social, economic, and political determinants that are shaping their still too vulnerable lives.

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Quality, equity, and dignity for women and babies

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This *Lancet* Series on maternal health[1–6] comes just 1 year after countries committed to the Sustainable Development Goals (SDGs). The SDGs call on all stakeholders to leave no one behind in addressing the unfinished agenda for maternal and child health. The Global Strategy for Women's, Children's and Adolescents' Health (Global Strategy)[7] calls for integrated solutions to prevent maternal, newborn, and child deaths and stillbirths and to realise a world where women and children thrive and transform their communities and nations. To achieve this, we must address social determinants of maternal and newborn health, and improve access to respectful, high-quality, integrated care.

GMB Akash/Panos

As representatives of civil society organisations working with women and children, we are deeply concerned about the divergence in the burden of poor maternal health "reflecting inequities in wealth, rights, and access to care",[1] and the concomitant effect on newborn and child health, and survival and adverse birth outcomes. The health and survival of women and their babies are inextricably linked; a coordinated, integrated "continuum of care" approach that optimises the health of the mother–baby dyad is required to fully maximise the potential benefits. Linking health care for a mother and her baby promotes greater efficiency, lower costs, reduces duplication of resources, and maximises the effect on their health and survival in the same way investments in family planning and reproductive health improve health and wellbeing of women and their children.[8] The investment case is strong, since the return on investment includes not only averted deaths (maternal, newborn, and stillbirth), but also improved child neurodevelopmental outcomes and reduced maternal morbidities.[9]

There have long been calls to integrate maternal and newborn baby health priorities. A comment by Ann Starrs in *The Lancet* Every Newborn Series[10] challenged the maternal and newborn health communities "to pledge to each other that any policy, programme, or initiative focusing on either maternal or newborn health will incorporate the other as well". 2 years later, the global health community seems to have heeded that call. The 2015 Global Maternal Newborn Health Conference gave

voice to a shared vision of maternal and newborn health. Two strategies developed in the lead-up to the SDGs—the Every Newborn Action Plan and Strategies toward Ending Preventable Maternal Mortality—converged with common objectives,[11] and were incorporated into the Global Strategy.[7] The Global Financing Facility supports countries in identifying national priorities across the spectrum of reproductive, maternal, newborn, child and adolescent health (RMNCAH) and was built upon a full potential investment case.[12] *The Lancet* has also published multiple Series relating to maternal–newborn health in the past 2 years: Midwifery (2014),[13] Every Newborn (2014),[14] Ending preventable stillbirth (2016),[9] and Maternal health (2016).[1–6] Even though these Series' titles appear siloed in approach, each Series calls for integration. Evidence also indicates that women are more satisfied with a more integrated approach.[15]

With the many global strategies in place and multiple *Lancet* Series published, one wonders whether countries are effectively supported to act upon these priorities as well as respond to what women want and deserve, in terms of quality, accessible, affordable, respectful maternal and newborn health care. How can governments, UN agencies, donors, private sector organisations, civil society, and other stakeholders work with women, communities, and countries to end preventable deaths in the face of the great divergence described in this Series?

One promising development is WHO's Quality of Care Framework for Maternal and Newborn Health[16] with accompanying technical standards and guidelines for quality of care.[17] We are hopeful that the roll-out of the implementation framework—unlike the development of the framework itself—will provide opportunities to engage women and local stakeholders in the process of defining quality of care.

To this end, a new maternal–newborn health advocacy effort is underway to support implementation of the framework, influence supportive global and national policies and investments, and unify stakeholders in joint action with emphasis on the human rights-based goals of equity, universal coverage, access to quality care services, and dignity and respect for all women and babies. This effort takes up the call by Koblinsky and colleagues[6] "to advocate for increased attention to maternal–perinatal health, and ensure women's rights and agency are acknowledged, which includes involving women in their own health care". Defining of priorities at national and local levels will require the voices of women, families, and broader civil society to be a starting point and not an afterthought. Efforts to mobilise citizens' voices, such as the Citizen Hearings, will be fundamental to successful implementation.

For more on **Citizen Hearings** see http://www.citizens-post.org

This Series highlights two fundamental issues that need to be addressed to improve maternal health: quality of maternal health care for all women and access to care for those left behind. It is a call for quality, equity, and dignity. Although similar, the new WHO initiative and accompanying advocacy movement call for a unified approach—one where maternal and newborn health communities are no longer in siloes or perceived competition but rather working together on an integrated effort to improve quality, equity, and dignity for all women and babies.

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Implementation and aspiration gaps: whose view counts?


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The Lancet's Maternal Health Series[1–6] paints a sobering picture of the state of maternal health today. The Series focuses on the "mismatch between burden and coverage", which "exposes a crucial gap in quality of care"[6] and spotlights the millions of pregnant women and adolescents who never get access to services at all. But 30 years after the start of the safe motherhood initiative, this mismatch exposes something else as well: a dangerous disconnect between the way the global health community has framed problems, proposed strategies, and pushed solutions, and the lived experience of people and providers. Thus the quality and access gaps defined in the *Lancet* Series through epidemiological analysis and quantitative data could also be framed as implementation and aspiration gaps, drawing on a wider range of empirical data to speak a different truth to power.

Take the example of facility-based delivery care. The central aim of global skilled-birth-attendance strategies has been to ensure that routine births are managed in accordance with evidence-based practices and that obstetric complications are treated in facilities where emergency obstetric care (EmOC) is delivered. Whether women are driven to deliver in facilities by their own desires, by financial incentives, or even by government compulsion is often unclear—and rarely considered to matter. Seemingly, what counts is that facility-based delivery has increased, sometimes dramatically. What do women experience when they arrive at facilities ready to give birth?

Suellen Miller and colleagues[2] identify 51 high-quality global and national clinical practice guidelines issued since 2010 for routine maternity care in facilities. Focusing on middle-income countries to determine what actually transpires, they document pervasive, health-threatening deviations from those guidelines, characterised by too little, too late (insufficient appropriate care) and too much, too soon (excessive medicalisation).[2] Other recent reviews[7] round out the picture by exposing a startling range and level of disrespectful and abusive treatment, in countries both rich and poor.

Implementation gaps are not limited to the four walls of the health facility. Oona Campbell and colleagues[3] show that the indicators we in the global health community have so confidently promoted for coverage measurement at the population level often serve only to hide catastrophic failures. They say that "governments and policy makers can no longer pretend to provide life-saving care, using phrases such as skilled birth attendant and EmOC to mask poor quality".[3] Pretend is perhaps a good choice of verb. Campbell and colleagues[3] show that standardised, globally formulated strategies pressed upon countries in an attempt to make services widely available and accessible ultimately ignore the varied topographies, health-system configurations, and demographic characteristics of different countries—which makes achievement of globally determined norms at a globally determined pace manifestly unrealistic.

A view from the ground would show globally formulated strategies ignore many other things as well: different histories, governance styles, and social dynamics; minimal state capability to influence the dynamics at the periphery of the system;[8] and corrosive distrust of health systems by both the people who work for them and the people meant to benefit from them.[9] A view from the ground would show that people's interactions with maternal health services are never only about attaining health outcomes. These interactions are also about aspirations to have some control over their birth experience, to be treated with dignity and respect, and to use their choices around childbirth to signal who they are and who they want to be.[10,11]