

Maternal mortality: it's time to get political

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Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.

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Nigeria has the 47th highest gross domestic product (GDP) worldwide and is the world's 8th largest exporter of petroleum. It has a maternal mortality ratio (MMR) of 800/100 000 live births. In contrast, Sri Lanka is 78th on the GDP list but has an MMR of only 92. Among the wealthy countries, Sweden has the 20th highest GDP and a MMR of 2, while USA, despite being the richest country in the world, has a MMR of 17.^{1,2}

If we are to reduce maternal mortality worldwide, it is crucial that we understand the reasons for the wide variation in MMRs. One would expect that the MMR would correlate with the prevalence of major complications of pregnancy, but such complications occur in a remarkably constant 15% or so of pregnancies throughout the world. Nor does the MMR correlate well with a country's wealth as the examples above show. What is, however, highly predictive of a country's MMR is the quality of its health services. Comparing each country's MMR and healthcare quality (as defined in the World Health Organization World Health Report of 2000) shows the two to be closely correlated (Figure 1).^{2,3} 'Quality of health care' is used here in its holistic sense—not just as a measure of the best the country can provide in its large teaching hospitals and private clinics but how effectively good quality health care reaches the country's poorest in rural areas well away from the capital. It also takes into account the health services' effect on the nation's health, the way the health workers treat individuals on a personal level (as regards dignity, confidentiality and client orientation) and the fairness of financial contributions.

The UK provides a classic example of the importance of the effect of a good quality health service on maternal mortality rates. It is no coincidence that the major fall in its MMR coincided with the launch of the NHS in the 1940s which provided free care for all at the point of delivery.⁴ The quality of maternity care also improved greatly at this time as blood transfusions and antibiotics became available. The NHS made these advances available to the many and not just the privileged few. Conversely, the recent crisis at Northwick Park Hospital in London shows how quickly maternal mortality rates can rise if the quality of maternal care deteriorates.⁵

The impressive second report on the South African Confidential Enquiries into Maternal Deaths emphasises the pivotal role of health services in reducing MMRs.⁶ Of their ten key recommendations, all but one relates to improvements in the health services rather than introducing new procedures or therapies. They recommend speeding up access to services (better ambulance services and referral systems), service development (better contraceptive/abortion services and improved antenatal screening) and improved quality of care (written protocols, optimising levels of staff and equipment, blood transfusion, partogram use and effective anaesthetic services). The one recommendation that is not directly health service related is the final one that calls for the empowerment of women.

If tuberculosis is the disease of poor housing, and gonorrhoea a 'social disease', then surely maternal mortality is the classic example of a disease of poor health services.

For those of us trying to reduce maternal mortality from a medical perspective, we will be unable to achieve fundamental change without a massive improvement in health services in those areas of the world that are currently poorly served. Indeed, as exemplified in the title of the BJOG 2005 supplement on the developing world, much of the research on

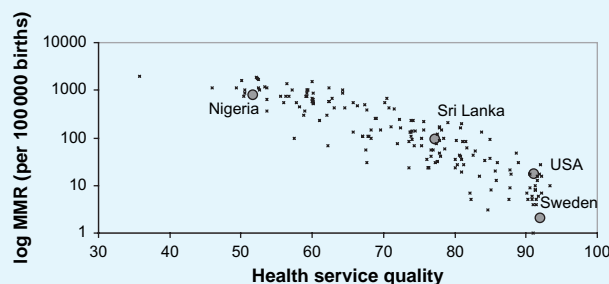


Figure 1. Correlation of MMRs (per 100 000 live births) and overall health service quality (data from WHO 2000 and WHO 2004).^{2,3}

reducing MMRs is focused on 'the art of achieving good outcomes with few resources'. We may develop low-cost solutions that punch above their weight (e.g. misoprostol), think of creative ways of providing low-cost health care (e.g. women's groups or nonmedically trained surgeons) or debate the priorities for improving the health services (e.g. ambulances or audit). However, it is clear that the impact of these will be small without massive improvements in the infrastructure of the health services. Also, these will only be obtained through political change.

Shiffman and Okonofua,⁷ writing in this month's *BJOG*, address the state of political priority for safe motherhood in Nigeria and discuss ways in which pressure can be placed on politicians to produce change. They argue that a number of factors have come together to 'open a policy window' for the reduction of maternal mortality in Nigeria. These relate to the arrival of democratic government in 1999, increased pressure from both Nigerian and international organisations and a new commitment from within the government. However, they point out that in order to take advantage of this opportunity, the numerous safe motherhood groups need to amalgamate into a single powerful force, local and regional government need to take maternal mortality seriously and central government has to provide additional resources. They argue that if we are to take advantage of this policy window, then the maternal mortality advocates must come together to 'transform their moral and technical authority into political power'. They end with a call for safe motherhood advocates to develop political as well as medical solutions to the problem of maternal mortality.

The call for political action is not new, but it deserves repeating. For physicians involved in the safe motherhood movement, it is too easy to retreat into medical research, away from the unfamiliar and often dirty world of international politics; yet, it is there that we need to go to achieve real change. The article by Shiffman and Okonofua, together with the South

African confidential enquiry report, offer a blueprint for the way in which political change can lead to the much-needed reduction in maternal mortality throughout the world.

What can governments do? Fundamentally, governments need the ability to *finance* an effective maternal health service. To achieve this, global and national changes are needed. Globally, this requires fair international trade agreements and a solution to the brain drain. National prerequisites are political stability, good economic and financial management of the country's wealth and an end to corruption.

Second, governments need to promote *high-quality care*, especially in rural areas. This will take decentralisation of care systems, a regular supply of well-trained staff and consumables and national and local audits to critically evaluate the service. In addition, if we are to achieve real reductions in the MMR in countries with high rates of unsafe termination of pregnancy, safe termination services will need to be provided.

Finally, women need to be able to *access* this high-quality health care. This means free health services located in rural areas, effective transport systems and, in a wider context, education and empowerment of women to enable them to make decisions for themselves. Disempowered women too readily accept poor health and poor quality health care.

Achieving this list will be no mean feat. But, if we rely on medical advances to deliver reductions in maternal mortality, then we will be waiting for a long time. Political action is needed, and it is needed rapidly if we are to achieve the ambitious targets set in the Millennium Development Goals for 2015. ■

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