



THE RIGHT TO SAFE MOTHERHOOD:

OPPORTUNITIES AND CHALLENGES FOR ADVANCING GLOBAL MATERNAL HEALTH IN U.S. FOREIGN ASSISTANCE

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ABOUT THE REPORT

The causes of maternal mortality and morbidity are no mystery. Women die and suffer debilitating disease and injury during pregnancy and childbirth because they bleed to death, acquire infections, have underlying but treatable health conditions, or obtain unsafe abortions.

The keys to improving maternal health are equally clear. Family planning information and services must be available and affordable to girls, adolescents, and women without discrimination or stigma. Pregnant women must have timely access to quality, respectful care before, during, and after childbirth. Abortions must be made safe and legal, and post-abortion care must be fully integrated into health systems. When women's roles and contributions are valued, and their rights are recognized, maternal health programming and services will receive significant and enduring benefits.

Although valuable data about maternal health is being produced, and increasingly is being used to drive policy decisions, there has been a tendency to focus attention too narrowly on the perinatal period and the obstetric causes of death rather than on the social, political, and legal environments that endanger women's health. This report examines the upstream threats to women and girls: the obstacles to accessing proper care and the structures that keep women from exercising their rights.

While the international community has prioritized maternal health through its *Call to Action* for ending preventable child, maternal, and newborn deaths, and the United States Agency for International Development (USAID) has issued a *Vision for Action* that recognizes many of the key barriers to progress, there has been little consideration of the donor systems and policies that undermine and contradict program goals. We hope this report will open a conversation about how those systems and policies can be strengthened.

This report is based on a review of published literature, accompanied by candid, not-for-attribution interviews with policymakers and practitioners from the U.S. government, non-profit partners, and advocacy organizations. Based on these interviews and studies, CHANGE identifies six policy challenges requiring attention from Congress and the Administration.

Improvements in U.S. policy and programming will not solve all the problems that make pregnancy and childbirth so dangerous for women around the world. However, they will ensure that U.S. resources are targeted effectively and used efficiently to empower women to seek and receive the care they need.

Serra Sippel

President

Center for Health and Gender Equity (CHANGE)

EXECUTIVE SUMMARY

WE KNOW WHAT CAUSES MATERNAL DEATH AND DISABILITY AND HOW TO PREVENT IT.

Each year, 289,000 women die in pregnancy and childbirth, 99 percent of them in the developing world.¹ Complications during pregnancy and childbirth are the world's second leading cause of death for girls aged 15-19.² The majority of maternal deaths are due to four direct causes: hemorrhage (27%), hypertension (14%), sepsis (11%), and unsafe abortion (8%). Indirect causes, such as HIV/AIDS, malaria, and other underlying health conditions, account for another 27.5% of maternal deaths.³ For most of these complications of pregnancy and childbirth, simple and relatively inexpensive interventions are available.

DESPITE THIS KNOWLEDGE, GLOBAL PROGRESS ON MATERNAL HEALTH HAS BEEN LAGGING.

Of the eight Millennium Development Goals (MDGs) adopted by the world's leaders in 2000, the goal for reducing maternal mortality is the furthest from being met.⁴ The reason is straightforward: women are not getting the care they need. The failure to take effective action is a violation of women's rights. The World Health Organization (WHO) has recognized that “women's reproductive health risks are not mere misfortunes and unavoidable natural disadvantages of pregnancy, but, rather, injustices that societies are able and obligated to remedy.”⁵

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ADVANCING MATERNAL HEALTH MEANS MORE THAN JUST AVERTING DEATHS.

For every maternal death, more than 40 women suffer severe complications of pregnancy or childbirth that cause injury, infection, or disease — a total of 12 million women each year.⁶ Promoting maternal health requires preventing and treating morbidities — health conditions that are attributed to or aggravated by pregnancy and childbirth and negatively impact a woman's well-being⁷ as well as protecting the basic human rights and human dignity of all pregnant women and mothers.

6 MAJOR FACTORS IMPEDE FASTER PROGRESS ON MATERNAL HEALTH.

- 1** *Unmet need for family planning.* If all women with an unmet need for modern contraception were using it, global maternal mortality would be reduced by nearly one-third.⁸
- 2** *Unsafe abortion.* In addition to providing safe abortion care and treating complications of unsafe abortion, it is important to reduce stigma against women who have had abortions, which can prevent them from seeking or obtaining proper care.
- 3** *Underlying health conditions.* Women living with HIV have an eight-times-greater risk of death in pregnancy than HIV negative women, and an increased risk of acquiring other infections during pregnancy, childbirth, and the postpartum period.^{9,10}

- 4 *Disrespect and abuse.* Women choose to give birth at home not just because they live too far from health facilities or because they can't afford treatment, but because they have experienced (or fear they will experience) humiliation, maltreatment, or discriminatory and substandard care.¹¹
- 5 *Human rights violations.* Early marriage, female genital cutting, and other forms of gender-based violence vastly increase the health risks in pregnancy and childbirth.^{12,13}
- 6 *Weak health systems.* In most countries with high maternal mortality ratios, health workers are poorly trained and inadequately paid, facilities lack access to basic equipment and commodities, and infrastructure such as roads, electricity, and sanitation are unreliable.¹⁴

U.S. AND GLOBAL EFFORTS TO ADVANCE MATERNAL HEALTH FACE 6 KEY POLICY CHALLENGES.

- 1 *Integration of programs and funding streams is essential for advancing maternal health, but there are multiple impediments to doing so.* Bureaucratic fragmentation and stovepiping of resources make it difficult to create cohesive and effective programs.
- 2 *Progress is not sustainable without country ownership, but countries may not prioritize maternal health or might not choose the most effective interventions.* Donor priorities may or may not match up with those of partner governments, and country plans do not always reflect the interests of women and girls.
- 3 *There are no quick fixes for advancing maternal health.* While child health interventions tend to be workable in places where health systems are under-resourced and dysfunctional, maternal health interventions tend to be more complicated.
- 4 *The most important and effective maternal health interventions are highly politicized.* Family planning-related restrictions on U.S. foreign assistance and their expansive interpretation have created a chilling effect on sexual and reproductive health and rights programs overseas.
- 5 *Just because you build it, doesn't mean they will come.* Improvements in facilities, training, medicine, and technology have not always led to hoped-for reductions in maternal mortality because they don't reach all women who need care.
- 6 *If women are not valued, their needs will not be prioritized.* Women, adolescents, and girls must be treated as more than recipients of health care. They must be engaged and empowered as agents of change.

INTRODUCTION

The world has recognized that ending preventable maternal mortality is not only imperative, but achievable. Together, nations have committed themselves to eliminating preventable causes of death among pregnant women and mothers by 2035.

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A world that is safe for mothers requires that women are able to choose whether and when to become pregnant, as well as where and how to give birth. Women must feel confident of receiving high-quality, non-judgmental, non-discriminatory, and non-abusive care from health professionals. They must have access to health facilities that are properly staffed, maintained, equipped, and stocked with medicines. And they must have the financial, logistical, and decision-making power to avail themselves of the necessary care.

Despite impressive gains in maternal health over the past 15 years, most of this vision remains distant. Statistically, becoming pregnant is the most dangerous thing a woman does in her lifetime, and 289,000 women die each year during pregnancy and childbirth.¹⁵ The global goal for reducing maternal mortality by three quarters between 1990 and 2015 — one of eight Millennium Development Goals (MDGs) adopted by the world's leaders in 2000 — will not be met.¹⁶ Progress has been extremely uneven across regions, often leaving out the poorest and most marginalized women and overlooking the special needs of girls and adolescents. Of the 75 countries where 95 percent of preventable maternal, newborn, and child deaths occur, only 20 countries are on track to meet the maternal mortality goal, and only six out of the 20 are in sub-Saharan Africa.¹⁷ Early marriage, female genital cutting (FGC), and restricted access to family planning information and services remain particular concerns for girls.

The reason progress is lagging on maternal health is straightforward: women are not getting the care they need. According to the Guttmacher Institute, of the 125 million women around the world who give birth each year, 54 million make fewer than four antenatal visits (the minimum recommended by the World Health Organization), 43 million do not deliver their babies in a health facility, 21 million experience major obstetric complications but do not receive care, 33 million have newborns with health complications who do not receive care, and 1.5 million are living with HIV—more than one-third of whom are not receiving antiretroviral treatment.¹⁸ In some countries, more than half of the poorest mothers and children received two or fewer of the eight preventive interventions that are deemed essential for maternal health.¹⁹

The failure to take effective action is a violation of women's rights. The WHO has recognized that “women's reproductive health risks are not mere misfortunes and unavoidable natural disadvantages of pregnancy, but, rather, injustices that societies are able and obligated to remedy.”²⁰

Providing access to affordable, high quality, respectful maternity care is not a matter of preferential treatment for women; it is recognition that the failure to do so is a form of discrimination against women. There is no comparable threat to the health of men.²¹

As Mahmoud Fathalla, Chair of the WHO Advisory Committee on Health Research, noted, “Women are not dying of diseases we cannot treat ... they are dying because societies have yet to make the decision that their lives are worth saving.”²²

PART I: CAUSES OF MATERNAL DEATH AND DISABILITY

The majority of maternal deaths are due to four direct causes: hemorrhage (27%), hypertension (14%), sepsis (11%), and unsafe abortion (8%).²³ For most complications of pregnancy and childbirth, simple and relatively inexpensive interventions are available. However, six major factors increase the need for, or reduce the effectiveness of, emergency obstetric care.

1 UNMET NEED FOR FAMILY PLANNING.

By far, the single most important way of reducing maternal mortality and morbidity is through access to voluntary family planning. The U.S. Agency for International Development (USAID) has called family planning “one of the most effective interventions in the history of public health,”²⁴ and estimates that meeting women’s need for contraceptives would save the lives of approximately 80,000 women and 1.1 million infants annually.²⁵ Voluntary family planning is just as important for women who want to have children as for women who don’t, because spacing pregnancies so that there are at least two years between births, timing them to occur between the ages of 18 and 35, and avoiding more than four births reduce the health risks to mother and newborn.²⁶

2 UNSAFE ABORTION.

More than half of the 36 million abortions that are performed around the world each year — a total of 20 million — are performed either by persons lacking proper training or in settings lacking proper hygiene, supplies, and equipment which is why they are considered “unsafe.”²⁷ About 40% of these unsafe abortions result in complications that require medical care in a facility, but only about three-fifths of those who need care receive it.²⁸ Because stigma often prevents women who have had abortions from seeking or obtaining proper care, researchers have argued that “the underlying causes of morbidity and mortality from unsafe abortion today are not blood loss and infection but, rather, apathy and disdain toward women.”²⁹

3 UNDERLYING HEALTH CONDITIONS.

Diseases and underlying health conditions that complicate pregnancy, such as malaria, anemia, malnutrition, and HIV, are responsible for an estimated 27.5% of maternal deaths.³⁰ Unlike direct obstetric causes of death, which tend to take place immediately around childbirth, these illnesses often take the lives of women well before or well after delivery. Of these conditions, HIV/AIDS is the world’s single leading cause of death for women of reproductive age.³¹ Women living with HIV not only have an eight-fold greater risk of maternal mortality, but also an increased risk of acquiring other infections during pregnancy, childbirth, and the postpartum period.³² Of the 1.5 million pregnant women living with HIV, 38% receive no antiretroviral medication at all, and of those who do receive it, nearly 60% are receiving care only to prevent mother-to-child transmission (PMTCT).³³

4 DISRESPECT AND ABUSE.

Experts agree that one of the key strategies for reducing maternal mortality is to increase the proportion of women who either deliver their babies in health facilities or are attended by skilled birth attendants. However, merely establishing more health facilities and training more birth attendants does not guarantee that women will utilize them. A litany of documented violations of the rights of pregnant women and mothers prevent women from seeking and receiving proper care: physical and verbal abuse, humiliation, non-consented and non-confidential care, discrimination, abandonment of care,

and detention of mother and newborn in facilities.³⁴ Rather than being “a phenomenon of a few bad apples,” say leading researchers, disrespect and abuse “runs wide and deep within the maternity services of many countries.”³⁵

5 HUMAN RIGHTS VIOLATIONS.

Early marriage is one of the most dangerous practices for girls, because pregnancy before the age of 18 is linked with increased risk of obstetric fistula and life-threatening complications, as well as higher rates of newborn and child death.³⁶ Female genital cutting (FGC) is associated with prolonged labor, hemorrhage, and adverse obstetric outcomes.³⁷ Violence against pregnant women increases the likelihood of miscarriage, stillbirth, and low-birth-weight babies.³⁸ The risks of forced marriage, trafficking for the purpose of sex, and rape are magnified during conflict and disaster, when women and girls are especially vulnerable due to the loss of homes, livelihoods, and support networks.

6 WEAK HEALTH SYSTEMS.

In most countries with high maternal mortality ratios, there is a shortage of well-trained doctors, nurses, and community health workers. Facilities often lack access to lifesaving commodities and basic medical equipment. Female health workers in particular tend to be poorly paid, forced to work long hours in unsafe, isolated and stressful environments, and treated without respect.³⁹ Corrupt or ineffective management, inadequate budgets, limited recordkeeping, absence of data, and poor infrastructure — including a lack of clean water and sanitation, impassable roads, and unreliable electricity — keep health systems from functioning properly.

PART II: THE GLOBAL RESPONSE

To help developing countries meet their obligations to advance maternal health, the United States and the international community have established a number of different strategic campaigns, financing mechanisms, and organizational structures. Although these efforts are interrelated and complementary, they are often separately conceived and administered.

INTERNATIONAL AND MULTILATERAL EFFORTS

Building on the world's commitment, through the MDGs, to reduce maternal and child deaths, several international campaigns and initiatives have been established to speed progress towards meeting the maternal health targets.

In September 2010, U.N. Secretary General Ban Ki-moon launched a movement known as *Every Woman Every Child* to bring together governments, philanthropic institutions, United Nations agencies, businesses, and civil society organizations to put into action a *Global Strategy for Women's and Children's Health*.⁴⁰ Under the overall rubric of *Every Woman Every Child*, a variety of commissions, working groups and steering committees have been created to measure progress, identify promising innovations, and ensure coordination and accountability. The movement also resulted in the creation of the *Every Newborn Action Plan*, which provides a roadmap and joint action plan for putting the Global Strategy into action with respect to saving newborn lives.⁴¹

Also in 2010, the G8 issued the *Muskoka Declaration*, pledging an additional \$5 billion over 5 years to prevent 1.3 million child deaths, avert 64,000 maternal deaths, and expand access to modern methods of family planning by an additional 12 million couples, all by 2015.⁴²

2012 saw the initiation of *Family Planning 2020*, a global partnership to enable 120 million more women and girls to use contraceptives by 2020,⁴³ as well as the issuance of *A Call to Action*, a global pledge to end preventable child deaths, which has been signed by over 178 governments. It was subsequently expanded to *A Promise Renewed*, which aims to end preventable child, maternal, and newborn deaths by 2035.⁴⁴

Most recently, in July 2015, the World Bank and several bilateral donors, including the United States, launched a Global Financing Facility in support of *Every Woman Every Child*, with \$12 billion in funding from a wide variety of public and private sources.⁴⁵

UNITED STATES GOVERNMENT STRATEGIES AND INITIATIVES

By galvanizing the call for an end to preventable maternal, newborn, and child deaths by 2035, the United States has exercised international leadership to meet and exceed the MDG targets. USAID, under the direction of then-Administrator Raj Shah, laid the foundation for progress with improved data collection, regular portfolio reviews, and evidence-based strategies for transformational change.

In June 2014, USAID laid out its *Vision for Action* on preventing maternal mortality, which focuses on 24 countries that account for 70 percent of maternal deaths.⁴⁶ The *Vision for Action* seeks to incorporate the best practices and lessons learned in recent years, such as expanding the focus on indirect causes of mortality (i.e., HIV/AIDS, malaria, malnutrition), ensuring quality and respectful care, moving toward universal health coverage, partnering with the private sector, and supporting

accountability measures. It also selects nine maternal health indicators, for which baselines are measured and time-bound targets are set, and identifies 10 “strategic drivers” that will enable progress towards achieving these targets.

In January 2015, USAID followed up with a compilation of evidence for its approach, laying out the main causes of maternal mortality and morbidity and the most effective interventions for each.⁴⁷ USAID has also issued *Acting on the Call* reports in 2014 and 2015, which document country-by-country commitments and targets for preventing child and maternal deaths.⁴⁸ In conjunction with the July 2015 Financing for Development conference, USAID released an innovative *Financing Framework to End Preventable Child and Maternal Deaths*, which identifies a broad range of private and public mechanisms and financial tools that can be used to solve particular maternal and child health care resource gaps.⁴⁹

In addition to these strategies and action plans, the United States carries out a number of related programs and initiatives that aim to advance maternal health. In December 2014, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) announced a \$210 million partnership with the Bill & Melinda Gates Foundation and the Nike Foundation, known as the *DREAMS Initiative*,⁵⁰ to reduce new HIV infections in adolescent girls and young women living in high-burden areas by 25% in 2016 and 40% by 2017.

Saving Mothers, Giving Life is a public-private partnership launched by then-Secretary of State Clinton in 2012 to test an integrated approach to increasing facility-based childbirth in two pilot countries, Uganda and Zambia, over five years. The program entered its second phase in August 2014, expanding into new districts and increasing attention to newborns, and is now being coordinated by USAID.⁵¹

Saving Lives at Birth is one of USAID’s signature “grand challenges for development,” seeking groundbreaking innovations that can leapfrog conventional approaches in order to reach pregnant women and newborns in the hardest-to-reach places. Its search for “off the beaten track” solutions that are low-cost, effective, scalable, and measurable is now in its fifth round, providing seed grants and awards for transition to scale.⁵² In July 2015, 17 new award nominees were announced. Nominees included the University of Nairobi for a rewards system to encourage antenatal care attendance, and Massachusetts-based Diagnostics for All for a low-cost, rapid test for anemia, HIV, hepatitis B, and syphilis.⁵³

In addition to these partnerships and special initiatives, the routine work of PEPFAR, the President’s Malaria Initiative, Feed the Future, USAID’s Neglected Tropical Disease Program, and USAID programs for water, sanitation and hygiene, education, democracy, economic empowerment and gender equality, among others, all have important benefits for maternal health.

U.S. GOVERNMENT ROLES AND RESPONSIBILITIES

USAID is the primary U.S. government agency responsible for promoting maternal, newborn, and child health and sexual and reproductive health and rights in development. It leads policy formulation, engages with multilateral institutions and other bilateral donors, prepares strategies, provides funding, reports on progress, and monitors and evaluates results. Most of its activities are carried out by contractors and grantees, both U.S.-headquartered and locally-based, and in a limited number of cases USAID provides direct funding to foreign government ministries (usually in the form of program reimbursements). USAID generally seeks to incentivize policy change, build local capacity (of national and local governments as well as civil society organizations), and support the development of accountable systems and processes, rather than to deliver specific commodities or services to individuals and communities.

Most of USAID’s maternal health work is carried out through its country missions, with the support of the Washington, D.C.-based Global Health Bureau, and its offices for Maternal and Child Health (MCH) and Population and Reproductive Health (PRH). MCH and PRH receive different streams of funding, which are specified by Congress, and maternal and child health money is not used for family planning.

In addition, several offices within USAID’s Democracy, Conflict and Humanitarian Assistance Bureau (DCHA) play important roles in saving the lives of women, newborns, and children: the Office of Foreign Disaster Assistance (OFDA), which leads in humanitarian relief operations and responds to the needs of internally displaced persons (IDPs); the Office of Transition Initiatives (OTI), which provides short-term assistance in countries transitioning to peace and democracy; and the Office of Food for Peace (FFP), which delivers emergency food aid. Each of these offices receives its own dedicated funding, none of which is governed by maternal health strategies or specifically allotted for maternal health.

At the State Department, one of the central goals of the Bureau for Population, Refugees and Migration (PRM) is “to promote healthy populations by supporting sexual and reproductive health and reproductive rights, voluntary family planning, women’s empowerment, development, and efforts to combat HIV/AIDS.”⁵⁴ Although PRM plays an important role in international policy-setting, it does not do much direct programmatic work. Most of its funds flow through international organizations such as the U.N. High Commissioner for Refugees (UNHCR), the U.N. Population Fund (UNFPA), and the International Committee of the Red Cross (ICRC) to support their reproductive health work in developing countries and their specific activities in support of refugees. PRM is not subject to USAID’s “Vision for Action,” but works with USAID’s humanitarian bureau on addressing gender-based violence in humanitarian emergencies.

The State Department’s Office of the U.S. Global AIDS Coordinator (OGAC), is responsible for managing the PEPFAR program. It receives its own budget for combatting HIV/AIDS, and transfers the money to various agencies that actually implement the activities, including USAID, the Centers for Disease Control (CDC), and the Department of Defense (DOD).

Although PEPFAR is a data and evidence-driven program, none of its global targets relate directly to preventing maternal mortality. It has, however, played an important role in pushing the global community to support antiretroviral therapy (ART) for all HIV-infected pregnant women and to continue that treatment for life (a guideline known as Option B+).⁵⁵ In addition, through its DREAMS Initiative, PEPFAR seeks to reduce HIV among adolescent girls, which will significantly advance maternal health. The overall budget for HIV/AIDS prevention and treatment is roughly seven times USAID’s budget for maternal and child health.

The Centers for Disease Control (CDC) and National Institutes of Health (NIH) address global maternal health by providing scientific and technical assistance, supporting research collaboration, and conducting disease surveillance and response. Many of their global programs are financed by the State Department and USAID, while their core funding comes from other sources.

Finally, a range of other federal departments and agencies, including DOD, Department of Health and Human Services, Department of Agriculture, Millennium Challenge Corporation, Peace Corps, U.S. African Development Foundation, and Inter-American Foundation, support programs related to maternal health.

In sum, there are many agencies and offices whose work significantly affects global maternal health, but they each have separate budgets, separate priorities and initiatives, separate strategies and planning processes, and separate ways of operating. They are not always aware of what the others are doing on maternal health and do not consistently coordinate their efforts. The whole-of-government commitment to ending preventable child and maternal deaths, however, is designed to improve intra- and inter-agency communication and planning.

U.S. FUNDING AND PROGRAMS

U.S. government funding for global maternal health programs is made available through several different budget accounts, under the control of various congressional committees and subcommittees. Overall funding for U.S. global health programs (including funding through the State Department, USAID, CDC, NIH and DOD) has remained relatively steady at the level of \$10 billion per year since FY 2010,⁵⁶ of which approximately \$8.4 billion is contained in the budgets for the Department of State and USAID.⁵⁷ Of the \$8.4 billion, the largest proportion — about 70% — is for HIV/AIDS prevention and treatment.

Funding for maternal and child health represents approximately 10% of the entire global health budget, although it has been growing both in absolute terms and as a proportion of total U.S. global health funding. The maternal and child health budget (counting the budgets at USAID and the CDC, as well as contributions to UNICEF, but excluding nutrition) rose from \$936 million in FY 2010 (9% of U.S. global health funding) to \$1.143 billion in FY 2015 (11% of U.S. global health funding).⁵⁸

Of all the global health programs for FY 2016, President Obama requested the largest increase for maternal and child health (up \$55 million, an increase of 8%), followed by family planning and reproductive health (up \$14 million, an increase of 3%), whereas most other health categories were reduced.⁵⁹ Overall global health funding was reduced by 3.2% in the International Affairs budget request, with bilateral PEPFAR funding remaining flat but an 18% cut in the U.S. contribution to the Global Fund to Fight AIDS, TB and Malaria.⁶⁰ Preliminary congressional action, as of July 2015, resulted in significant changes to this request. The House Appropriations Committee increased maternal and child health funding by more than \$100 million above the President's request, but did so by making a nearly 25% cut in family planning. The Senate Appropriations Committee adopted the President's requested increase for family planning, but returned maternal and child health to the lower FY 2015 levels.⁶¹ Both Committees restored funding for the Global Fund, and for overall global health programs, to at least FY 2015-enacted levels.⁶²

It is very difficult to estimate what proportion of maternal and child health funds are used for interventions specifically directed at the health of pregnant women and mothers. This is partly because most interventions have interrelated impacts on maternal, newborn, and child health, and partly because detailed, project-level data is not available for analysis. However, we do know that 25-30% of maternal and child health resources are for a contribution to the Global Alliance for Vaccines and Immunizations (Gavi), for the introduction of new vaccines that have the greatest potential for additional impact on child survival.⁶³ Another 6-9% is devoted to polio eradication, which typically strikes children and is combated through immunization campaigns and coverage.⁶⁴ Choosing where to focus the remaining funds is a delicate balance among political priorities, cost per lives saved, and partnership opportunities.

PART III: POLICY ISSUES AND CHALLENGES

The United States and the international community are aware of the impediments to advancing maternal health in developing countries, and have sought to address them, with varying degrees of success, in their global strategies and action plans. However, donors have paid less attention to the political, financial, and bureaucratic factors that detract from the effectiveness of their own policies, programs, and strategies. Six key dilemmas require further consideration:

1. INTEGRATION OF PROGRAMS AND FUNDING STREAMS IS ESSENTIAL FOR ADVANCING MATERNAL HEALTH, BUT THERE ARE MULTIPLE IMPEDIMENTS TO DOING SO.

Perhaps the greatest challenge for maternal health programming is bringing together the wide range of agencies, strategies, programs, and budgets into one cohesive whole, without stifling innovation and flexibility or creating bureaucratic delays. It requires finding the right balance between interventions that are specifically targeted at pregnant women and newborns, and those that have a more pronounced impact on women, children, and adolescents. It means integrating long-term development programs with emergency assistance, and disease-specific efforts with other health and non-health interventions. Importantly, it means weaving together separate and competing budgets at a time when resources are scarce and sometimes under attack.

Maternal, newborn, child

The entire field of family health is structured according to somewhat arbitrary definitions and cutoffs that leave gaps, overlaps, and inconsistencies. For instance, the WHO defines “maternal” as the period from inception of pregnancy to 42 days after childbirth or termination of pregnancy, while “newborn” means the first 28 days of life. “Child” refers only to children under 5 (including newborns), and “adolescent” to individuals aged 10-19 (or 15-19 in the case of adolescent pregnancy).⁶⁵ Thus women who are trying to become pregnant, or may become pregnant, are not a focus of attention in maternal health programs since they don’t meet the definition of “maternal” although they are covered by family planning programs. Newborns are counted in child mortality rates, but they are not the primary targets of child survival programs, which are generally designed to address the primary causes of death for slightly older children. Meanwhile, children between the ages of 5 and 10 fall through the cracks entirely. To be fair, these definitions are derived from evidence about when the most deaths occur, but

they make it difficult to provide care and track results along an uninterrupted continuum.

While the key interventions for maternal health (family planning, skilled birth attendance, treatment for HIV) are somewhat distinct from those for child health (immunization, oral rehydration, antibiotics, insecticide-treated bednets), they are much more difficult to separate from those for newborn health. Yet maternal and newborn health tend to be treated as separate spheres. Donor agencies and government ministries often have different program officers or management units and



Rwanda reduced its maternal mortality rate by 77% from 2000 to 2013, while also reducing under-5 child mortality by 70%.

The decline in maternal mortality is linked to increased skilled birth attendance and improved access to voluntary family planning — both achieved by training 45,000 community health workers, implementing village-level integrated case management, and developing community-based health insurance plans that cover ambulance transport.^a

separate working groups for maternal and newborn health, and each side gives comparatively little emphasis to the other.⁶⁶

Development, humanitarian

Sixty percent of preventable maternal deaths, 53% of under-five deaths, and 45% of newborn deaths are now taking place in fragile states and humanitarian settings.⁶⁷ Yet USAID's *Vision for Action* was developed without significant participation from the offices at USAID and the State Department working in crisis and conflict zones, and does not address any special needs or considerations when working in areas outside government control. For instance, there is no mention of the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations, and no discussion of the fact that the U.S. government supports family planning and reproductive health services for refugees (people who have fled across international borders) but not for IDPs (people who have fled to other areas inside their own countries).

The lack of integration of development and humanitarian work is a problem across the board, not limited to maternal health. Developmentalists and humanitarians work in different bureaus with very different cultures and operating procedures. Despite ongoing concern, the gap between emergency response and long-term development, has only been partially filled by units such as USAID's Office of Transition Initiatives. Increasingly, humanitarian emergencies have become protracted crises, where the conditions are not ripe for sustainable development but people are left without livelihoods, social services, or control over the decisions that affect their lives for years or even decades at a time.

Departments, agencies, offices

Although ending preventable child and maternal deaths by 2035 is an Administration-wide goal, the *Vision for Action* is a guide that applies only to USAID. Certainly, USAID would like other departments and agencies to refer to it, but it neither dictates nor constrains other agencies' activities.

Since PEPFAR's primary mission is to control the HIV/AIDS epidemic, advancing maternal health is mainly a welcome secondary effect. The DREAMS Initiative was developed without meaningful input from USAID, and PEPFAR does not track specific indicators for HIV-related maternal deaths. As a matter of policy, PEPFAR does not support any method of contraception other than male and female condoms, and it takes confidence and creativity on the part of its field representatives to design programs that have a broader health impact beyond preventing and treating HIV/AIDS. PEPFAR operates in 16 countries that are not a priority focus for maternal mortality, and USAID's maternal and child health programs are carried out in 9 countries without PEPFAR-supported efforts. They overlap in 15 countries.⁶⁸

By the same token, USAID's indicators for maternal health are not integrated with HIV/AIDS or family planning. Maternal and child health programs are not required to track how well they are reaching women living with HIV, how many mothers have received postnatal family planning counseling, or the proportion of pregnant women treated for STIs. Maternal and child health funding is not used to support family planning, and reproductive health programs do not have specific maternal health goals. However, integration tends to be better at the field level, where funding streams can be woven together to build comprehensive programs if there is a mission director who makes it a priority.

Although improved data collection would help bridge some of these gaps, it is expensive and time consuming. Each additional indicator being tracked requires coordination with partners, as well as training for those who set policies, manually record the data, enter it electronically, and analyze the results. But even U.S. government agencies fail to encourage integrated programming in the individual performance metrics of staff members and operating units, and if they are not being rated on it, they are unlikely to prioritize it. As the saying goes, "what you measure is what you treasure."

To the contrary, there are strong bureaucratic incentives for working in silos. Each agency, bureau and office would like to receive credit and recognition for its own contributions and its own successes. To be assured of continued funding, each needs to choose indicators that will allow it to demonstrate progress and to attribute that progress to its own programs. In the real world, not only is it extremely difficult to sort out credit for gains, but any attempt to do so works against cooperation and creates friction among partners. It can also undermine the legitimacy of fragile governments, whose authority may be eroded by perceived over-dependence on foreign donors.

Funding streams

Of all the sources of fragmentation, the most significant is separate funding streams. Trying to build an integrated program out of multiple pots of money, each with its own priorities, indicators, legal restrictions, and managers, is like trying to put together a puzzle out of a mismatched pile of odd pieces.

Vertical funding not only undermines the principle of country ownership — since countries can only take what they are given rather than choosing what they need — but replicates itself in partner governments and in local service delivery. The source and type of funding a facility gets determines what kind of laboratories it will have, what kind of testing it does, what kind of commodities and medicines it stocks, and what kind of training its staff receives. A health clinic funded solely with PEPFAR money might not carry essential maternal health medicines or provide family planning services. And depending on the color of the money, different government ministries or offices might be responsible for overseeing separate programs in the very same facilities.

Just like in the United States, people in developing countries don't want to receive care in five different places, they want a one-stop shop, especially in rural areas. They don't want to be stigmatized by going to a facility that provides *only* HIV services or *only* family planning services. But more than a problem of separate clinics, it's a problem of clinics that are unevenly staffed and equipped, where basic services like anemia testing or anti-hypertensive treatment are left out because donors preferred the newer, shinier objects.

Ultimately, the administrative burdens associated with multiple funding streams will need to be addressed to create better integrated programs and services.⁶⁹ Donors must not only build synergies and interactions between the various disease-specific and age-specific programs, but also pay more attention to non-health interventions, such as education, gender equality, and transportation, which are critical to maternal and child health outcomes.⁷⁰ This must be done through evidence-based programs with sustainability at the core, rather than simply cramming more curricula into the same training sessions or supplying more types of medicine and equipment that providers remain ill-prepared to utilize.

2. PROGRESS IS NOT SUSTAINABLE WITHOUT COUNTRY OWNERSHIP, BUT COUNTRIES MAY NOT PRIORITIZE MATERNAL HEALTH OR MIGHT NOT CHOOSE THE MOST EFFECTIVE INTERVENTIONS.

One of the keys to sustainability — that is, to ensuring that development gains are long-lasting and can continue to grow without further assistance from donors — is enhancing country ownership. Although the term is not always well-defined, country ownership generally refers to control by developing country institutions — national and local governments, civil society organizations, and the private sector — over development priorities, implementation, and resources.⁷¹

While progress is more transformative and more enduring when countries play a leading role in their own development, following the lead of developing countries can be difficult. First, donors have their

own ideas about where development resources should be focused, and they are accountable to their own taxpayers about how foreign aid resources are spent. These ideas may or may not match up with the needs and desires of the intended beneficiaries.

Second, developing countries often interpret “country ownership” to mean “government ownership,” and their governments may not always reflect the will or the best interests of the populations they serve. Some national strategies and priority-setting processes are more inclusive than others, but even in the most participatory approaches, the voices of women and marginalized groups may not be fully heard or equally valued.

This problem is particularly acute in the area of maternal and child health, which requires addressing politicized areas such as women’s rights, women’s empowerment, and family planning. Increasingly, the governments in some developing countries are fueling a backlash against the international human rights agenda, which they portray as a foreign import or an imposition of northern values. More and more governments are closing down political space for the activities of non-governmental organizations (NGOs) by subjecting them to harsh registration requirements, limiting the legal scope of their speech and activities, and prohibiting them from receiving foreign funding.⁷² Underneath it all, some governments are philosophically opposed to the idea of gender equality and resist social change.

Third, the United States and other donors often gauge the level of country commitment to a particular goal or sector by the amount of its own resources that a partner government devotes to it. Yet given the high level of donor support for health programs, some countries have chosen to focus their own funds in other areas. In fact, over the years, donor funding for health has been growing as a percentage of overall global health spending, with developing countries shifting their own spending away from health.⁷³

Country ownership is further complicated by the fact that the authorities, resources, capacities, and budgets of those who make the policies — usually at the national level — are far greater than those of the district and local governments who are often responsible for carrying them out. In one country after the next, decentralization efforts have transferred responsibility for health care to the sub-national level, without providing the resources necessary to execute that responsibility effectively.

To ensure that women’s needs are met in country-owned programs, donors must not only recognize that there is a considerable gender influence on priorities and budgets, but help find ways to correct for it. One way is for donors to strengthen the advocacy capacity of civil society organizations, particularly those led by and working on behalf of women and girls, to support their efforts to conduct monitoring, oversight, and feedback on government performance. Another is to encourage processes like participatory budgeting, which can help to overcome structural impediments to women’s rights and ensure that women’s voices are heard.⁷⁴ In the health sector, letting patients and providers know their rights and responsibilities, and establishing mechanisms that allow patients to report grievances and providers to resolve them, could help improve facility-based care. As the authors of a landmark study on disrespect and abuse noted, “there are few examples of patient charters, complaint boxes, and processes for registering complaints by patients or “incident reports” by staff, and even fewer reports of effective enforcement of accountability mechanisms.”⁷⁵

In addition, by supporting improvements in the availability and quality of sex-disaggregated data, and by helping governments and civil society to understand and use that data, the United States can promote feedback loops that hold governments accountable to their own people and enable continuous improvement of programs.

Finally, routine monitoring and rigorous evaluation need to be made a regular part of maternal health programs. While USAID has issued a strong evaluation policy and ramped up human and financial resources for evaluation, the pressure on missions to “get money out the door” and show quick results has interfered with their ability to conduct baseline surveys and design programs that allow for valid

measurement. Moreover, program participants and beneficiaries largely have been left out of the process of determining what counts as success and whether it has been achieved.⁷⁶

3. THERE ARE NO “QUICK FIXES” FOR ADVANCING MATERNAL HEALTH.

Although this report has identified specific interventions that are important for advancing maternal health and rights, these improvements are unlikely to be successful in isolation from one another and from the broader health care environment. What ultimately is required is a strengthening of overall health systems in developing countries, from the quality and availability of services at the community level all the way through provider training and accreditation, facility management, policy formulation, and system financing at the national level. To a large extent, a country’s performance on maternal health is a good indicator of how functional its overall health system is.

To a large extent, a country’s performance on maternal health is a good indicator of how functional its overall health system is.

By contrast, child health interventions tend to be clear, discrete, and easily understandable to the lay person: immunizations; vitamin and mineral supplementation; breastfeeding; insecticide-treated nets. Many of these things can be delivered in places where health systems are under-resourced and dysfunctional because they can be administered at home, at the community level, or by health care workers with minimal training.

The challenges for health systems strengthening are many. Stovepiped funding streams provide support for targeting specific diseases, but not for broad-based systemic improvements. The health care workforce generally suffers from low pay, long hours, high stress, inadequate training, and poor working conditions. Facilities may lack dependable electricity, clean water, and protective gear, not to mention basic medications and supplies, putting workers at direct risk of injury and disease. Building the capacity of providers and facilities can be expensive and time-consuming, given the amount of training, infrastructure, and equipment that is required. Moreover, the rapid pace

of global innovation and scientific advance escalates the demands on providers to quickly adapt to new methods and technologies. With limited attention spans and one- to five-year funding cycles, donors rarely provide the kind of long-term, core support that is needed.

Much of the required progress on maternal health is dependent upon reaching “the last mile”: women in the most remote, underserved, underrepresented places. More often than not, these women are poor and live in rural areas and/or in fragile or conflict-affected states. It is more difficult and more expensive,



Cambodia undertook a systematic program to improve the utilization of maternal and newborn health services in public facilities, which contributed to a two-thirds reduction in maternal mortality since 1990. The program included 24-hour operation of health centers, additional delivery rooms and maternity waiting houses, increased antenatal care visits, and financial incentives for births attended by a skilled midwife. As a result, the proportion of pregnant women who had at least one antenatal check-up increased from 39% in 2000 to near 90% in 2010, skilled birth attendant-assisted deliveries went from 46% in 2007 to 70% in 2010, and deliveries in a health facility rose from 26% to 59% over the same period. Impressively, the poorest segment of the population increased their facility-based deliveries at twice the rate of the richest quintile.^b

on a per-person basis, to reach them than to provide the same services to poor women who live in urban settings and stable environments. This challenge is not unique to maternal health — it underlies much of the inequality found within nations and complicates global efforts to end extreme poverty.⁷⁷

4. THE MOST IMPORTANT AND EFFECTIVE MATERNAL HEALTH INTERVENTIONS HAVE BEEN HIGHLY POLITICIZED.

Saving children’s lives has never been controversial. Democrats, Republicans, and Independents alike have agreed that ending preventable child deaths ought to be a policy priority.

When it comes to maternal deaths, however, too often politics have diverted attention from the value of women’s lives.

When it comes to maternal deaths, however, too often politics have diverted attention from the value of women’s lives. Because reducing maternal mortality requires expanding access to voluntary family planning, increasing access to safe abortions, and raising the status of women, it has occupied a far less prominent place in U.S. foreign policy and U.S. foreign aid budgets, and has been actively thwarted by damaging policies.

For more than 40 years, a provision of the Foreign Assistance Act of 1961 known as the “Helms Amendment” has prohibited the use of U.S. foreign assistance funds to pay for the performance of abortions “as a method of family planning” or to “motivate or coerce” any person to practice abortions. Similarly, the Siljander Amendment, included in annual appropriations acts since 1981, prohibits the use of appropriated funds “to lobby for or against abortion.”⁷⁸

Together, these and other family planning-related restrictions on U.S. foreign assistance have contributed to an environment in which “discussion of unsafe abortion remains limited, and that of safe abortion, decidedly taboo.”⁷⁹ Even in countries where abortion is legal, USAID and its partners are discouraged from attending conferences, conducting advocacy, or providing services that have any bearing whatsoever on abortion. For instance, even though USAID is permitted to support post-abortion care, it has declined to purchase life-saving equipment for that purpose, such as manual vacuum aspiration kits for treatment of incomplete abortions.⁸⁰ Although a provision included in annual appropriations bills, known as the “Leahy Amendment,” clarifies that information and counseling about all pregnancy options is permitted, in practice this provision is often ignored.⁸¹

Another example of the way that these laws have been used to thwart free speech and effective maternal health advocacy can be seen in Kenya, where a new constitution was adopted in 2010 that provided for land and judicial reform and reined in the powers of the president. The changes were broadly supported by the United States and all Western donors. But after learning that the U.S. Embassy and some U.S. aid grantees had pressed for adoption of the new constitution, which also happened to permit abortion to save the life of the mother, several Members of Congress complained to State Department auditors that activities in favor of constitutional modernization ran afoul of the Siljander Amendment.⁸² A Government Accountability Office (GAO) investigation found that U.S. officials did not give an opinion publicly on the issue of abortion or attempt to influence that portion of the constitution, and there was no evidence that U.S.-funded civic education efforts used the abortion provisions as a rationale for voting for or against the new constitution. Even so, the report recommended that the State Department and USAID should issue specific guidelines on how to comply with the Siljander Amendment.⁸³

Politicization and fear of unwittingly violating family planning restrictions has also led successive U.S. Administrations to interpret the Helms Amendment far more broadly than the law requires. Prohibitions on the use of funds “to pay for the performance of abortions as a method of family planning” do not preclude the U.S. from supporting abortions to save the life of the woman or in cases of rape or incest, or from treating complications of unsafe abortion. Yet even pro-choice, Democratic Administrations have failed to affirm this clearly and publicly. As a result, these restrictive laws and their expansive interpretation have created a chilling effect on sexual and reproductive health programs overseas.⁸⁴

5. JUST BECAUSE YOU BUILD IT, DOESN'T MEAN THEY WILL COME.

Much of the effort to advance maternal health has been focused on the supply side: better facilities and medicines; more, and more highly-skilled birth attendants; increased availability of supplies and equipment. However, these improvements have not always led to hoped-for reductions in maternal mortality. In some cases, low-quality services have prevented facility-based care from significantly improving outcomes. Disrespect and abuse have discouraged some of the most disadvantaged groups from obtaining care. And the priority given to developing new technologies has sometimes outpaced the research on stimulating demand for them.

Quality

Increasing contact between pregnant women and health care providers, through antenatal checkups, skilled birth attendance or facility-based delivery, and postnatal care, has been one of the core objectives of global maternal health programming. Much less attention has been paid to the content of such visits and to the establishment of minimum standards of care.⁸⁵

For instance, antenatal checkups too often consist of nothing more than a cursory measurement of weight and blood pressure, without testing or treatment for HIV, TB, malaria, syphilis, or anemia. Public health facilities regularly experience stock-outs of essential maternal health commodities.⁸⁶ And some facilities are so unhygienic and under-equipped that women prefer to give birth at home.

Giving the right interventions to the right people at the right times is essential, but only the number of interventions is generally measured: how many pregnant women receive at least one antenatal checkup, how many receive at least four, how many use skilled birth attendants, how many deliver in facilities. There are no clear and consistent standards or indicators for what should happen at each of these visits, what skills a birth attendant should have, or what level of care a facility is able to provide. To reach “the last mile,” we need to know how well these interventions are serving the needs of the most marginalized and hardest-to-reach populations, such as women living with HIV, adolescents, and IDPs.

Acceptability

Knowing what works in theory is not the same as knowing what works in practice. Advancing maternal health requires not only developing improved products and technologies, but also creating demand and acceptance for them.

There are a host of structural, political, and social reasons why women do not seek the care they need. They may live too far from facilities and lack adequate transportation, they may not be aware of the risks of home-based delivery, or they may not have the financial and decision-making power within their families to seek and receive professional care. A study in Sierra Leone found that 68% of the time, the decision about where a woman delivers is made by the husband at the onset of labor.⁸⁷

Further complicating these decisions is the problem of disrespect and abuse, which discourages women from seeking the care that is available to them and diminishes the benefits of the care they receive. Despite evidence that this is a widespread problem, there is still no international consensus on how it should be scientifically defined and measured, and much work remains to be done to develop the most effective methods for reducing it.⁸⁸

The problems of poor quality of care and disrespect and abuse cannot be rectified through the construction of new facilities or the development of new medicines. They will require that countries better train, recognize, pay, empower, and support front-line health workers. They will require research on social marketing, behavior change, and methods of delivering care at the community and household level. And they highlight the need for greater attention to clarifying, publicizing, monitoring, and protecting the rights of pregnant women and mothers.

Cost-effectiveness

Science, technology, and innovation have been enormously important in saving women's lives. New medical treatments and improved methods of service delivery have brought down the cost of care and vastly improved the effectiveness of interventions. Cell phones, for instance, allow providers to better track pregnancies and provide information and support, while mobile money enables women to start their own savings and pay for their own services. Products like Uniject, a combination vaccine, needle, and syringe in a single unit, have taken the complexity out of needles and syringes, allowing even minimally trained health workers to give injections of lifesaving medicines.⁸⁹

However, there is a danger that new technologies may distract attention from simple, proven, low-cost, high-impact solutions. Commercial incentive structures do not always lend themselves toward expanding access to affordable and available medicines, such as misoprostol to treat postpartum hemorrhage, routine contraceptives, and commonly prescribed antibiotics. Female condoms, which have been shown to have good acceptability, high rates of efficacy, and unique benefits, have suffered from anemic commitment by most donors, program implementers, and governments.⁹⁰ It is much easier to build partnerships around new drugs than to do the hard work of behavior or systems modification.

Coverage

In order to save the greatest number of lives, maternal health programs have tended to concentrate their effort on the time period around labor and delivery, when the risk of death is highest.⁹¹ While this may make sense from a statistical perspective, it shortchanges the whole range of cheaper and easier preventive steps that make obstetric complications less likely. As an analogy, if the goal is to reduce deaths from heart disease, one must do far more than improve ambulance and emergency room services for treatment of heart attacks. Reducing smoking, improving diets, increasing exercise, and expanding screening for diabetes and hypertension are essential.⁹²

Broadening the continuum of care, from outreach to adolescents who may become pregnant to family planning counseling for mothers, would enable more of a preventive focus and correct the over-reliance on emergency response. Demonstrating a commitment to women's health before pregnancy and after childbirth will help to address maternal morbidities and enable a shift, as the WHO recommends, "from a system focused on emergency care for a minority of women to wellness-focused care for all."⁹³

6. IF WOMEN ARE NOT VALUED, THEIR NEEDS WILL NOT BE PRIORITIZED.

Making maternal health a priority, for developed and developing countries alike, ultimately depends on gender equality. Women and men, girls and boys must be accorded equal rights, responsibilities, and opportunities. The different behaviors, aspirations, and needs of women and men must be considered, valued and favored equally. When this happens, the process of allocating resources will be made without discrimination on the basis of gender, and imbalances in benefits available to all genders will be rectified. In most places, this seems a distant vision.

Gender equality and women's empowerment are prominent among the MDGs as well as the new Sustainable Development Goals (SDGs). MDG 3, with a goal of "Promoting Gender Equality and Empowering Women," has measured success on the grounds of eliminating gender disparity in all levels of education, as well as the share of women working outside the agricultural sector and the proportion of seats held by women in the national legislature. SDG 5, to achieve gender equality and empower all women and girls, calls for ending all forms of discrimination against all women and girls everywhere; eliminating all harmful practices, such as child, early, and forced marriage and female genital cutting; ensuring women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life; and ensuring universal access to sexual and reproductive health and reproductive rights.⁹⁴

To achieve these ambitious goals, the United States and its local and international partners will need to place a premium on women's health, women's rights, and women's capacity to become agents of change. A human rights-based approach would complement the current medical and scientific orientation by emphasizing accessibility and acceptability of health care, based on principles of participation, equity, non-discrimination, informed choice, and accountability.⁹⁵

At the implementation level, women's rights can be promoted through adjustments to the program cycle, budget sub-allocations, and results indicators. Women and girls, including those living with HIV, can be brought into the design, implementation, and evaluation of programs.⁹⁶ Childbirth can be "humanized" by training providers to be more empathetic, and by encouraging facilities to allow women their choice of birth companion and birthing position, as well as the freedom to move about and drink during labor.⁹⁷ Patients can be informed of their rights to privacy, informed consent, non-discrimination and confidentiality, and given the opportunity to report grievances and have them addressed. Maternal care services can include specialized outreach to girls, adolescents and stigmatized groups. When funds are made available for these purposes, and progress in these areas is measured, then the health and human rights of women will be better protected.

CONCLUSION

The United States and the international community have agreed on a global goal of ending preventable maternal mortality, reducing the ratio of maternal deaths to less than 70 deaths per 100,000 live births by 2030, and to less than 50 deaths per 100,000 live births by 2035.

These targets are ambitious, but achievable. To reach them, donors and developing countries alike will need to increase the amount of public and private resources made available for maternal health, and to improve the targeting and effectiveness of those resources.

We know the major causes of maternal death and disability: bleeding, high blood pressure, infections, unsafe abortion, and underlying health conditions such as HIV/AIDS. We also know specific medical interventions to address each of these causes, which is why these deaths are considered “preventable.”

However, responding to obstetric emergencies is difficult and costly. Focusing narrowly on the period around labor and childbirth means missing important opportunities to prevent complications from arising. It relies on the assumption that women in need of emergency care have the logistical, financial, and decision-making power to obtain it. And it presumes that women themselves desire and seek this care — and that, once they arrive at a facility, they will receive it in a respectful and non-discriminatory manner.

Developing countries, in partnership with the United States and the international community, have begun to address some of the rights-related aspects of maternal health. They have sought to make health care more accessible through community-based treatment options, and have begun to incorporate data and evaluations into policy decision-making and programmatic design. But there is still a distance to go.

Further advances will require that the United States and other donors take steps to reduce stovepiping of financial and human resources. This means not only enabling disease-specific funds to be used for broader health systems strengthening, but also integrating the goals and indicators of programs for maternal, newborn, and child health with each other, and with programs for family planning, HIV/AIDS, tuberculosis, malaria, neglected tropical diseases, nutrition, water and sanitation, education, human rights, democracy, women’s empowerment, and gender equality. Developmental programs and strategies must take into account the special challenges of working in conflicts and emergencies, while humanitarian programs must consider the special needs of pregnant women and mothers. To achieve sustainable impact, donors and developing countries alike must have the courage to address politically-sensitive issues such as unsafe abortions and contraceptive use in an evidence-based and compassionate way.

U.S. programs for maternal health are generally on the right track. The vision and strategy documents that are intended to guide programmatic decisions recognize the importance of all these factors and identify the key obstacles to progress. However, moving from policy to implementation is never easy. Restrictive laws and vertical funding streams make it difficult to cobble together integrated, effective programs, and in some cases even to discuss the full range of possible solutions. Despite vast improvements in the quality and quantity of data available about U.S. foreign assistance, including through the Foreign Assistance Dashboard,⁹⁸ as well as in the number, rigor, and transparency of program evaluations,⁹⁹ there is still a lack of project-level data about exactly how U.S. maternal health resources are being spent, and where the gaps are.

In bringing adequate attention and resources to bear on maternal mortality and morbidity, we must always keep in mind that medical and technical advances do not automatically translate into lives saved and disabilities averted. Women will opt against prenatal care and facility-based deliveries if they believe they will be disrespected, abused, and maltreated. Girls will be married in childhood and become pregnant before their bodies are sufficiently developed if their lives and voices are not valued, and if

they lack access to comprehensive sexuality education and voluntary family planning services. Women will continue to risk their lives to end unwanted pregnancies unless safe abortions are made widely available, and information and referrals are freely provided. To sustainably advance maternal health, the U.S. must begin by addressing the constraints embedded in its own approach, and examine whether its resources are invested in the interventions and methodologies that are likely to generate the most positive and longest-lasting results.

ACRONYMS

ART	Anti-Retroviral Therapy
CDC	United States Centers for Disease Control and Prevention
DOD	Department of Defense
FGC	Female Genital Cutting
GAO	Government Accountability Office
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IDP	Internally Displaced Person
MCH	USAID Office of Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organization
NIH	National Institutes of Health
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-To-Child Transmission (of HIV)
PRH	USAID Office of Population and Reproductive Health
PRM	State Department Bureau for Population, Refugees and Migration
STI	Sexually-Transmitted Infection
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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ABOUT CHANGE

The Center for Health and Gender Equity (CHANGE) is a U.S.-based nongovernmental organization that promotes the sexual and reproductive health and human rights of women and girls globally by shaping rights-based and just U.S. policies. CHANGE advocates for effective, evidence-based policies and increased funding for critical programs. CHANGE believes that every individual has the right to basic information, technologies, and services needed to enjoy a healthy and safe sexual and reproductive life free from coercion and preventable illness.

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