

**Summary:**  
**A Symposium on Maternal Health and Foreign Policy**  
**June 27, 2006**

More than half a million women die every year in childbirth, a startling statistic that has not dropped in nearly two decades despite global progress in reducing infant and child mortality rates. “In some countries, getting pregnant is the most dangerous thing a woman can do,” said **Isobel Coleman**, senior fellow for U.S. foreign policy and director of the U.S. Foreign Policy and Women Program at the Council on Foreign Relations. Coleman and **Laurie Garrett**, the Council’s senior fellow for global health, convened a symposium on “Maternal Health and Foreign Policy” on June 27, 2006, to explore the causes of the high number of maternal deaths and address possible solutions.

In addition to the staggering rate of global maternal mortality, some 9 million more women are seriously injured or disabled each year due to complications in pregnancy or childbirth. In the Central Plateau region of Haiti, where the average woman has 12 pregnancies in her lifetime, pregnancy-related complications are the number one cause of death for women. The risk of a woman dying in childbirth in Sierra Leone is one in six; in Vietnam it is one in 270; and in Sweden it is one in 30,000. The U.S. ratio is one in 2,500, a fairly poor ranking among the world’s wealthy nations. Despite these figures, and the UN Millennium Development Goal of reducing the global maternal mortality rate (MMR)—the number of deaths of the mother per 100,000 live births—by three-quarters by 2015, the United States allocates only about \$10 million to maternal health programs, out of the proposed 2007 United States Agency for International Development (USAID) total budget of some \$9 billion.

The symposium explored the relevance of this critical social and health issue for foreign policy. “At a time when there’s so much attention paid to global health, it’s extraordinary that in the one area where no new technology or science is needed, we’re going backwards,” Garrett said. “And tragically, this backwards movement is the result of the mistaken mixing of the issue of maternal health with abortion. We’re trying to draw attention to the gap in foreign policy caused by the world’s lack of attention to the survival of mothers,” she said.

**Lynn Freedman**, associate professor of clinical population and family health at Columbia University’s Mailman School of Public Health, and **Geeta Rao Gupta**, president of the International Center for Research on Women, worked to contextualize the issue of maternal mortality in the first session. “Why is the number of maternal deaths still so high?” Coleman asked.

The answer is complex, Freedman explained. Maternal mortality is not sensitive to factors that reduce child mortality, including improved nutrition. For women in childbirth, the essential factor is access to medical care when they need it—namely during birth. But too many women in poor countries live in rural areas far from a trained health worker who could intervene at the critical time. “We have the technical means to

address the complications that kill women. Women die because they don't have access to the services that could save them," said Freedman.

Gupta agreed, advocating against the idea that women in conservative societies don't like going to hospitals for "cultural reasons." "With everything related to gender equality, a lot of people try to argue that it's a cultural practice," she said. "Don't ever buy that. Very often, the cultural label is just a justification." If reliable, safe health services exist, women will seek them out, she argued.

The symposium's panelists agreed that the deeply ingrained prejudice against women that exists in many traditional societies—such as South Asia and Sub-Saharan Africa, where the MMR is especially high—ultimately leads to limiting their access to critical services like education and health care. "The fact that women are unequal means there is less investment in their well-being," Gupta said. "When women and young girls are not valued, they lose out from the very first step."

**Dr. Allan Rosenfield**, dean of the Mailman School of Public Health at Columbia University and author of a pioneering paper on maternal health, noted in the second session, "We have not seen dramatic advances in the last 20 years," as governments have focused their health care efforts on other areas. Rosenfield, along with panelist **Mary Robinson**, former president of Ireland and UN High Commissioner for Human Rights, further discussed recommendations for U.S. foreign policymakers and the international community.

The symposium's recommendations include:

- **Focus on long-term investments in the health systems** of poor countries, instead of looking for a "silver bullet" vaccine that will magically cure diseases like malaria and HIV/AIDs. "The mentality of donors and governments is to try to seek quick, low-cost solutions instead of committing to long-term infrastructure improvement," Gupta said. To this end, a broader array of health workers—not just doctors, who are increasingly rare in poor countries—must be trained to be able to care for women in childbirth. Health systems must be bolstered by improvements in roads and transportation options, so women can reach health services when necessary, as well as by strengthening health ministries.
- **Improve women's access to family planning tools**, including contraception. Programs that discuss family planning, contraception, or abortion are increasingly under attack around the world, partly because of U.S. policies that prevent donor funds from going to any clinic overseas that even counsels patients on the option of abortion. Yet preventing unwanted pregnancies reduces the number of abortions, and thus the number of maternal deaths from unsafe abortions, Gupta explained. "Family planning and controlling our reproductive rights is a fundamental part of women's human rights," Freedman concurred.

- **Invest in human capital** to improve not only health care, but also economic development. To critics who claim poor countries can't afford to invest in health care while pursuing economic growth, the panelists replied that those countries can't afford not to. "Countries that have succeeded in producing economic growth first made investments in human capital," Gupta said, citing India's investments in education and rural health care as a basis for its current growth. Moreover, investments in girls' education raise both the perceived and real value of women, which is likely to effect how investments are made in the services from which they benefit most.
- **Address the growing problem of "brain drain,"** specifically related to health-care workers, whose departure in droves often leaves their native countries' health systems at the point of collapse. To counter this, Rosenfield argued, "We ought to be working very hard to increase the pay scale for doctors and nurses [internationally]."
- **Eradicate the notion of women as "vessels"** for childbirth, without an inherent right to health care for themselves. Many programs in the past two decades have focused on preventing the transmission of diseases like HIV/AIDS from the mother to her child, without offering continued care for the mother. "The focus was on infant mortality, instead of maternal mortality," Rosenfield said. Garrett said that attitude has to be changed: "Women deserve equal [health care] treatment, not just to prevent orphans." Rosenfield noted many women's health advocates are now speaking of "safe motherhood" instead of "right-to-life," to expand the idea of maternal health to include more than just the abortion issue.
- **Find a common language for advocates** for the right to life of both the mother and the baby. Robinson said the debate is already shifting to include both those issues: "There's never been a point where there's so much agreement on what's to be done." She stressed that advocates on both sides of the abortion debate have the common goal of reducing abortions. Both she and Rosenfield spoke of the need to get women's health on the agenda of health ministers and in the budgets of finance ministers in order to affect real change.
- **Balance the effect of political pressure** on women's health issues. In the international arena, Garrett said, "Everything to do with women's rights and maternal health [is linked] to abortion." Robinson agreed that the political pressure on these sensitive issues has only increased: "Sadly, the political leadership in this country, because of the influence of the religious right, has played a very worrying role." Garrett also noted that interestingly, the United States has aligned with countries like Syria and Pakistan in the UN to eliminate language in international agreements that refers to women's rights to abortion, contraception, or even information about family planning. "When the United States allies itself with these countries internationally, it causes great damage," Robinson agreed.

- **Listen to the facts from people on the ground.** In response to a question about how to convince policymakers—mostly male—that maternal health is important and should be a nonpartisan issue, Rosenfield replied, “When we know that 30 percent to 40 percent of maternal mortality rates come from unsafe or failed abortions, we have to address it.” He called on the ‘silent majority’ of moderate, religious Americans to oppose the Bush administration’s tendency to make decisions based on ideological considerations instead of scientific evidence. Robinson, recalling a meeting she recently attended in Africa at which local women spoke out against the abstinence programs advocated by the Bush administration, said the challenge is getting policymakers to make decisions based on evidence from the group instead of their own beliefs. “The reality of women’s lives is the most compelling argument,” she said.