Practical lessons from global safe motherhood initiatives: time for a new focus on implementation

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The time is right to shift the focus of the global maternal health community to the challenges of effective implementation of services within districts. 20 years after the launch of the Safe Motherhood Initiative, the community has reached a broad consensus about priority interventions, incorporated these interventions into national policy documents, and organised globally in coalition with the newborn and child health communities. With changes in policy processes to emphasise country ownership, funding harmonisation, and results-based financing, the capacity of countries to implement services urgently needs to be strengthened. In this article, four global maternal health initiatives draw on their complementary experiences to identify a set of the central lessons on which to build a new, collaborative effort to implement equitable, sustainable maternal health services at scale. This implementation effort should focus on specific steps for strengthening the capacity of the district health system to convert inputs into functioning services that are accessible to and used by all segments of the population.

Introduction
The safe motherhood movement reaches its 20th anniversary as the global health field embarks on ambitious new efforts to transform its practice. With the Millennium Development Goals (MDGs), the Paris Declaration on Aid Effectiveness, and the launch of the Global Campaign for the Health MDGs,1 the principles of country ownership, aid coordination, and results-based financing will create a new approach to national policy-making and financing. The success of these initiatives depends on the ability of countries to steadily expand their capacity to implement integrated programmes for service delivery while progressively advancing coverage and equity.

Four major global safe motherhood implementation and evaluation initiatives of the past decade—Averting Maternal Death and Disability (AMDD), Immpact, the Skilled Care Initiative (SCI), and ACCESS (panel 1)—call for a renewed and intensified focus on implementation. In this paper we use our complementary experiences in the field to offer a set of central lessons on which to build a new, collaborative effort to initiate change on the ground, where women live and die.

The time is ripe for a shift in focus
For much of its history, the Safe Motherhood Initiative focused largely on global debates about strategies and priorities. Little attention was devoted to expanding the capacity of countries with high mortality rates to implement and sustain any such strategies or to learning from the few local-level initiatives that did exist. New attention to implementation is now needed.

Panel 1: Global Maternal Health Initiatives
Global initiatives can generate and synthesise evidence, develop instruments, create links for learning across countries, and provide technical guidance and support.

The Averting Maternal Death and Disability (AMDD) Program at the Mailman School of Public Health, Columbia University, is a global programme of research, advocacy, policy analysis, and programme support that is dedicated to the reduction of maternal mortality and morbidity. AMDD and its UN, non-governmental, and governmental partners have worked in some 50 countries in Asia, Africa, and Latin America with a focus on expanding availability, quality, and use of emergency obstetric care and addressing health systems factors that constrain or facilitate equitable access at scale.

Immpact is a global research initiative to strengthen the evidence-base on the effectiveness and cost effectiveness of intervention strategies for safe motherhood, and is coordinated by the University of Aberdeen, UK. It consists of a collaborative network of scientists spread across seven research institutions, and has developed measurement methods for robust evaluation of strategies, which were used to undertake major assessments in its first phase (2002–06) in Burkina Faso, Ghana, and Indonesia.

The Skilled Care Initiative (SCI) is a 5-year programme of Family Care International that aimed to increase the availability, quality, and accessibility of skilled maternity care in four rural, underserved districts in Burkina Faso, Kenya, and Tanzania through a multifaceted approach of health facility and community interventions.

The ACCESS Program works to expand coverage, access, and use of key maternal and neonatal health services across a continuum of care from the household to the hospital. The 5-year global programme is sponsored by the US Agency for International Development (USAID) and works with USAID missions, governments, non-governmental organisations, local communities, and partner agencies in developing countries.
Several factors are already in place. First, the safe motherhood community has coalesced around three key elements that are crucial for reduction of maternal mortality—family planning, skilled care for all deliveries, and access to emergency obstetric care for all women with life-threatening complications—all of which are firmly grounded in a sustainable health systems approach that engages communities and facilities.

Second, in many countries, national plans to accelerate progress on maternal and neonatal health have set overall priorities for implementation and monitoring and, in the process, generated political will and national ownership.

Third, virtually every country has committed to the MDGs, and leading donor and recipient countries have endorsed the new global initiatives being brought together under the Global Campaign for the Health MDGs to accelerate progress in reaching these goals. Lastly, promising mechanisms have been created for carrying advocacy messages, maintaining the public profile of maternal health, and strengthening coordination and collaboration in the discipline of maternal, newborn, and child health overall, in particular the Partnership for Maternal, Newborn and Child Health.

With these factors in place, we call for renewed energy, attention, and resources for implementation at the district or local level. However, the importance of generating political will, increasing funding, or launching advocacy campaigns that keep the issue in the public eye should not be discounted nor dismissed. Of course, national policy work should continue. But implementation of maternal health services on the ground has been woefully neglected in the global safe motherhood community. We believe that the time is right to change the balance and provide new priority to implementation.

**Global initiatives and local actors: lessons for implementation**

Although each of the four initiatives focuses primarily on a different aspect of maternal health efforts, on the basis of these varied experiences we believe that implementation efforts aimed at service delivery at scale, and thus achievement of MDG5, should be firmly embedded in a health systems approach. Ultimately, this tenet means that the following needs to be addressed: both the supply and demand side; both home and community dynamics and facility-based services in a home-to-hospital continuum of care; and both obstetric emergencies and routine deliveries.

But a health systems approach does not mean that every district in every country has to do everything all at once or use exactly the same strategy. Instead, countries or the relevant subnational planning and implementation units (usually states or districts), or both, should start where they find themselves, and proceed through a process of assessment, planning, progressive implementation, and monitoring, while keeping in steady focus the operational result they seek: equitable use of functioning, good quality services, and measurable health improvements.

To plan for implementation at scale needs prioritisation and vision. Selected elements of a plan might be put into operation immediately, whereas other elements need a longer timeline but demand immediate investment to set into motion progress along that timeline. Of course, plans need to be financially realistic and sound, but the approach of simply postponing serious attention to any crucial elements of a maternal mortality reduction plan, until a time when poor countries are prosperous, is not acceptable. Maternal mortality reduction is a global responsibility that is codified in international law and endorsed repeatedly in policy statements. For MDG5 to be achieved, support has to be available to responsibly implement all the essential elements of an evidence-based strategy to reduce maternal mortality.

In this paper we focus on interventions that are designed to avert deaths and injuries to women around the time of delivery and in the immediate postpartum period, when the risk to mother and baby is greatest. The number of maternal deaths can and should also be reduced through access to family planning, which enables women to control the number of times they become pregnant and thus risk maternal death. Furthermore, the risk of dying when pregnant can also be reduced through safe abortion services when legal, and treatment of abortion complications. Good intrapartum care has other important health effects. For example, it can reduce the risk of chronic morbidities, such as fistulas or uterine prolapse. Interventions for the mother at the time of delivery also have a substantial effect on perinatal mortality—an estimated 30–45% of newborn deaths and 25–62% of intrapartum stillbirths could be averted through good obstetric care.

Equally importantly, maternal health programmes that are well implemented strengthen the broader health system with collateral benefits for many other health disorders. For example, referral systems help victims of road accidents reach emergency care; blood transfusion services supply blood for all surgeries; improvement in facility management benefits the whole site; and community engagement can change accountability dynamics across all health services.

**Needs assessments and the importance of contextual variation**

We are not advocating a single universal approach to implementation, but neither are we suggesting that every situation is so unique that it has to start from scratch. In short, we know what to do, but how to do it varies by context. Understanding context entails an appreciation of the relation between supply and demand within the district level health system—ie, the continuum from home or community, up through health posts and health centres, to the first referral level facility. In many
countries where political and bureaucratic decentralisation has taken place, the district is also the level at which budgets are decided and authority over the direct functioning of the health system is lodged.

The ultimate goal is to ensure that every birth is attended by a skilled health professional (panel 2) and that every woman who has an obstetric complication receives care either in a basic emergency obstetric care facility (typically a health centre) or in a comprehensive emergency obstetric care facility (typically a district or subdistrict hospital; panel 3). Although there is not just one right strategy for attaining this goal, a strategy is crucial to guide implementation. This strategy should be based on evidence and on relevant information about the local context. For example, the recent *Lancet* series on maternal survival presented evidence to suggest that, if maternal survival is the outcome sought, then the best strategy for delivering intrapartum care at scale is one that enables women to routinely give birth in health centres, private clinics, or maternity homes that can assist with healthy births but which also include basic emergency obstetric care for managing complications and which provide ready access to well-functioning referral level care. Health centres would be staffed by fully qualified midwives as principal providers working in teams with midwife assistants or their equivalents, who can safely handle routine deliveries.

To develop and then plan for implementation of this strategy or any other evidence-based one, the following questions are crucial for every district: where do women give birth and under what circumstances (ie, what proportion receives skilled care)? Where is basic and comprehensive emergency obstetric care now available and which signal functions (panel 3) are missing? What is the profile of human resources—both clinicians and managers—that is now available compared with what is needed? What is the present pattern of and capacity for referral (ie, emergency transport, patterns of bypassing, etc)? Who is and who is not accessing care—ie, what is the equity profile? What are the demand-side barriers to use and what is their relative importance? This information will be expanded through the health management information system and through operations research as implementation and scale-up proceed.

Instruments already exist for many aspects of needs assessments for both supply-side and demand-side. For example, information about place of delivery and present status of skilled care can usually be identified in population-based data sets such as the Demographic and Health Surveys and in facility surveys such as the Service Provision Assessments. Instruments for needs assessments for emergency obstetric care have been developed by AMDD in partnership with UNICEF, UNFPA, and WHO, and have been used in some 48 countries (panel 4).

On the demand side, research undertaken by Family Care International (FCI), Immpact, and others confirms that there is substantial variation in the relative importance of different barriers, such as financial and geographical obstacles. This work also shows great variation in the relative importance of different cost elements—such as user fees, transport costs, and

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**Panel 2: WHO, International Confederation of Midwives, and International Federation of Gynaecology and Obstetrics definition of a skilled birth attendant**

“A skilled attendant is an accredited health professional—such as a midwife, doctor, or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns”.9

**Panel 3: Signal functions for basic and comprehensive emergency obstetric care**

**Basic emergency obstetric care**

1. Parenteral antibiotics
2. Parenteral oxytocic drugs
3. Parenteral anticonvulsants
5. Removal of retained products
6. Assisted vaginal delivery

**Comprehensive emergency obstetric care**

All of the above plus:
7. Surgery (eg, caesarean delivery)
8. Blood transfusion

**Panel 4: Needs assessments with the UN process indicators for emergency obstetric care**

Over the past decade, the UN process indicators for emergency obstetric care have been used in over 48 countries to assess the status and to monitor progress in the provision of emergency obstetric services. Findings from needs assessments with the UN process indicators have shown:

- Per population, most countries have enough comprehensive facilities for emergency obstetric care but very few basic facilities.11 Quality of care, however, needs to be improved at all levels
- Geographic distribution of facilities for emergency obstetric care is a challenge, especially in rural areas12
- Met need for emergency obstetric care is low. National needs assessments in nine countries in sub-Saharan Africa showed that met need was on average 28% (ranging from 12% in Mali to 48% in Benin), suggesting that too many women in these countries are not receiving treatment for their obstetric complications12
- Caesarean delivery rates in surveyed African and Asian countries were less than 3% and therefore below the UN recommended range of 5–15%.16,17
Panel 5: Contextual variation in barriers to financial access

Conventional strategies to reduce financial barriers tend to focus largely on the costs of services at the facility by abolishment or reduction of user charges. Yet in some contexts, the costs that households incur outside the facility—eg, drugs and supplies purchased as well as payments for transport to reach care—might represent a more important barrier than formal payments for the care itself. The size of these costs varies enormously by context. In Nepal, demand-side costs represent at least 60% of the costs of a healthy delivery. In Ghana, spending on non-facility cost accounted for almost half the cost of delivery. In contrast, in the Immpact study districts in West Java, Indonesia, which are densely populated, without topographical barriers, and with good roads, transport and other demand side costs represented less than 10% of the total costs of a routine delivery. Demand side costs are an especially important issue in countries where distances or topography make facilities physically difficult to access.

Panel 6: Targeting

The research of Immpact and other studies suggest that targeting services to poor groups is of little use since identification of poor individuals is usually inadequate, targeting stigmatises, and providers frequently prefer to deliver services largely to those who are able to pay high fees. Furthermore, and of great importance for emergency obstetric care, many more households than those defined as poor are at risk of impoverishment from the high costs of care. For example, the selective insurance for the poor people in Indonesia has almost been abandoned at a public hospital level for these reasons, where most women now receive highly subsidised emergency obstetric care. Geographical targeting can be beneficial in extending access to services in the poorest areas first. Such services include access to skilled delivery care, basic emergency obstetric care, and transport or transport subsidies to get to hospitals. This idea receives extensive support in published work, which reports that geographic targeting, especially if focused on fairly small areas (eg, district, subdistrict), is a cheap and effective way of reaching the poorest groups.

Finally, an often neglected area for needs assessment relates to equity across several dimensions of social disadvantage, including wealth, locality, religion, and ethnic origin. Techniques exist for showing the magnitude of inequity in the maternal mortality ratio with use of data from the Demographic and Health Surveys. Other indicators focus on specific services such as Unmet Obstetric Need, which provides an equity-sensitive measure of access to caesarean sections. New methods are being developed to assess equity in service use at the facility level. In maternal health, both the barriers to skilled care for routine deliveries and those to access emergency obstetric care in the event of life-threatening complications are especially important. Not only is the amount of the costs incurred for these services and the effect that these costs have on households very different, but the distinction between a planned event, such as routine delivery, and an unpredictable emergency has implications for the effectiveness of different financing mechanisms and policy initiatives such as targeting (panel 6).

From the bottom-up approach that begins with this type of needs assessment at the district level, issues will emerge that should be addressed at a centralised level of the health system, such as overall financing, procurement systems, and human resource strategies including employee posting and transfer policies. But implementation efforts at the district level should not wait until all such central issues are resolved. Implementation efforts—the transformation of existing and new inputs into functioning equitable services—can and have to begin immediately in the periphery and feed information and experience back up to the centre where, simultaneously, health systems structure and financing are being addressed.

In practice, the interplay between change at the service provision level and policymaking at the central level is rarely so straightforward. Incentives created by specific centralised decisions (eg, about compensation or career paths) or by the structure and financing of the system itself (eg, privatisation, decentralisation) can either ease or undermine local efforts to improve service delivery. Conversely, in the process of implementation, service providers and local managers can subvert even the best-intentioned policies created at the central level. Competent, committed managers at the district level—skills often absent in newly decentralised or weak health systems—are needed to ensure that policy change initiated from the top down and information generated in needs assessments from the bottom up do indeed come together to help produce equitable services of good quality.

Thus the new focus on implementation that we call for here is as much about management as it is about clinical care.

From inputs to functioning

Arguments about the effectiveness and theoretical impact of specific clinical interventions, such as misoprostol or active management of third stage of labour for postpartum haemorrhage, often mask the fact that none of the interventions in question, whether community-based or facility-based, will actually reach people in an equitable and sustained way without the infrastructural support of the health system. The field of maternal health has many examples of projects in which an intervention that is enthusiastically pursued ultimately has little effect on health outcomes because of failure to address the necessary health system support.

Inputs alone are not enough. The mere presence of health workers, drugs, supplies, and physical infrastructure does not necessarily produce functioning, responsive services. The results—ie, functionality and use—are what matter, not just the existence of the inputs. But understanding and tracking the relationship between inputs,
processes, and results will ultimately be an essential part of managing for results.

For example, within AMDD, a simple method—the emergency obstetric care building blocks—has effectively helped planners and managers break down the task of implementation for results into manageable pieces (figure 1). With this type of step-by-step approach, hundreds of facilities over the course of 3 to 4 years were able to more than double the met need for emergency obstetric care and substantially reduce case fatality rates, often by 50% or more.21

Additional instruments exist for almost every block in the pyramid. Adaptations of EngenderHealth’s COPE method were used to improve management in both FCI’s Skilled Care Initiative in facilities managing routine deliveries22 and in the AMDD programme in facilities providing emergency obstetric care.23 Other methods such as criterion based audits,26–28 verbal autopsies,29 forms of confidential enquiry,30 and appreciative inquiry31,32 have also been successful in assessment and maintenance of quality and functionality in facilities.

Such management instruments emphasise perhaps the most challenging area of implementation: human resources. Implementation at scale needs a sound human resource plan: a health workforce framework that considers planning, recruitment, education, deployment, and performance support of health workers.31

As in other areas of implementation, no universal solution for human resources exists. For example, in Nepal, a new skilled birth attendant policy focused on upgrading existing workers. On the basis of an analysis of all cadres of health workers involved in maternal health care, policymakers assigned resources and attention to selected groups for standardisation and upgrading to become skilled attendants. Conversely, in Afghanistan the situation clearly needed immediate production of new workers, since less than 500 midwives existed in the country in 2002. Therefore, a massive national effort to train and appropriately make use of midwives was launched in 2003.34 A national policy to expand skilled attendance, especially in rural areas, strong donor support, and clear technical leadership and resources led to a rise in the number of midwifery schools from six in 2003, to 23 in 2006, and the production of more than 1100 new competent midwives in 3 years. Skilled birth attendant coverage in the Herat province increased from 4% in 2003, to 43% in 2006.

Maternal mortality reduction also needs appropriate skilled human resources to treat life-threatening complications when women with obstetric emergencies are referred. Studies have shown that scale-up for results often requires fundamental changes in both inservice and preservice curricula to emphasise competency (rather than simply knowledge) in a core set of essential skills and to ensure that training fits the infrastructural realities of high-mortality, low-resource settings.30,31,32 But no one right combination of professional credentials exists. In many countries, delegation to lower cadres of workers—usually midlevel providers such as clinical officers or surgical technicians—has become a crucial strategy for health system functioning.33 In Mozambique, for example, non-physician surgical technicians posted to rural areas had an 88% retention rate after 7 years compared with 0% retention of physicians, resulting in 92% of all major obstetric surgeries being done at district hospitals in Mozambique by surgical technicians.38

None of these training approaches can be effective without careful planning for the deployment and support of trainees. For example, in the Afghanistan midwifery system supported by ACCESS and JHPIEGO, the focus of these new schools was on the midwifery service to the community, not simply on midwifery education. Recruitment of students was connected with planned deployment, with the student, their family, and local authorities committed to a 3–5 year rural work contract. Initial deployment success in provincially-based community midwifery schools was more than 80%, whereas government schools whose recruitment policies were less tied to planned employment had deployment rates lower than 50% on average.

Impact’s research has explored the effects that health financing schemes39 can have on health worker performance, sometimes with substantial consequences for equity. For example, its assessment in Indonesia showed that although the government had trained and placed a sufficient number of midwives in the study districts, midwives’ reliance on incomes from private practice means that women not able to pay for services are still disadvantaged in accessing them.40 Similarly in Burkina Faso, the absence of career progression including salary increase is probably an important factor behind the challenge of retaining experienced staff.41 The Ghana assessment showed that when user fees were eliminated,
the willingness of staff to shoulder increased workloads was partly linked to a general rise in public sector pay and allowances, even though most staff did not receive direct incentives to provide free delivery care.42

Such findings help to emphasise the important links between micro dynamics at the level of service delivery and macro dynamics at the level of health system structure and financing. Furthermore, they remind us that the health system is a core social institution made up of many different sets of social relations—ie, among health system staff, between health providers and the communities they serve, and within communities themselves. Implementation efforts cannot avoid addressing these relations and the power dynamics, including culturally specific gender and class or caste hierarchies, on which they are frequently based.

Accountability is the notion that has in recent years been regarded as the key to ensuring that this system of relations yields an equitable and efficiently functioning health system.49 Although accountability is often approached strictly as top-down enforcement of laws and regulations, experience in our initiatives support a so-called constructive accountability approach45 that encourages accountability to clients and other members of the full team who are associated with delivery care within the district health system, rather than solely to distant managers and supervisors.

Building constructive accountability into implementation programmes often means integration of community members or community-based institutions into the management of health services. Many techniques are able to achieve this effect. For example, in FCI’s work in Kenya, initially there was friction and mistrust between facility staff and community health committee members. A training programme helped to clarify the roles and responsibilities of the management committee and to strengthen members’ awareness about maternal health issues, their ability to serve as health ambassadors to and from the community, and their skills in key areas such as community mobilisation and fundraising.

In Burkina Faso, FCI worked extensively with local chiefs and traditional leaders in the Ouargaye district to heighten their awareness of and concern about maternal mortality. In one community, the local chief began to regularly attend antenatal clinics to urge women to return to the facility for delivery care. The use of skilled care increased from 25% to 56% between 2003 and 2006, partly because of the positive social atmosphere created by the local chiefs and partly because quality services were made available at health centres that were closest to where women lived.46

Although formal legal and regulatory mechanisms should, of course, be used to enforce some types of accountability (such as financial corruption), rights-based approaches have also been used effectively in implementation of programmes to create a responsive dynamic that is focused on teamwork for best possible client care. For example, the organisation CARE used an explicitly rights-based approach in its AMDD-supported programme in Ayacucho, Peru, to tackle a failing referral system in which poor clinical decisionmaking and slow action were reinforced by mistrust and condescension across different levels of providers. The introduction of a referral/counter-referral system, as well as training, clear protocols, two-way radios, and ambulances helped improve the situation, ensuring that staff at all levels saw themselves as part of a team which was working to improve maternal-health outcomes. With improvements in performance at both health centres and the referral hospital, and in their interactions with the community, met need for emergency obstetric care rose from 30% to 84% in 4 years.49,50

**Monitoring and evaluation**

Monitoring and evaluation is a fundamental part of a well-functioning health system, and thus it is an essential element of any implementation initiative. At a programmatic level, the rationale for tracking inputs, processes, and outcomes is clear: to improve performance, enhance effectiveness, and achieve results.50 Over the past 20 years, a large amount of experience has accumulated on many aspects of the monitoring and evaluation of programmes for maternal health.49–52 As the interdependence between health systems strengthening and initiatives for the reduction of maternal mortality has
become increasingly apparent, so has the overlap in their monitoring needs.

Indeed, as global health policy and development aid move increasingly toward results-based financing as a means for improvement of overall management of the health system and service delivery at the operational level, monitoring and evaluation have become very important. The challenge is to define a small number of indicators that will not overwhelm fragile reporting systems, but that capture district level programme inputs and management appropriately, which is necessary for both health system strengthening and maternal health specifically. One of the lessons learned in our and others’ initiatives, is the importance of linking coverage indicators to quality and equity. In Ghana, for example, Government removal of user fees was associated with an increase in the proportion of deliveries with health professionals, but the reduction in out-of-pocket payments for care was only 14% for the poorest women compared with 22% for the richest.

These developments in global health policy and financing mechanisms imply an increased commitment to strengthening district level reporting and data collection systems, and commitment to analysis, interpretation, and use of data. In the maternal health field, many measurement methods and techniques are now available, although further improvement is still needed. Some of these methods rely on the routine information system, like the UN process indicators for emergency obstetric care and quality of care audits, whereas others use secondary analysis of data from major survey programmes—eg, the Demographic and Health Surveys, and some need specific data collection activities such as key informant interviews. Measurement of health outcomes, such as maternal mortality, continues to present challenges for weak routine information systems, but several novel methods have emerged from AMDD and Imppact. Experience with the measurement of non-fatal outcomes, such as obstetric fistulae and psychological morbidities, is slowly increasing, and efforts are underway to improve analysis of perinatal outcomes.

Remaining challenges

The inputs needed for maternal mortality reduction are within the reach of all countries over the next decade if the necessary rises in aid and budget allocations are forthcoming. Recognition of the deficits in human resources and infrastructure that hamper maternal health programmes has been growing. But attention to the poor capacity of the overall organisational system to convert these inputs into functioning, equitable services is now urgently needed.

Efforts to strengthen capacity should focus on the organisational system that “is composed of a network of programmes of services, staff, facilities, structures (forums for discussion and collective decisionmaking

such as management boards, committees, etc), and processes of supervision, decisionmaking, information passing, financial flows, and so forth.” When systems capacity is ignored, inputs are often wasted and results scarce (figures 2 and 3). The challenge will be to address these elements of systems capacity not as mechanical cogs in a wheel, but as human interactions. Effective management of these interactions needs a continual, open-minded search to understand what incentives from inside or outside any particular health system drive people—eg, providers, patients, managers—to act as they do. The work of our four initiatives has shown the feasibility of eliciting context-specific information about the motivating factors that drive service quality and use, which can then help adapt policies and practices to address these factors directly.

Clearly these many dimensions of health-system functioning do not exist in isolation from the wider political economy that prevails in high-mortality countries and in the global system. Our call is not to ignore such issues. We recognise that maternal health is linked in profound ways to poverty and wider issues of socioeconomic development. Yet social and economic dynamics are not only questions for contributors to global policy. They also have tangible consequences in the actual functioning and use of these most basic services on which the lives of millions of women and neonates depend. Our call is to bring the fight for these services to the local level, and to support the efforts of those inside and outside the health system at that level who are able to initiate real and lasting change.

This leaves the question of what will it cost to implement this aim at scale? Here there are some known and unknown factors. Known factors encompass the various global costs on scaling-up maternal and newborn services. Although these costs vary according to model assumptions, the additional budget needed is clearly substantial—in the range of US$5·5–$6·1 billion per year by 2015, for the 75 priority countries. Present investment at a global level is insufficient, and donors will greatly need to increase financial contributions. The Global Campaign for the Health MDGs is hoped and expected to be the catalyst and mechanism for achieving this increase. Projections suggest that such funding requirements could be met if countries invested 15% of their national budgets in health (the Abuja target set by and for Africa), and if official development assistance rose further towards 0-7% of gross national income for countries in the Organisation for Economic and Co-operative Development.

The unknown factors in the scale-up costs lie at a country level. The global estimates are too crude for national planning, and there is an urgent need for context-specific budgets to be produced—ie, budgets which also need to cover improved resource tracking, so that both country and donor commitments are held accountable. Crucial information gaps exist on the costs of health sector reforms, and costs of recruiting, training,
and retaining sufficient numbers of skilled health personnel, who are vital to saving women’s lives. Strong evidence exists in support of major reform in the financing of maternal health services, and specifically the removal of user fees, which disadvantage the poorest women and exaggerate the poor-rich gap in terms of use and outcomes. For this bold move to succeed, governments have to replenish the income lost from the abolition of user fees, and should ensure rather than assume that the benefits reach disadvantaged groups and regions.

Conclusions

The focus of the global maternal health community needs to shift. Instead of energy spent on the fine points of precisely which effective interventions theoretically fit best into generic packages, we now need to address the health system that must deliver them. Yet virtually nothing in the maternal health field has been prepared or set up to address the type of systems capacity-building for scale that is the over-riding lesson of the diverse experiences of our four initiatives. To change this pattern will take creativity and courage. Creativity is needed to build political commitment and forge strong coalitions across programmes, sectors, professions, and countries, and to tap the expertise and local knowledge—so often hidden from the global view—to design and implement the new initiatives, incorporating the best of what is already known. Courage is needed not to confront what is wrong in health systems that do not function for people, especially those who are poorest, despite huge infusions of cash and development aid, and to demand and support a transformation.

Conflict of interest statement

We declare that we have no conflict of interest.

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