settings, systematic and regular post-partum follow-up care is rarely available. Even women who deliver in a health facility are often discharged within hours post-partum and are not seen again until some considerable time afterwards.

Very few developing countries have accurate data on maternal and newborn deaths and morbidities, and less than one developing country in three reports national data on post-partum care. Unlike the situation for disease-specific programmes, for maternal and child health very little attention has been paid to monitoring progress and evaluating programmes, even for the analysis and use of existing data. Policy decisions and programme planning are therefore often carried out without evidence-based information and programme evaluation.

This issue of the *Bulletin* contains several papers that focus on important technical areas, particularly the management of post-partum complications and saving pregnant women's and newborns' lives by providing evidence and recommendations for policy changes and programme implementation. Other papers provide evidence that simple but effective monitoring of programmes in developing countries is possible.

However, the challenges to be met are not new technologies nor new knowledge about effective interventions, because we mostly know what needs to done to save the lives of mothers and newborns. The real challenges are how to deliver services and scale up interventions, particularly to those who are vulnerable, hard to reach, marginalized and excluded. Effective health interventions exist for mothers and babies such as those described in this issue of the *Bulletin*, and several proven means of distribution can be used to put these in place. However, none will work if political will is absent where it matters most: at national and district levels.

A key constraint limiting progress is the gap between what is needed and what exists in terms of skills and geographical availability of human resources at local, national and international levels. Other challenges are how to address deteriorating infrastructures; how to maintain stocks of drugs, supplies and equipment in the face of increased demand; lack of transport; ineffective referral to and inadequate availability of 24-hour quality services – particularly emergency obstetric care services – and weak management systems. We need to challenge our policy-makers and programme managers to refocus programme content and to shift focus from development of new technologies towards development of viable organizational strategies that ensure a continuum of care and account for every birth and death. ■

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