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When a mother bleeds to death, so does the nation.

However, when a mother survives childbirth…her family, community, and country thrive.

This afternoon I want to focus my remarks on a country that has a growing maternal mortality problem.

It ranks 50th among nations in the rate of women dying while giving birth. More than 34,000 women *almost* die each year in this country from complications during pregnancy and childbirth, referred to as "near-misses." These near-misses result in severe health problems that can debilitate a woman for years.

The country I am talking about is an important focus of *Merck for Mothers*. The country I am talking about is the United States.

In developing *Merck for Mothers*, I spoke with many of the company's senior leaders. We all assumed that the project would focus on countries such as Nigeria and India, which have some of the highest numbers of maternal deaths in the world.

But at almost every meeting, someone would share a story about a wife or a daughter who nearly escaped death while giving life right here in the United States.

As our team met with community leaders in the United States the nature of the problem became clearer.

A country's maternal health system is a leading indicator of the quality of its care and each year 1,000 women die in this country.

Many of these deaths are from the preventable causes that are the focus of some of the sessions here today – diabetes, heart disease and hypertension.

African-American women are up to three times more likely to die during pregnancy and childbirth than Caucasian women – due to higher medical risks during pregnancy, as well as obstacles to receiving care.

In the U.S., one in three African-American women does not receive adequate prenatal care.

Right here in our nation's capital – D.C. ranks absolute last among states and territories for the rate women die while giving birth.

There are several barriers to accessing quality care during pregnancy. Within Latina and immigrant populations, language barriers are a major issue. Women at risk often receive inadequate treatment and are discriminated against because of a lack of insurance that has large hurdles for enrollment and reimbursement. Many women in both urban and rural areas lack access to transportation.

In the rural West, for example, some women live more than an hour's drive from a hospital with maternity care, leaving them vulnerable in the event of an obstetric emergency.

Another possible contributor to maternal mortality and morbidity in the United States is the rise in C-sections, which make up close to 32 percent of all deliveries – considerably higher than the WHO-recommended rate of 5-15 percent. Nearly half of all women who died from pregnancy and childbirth-related complications received C-sections. While a C-section can be a lifesaver, the procedure increases the risk of complications such as infection, bleeding and blood clots compared to vaginal births.

I began my medical career in New York City which has a maternal mortality rate far above the national average and even higher than Iran. Black women in New York City and women from the Caribbean in particular are more than seven times more likely to die from pregnancy-related causes than white women regardless of socio-economic status.

Some of New York City's poorest neighborhoods have maternal mortality rates almost five times greater than affluent neighborhoods in Manhattan.

In New York City, risk factors leading to pregnancy-related complications include obesity, pre-existing chronic health conditions and advanced maternal age.

This conference is about solutions.

We cannot bring down the rate of maternal mortality in the United States if we do not make progress on chronic pre-existing conditions that are the leading contributors to pregnancy-related complications and deaths.

Diabetes, obesity, asthma and cardiovascular disease are on the rise among women of all ages who are seeking prenatal care. Health providers should be speaking with women about risk factors (especially obesity) and connecting them with appropriate care.

Prenatal care must be recognized as a vital entry point for women into the greater health system. Women are often engaging with the health system for the first time as adults when they become pregnant. Their experiences in prenatal care can determine their attitude toward, and usage of, the health system from that point onward.

We also need better data to highlight systemic problems and inform changes in clinical practice at the facility level and beyond. Washington, D.C., for example does not have a maternal mortality review board and does not require mandatory reporting of maternal deaths.

A final area for our focus is the growing importance and need for community health workers. Many in this room have recognized community health workers as a critical extension of the health system and a cost-effective way to link women to care. Health workers in the community – often women themselves of reproductive age – have a unique understanding of their clients' communities and cultural sensitivity, and can optimize health care before, during and after pregnancy.

In my own daily work I am blessed with the ability to travel the world looking for new solutions. From these travels I can tell you that there are many innovations occurring outside the United States that can be saving lives here at home.

We need to look at how we can apply innovations from the developing world to our own backyard. Community health workers are using mobile technology, vouchers for family planning, emergency taxi services and other creative solutions to link women to affordable health care. These are solutions that have as much relevance in New York as they do in New Delhi.

So what is Merck doing? *Merck for Mothers* is a long-term global effort to reduce maternal mortality and save women's lives.

Merck is beginning with a 10-year commitment to help meet UN Millennium Development Goal 5, which calls for the reduction in the global maternal mortality ratio by 75 percent. Regrettably this is the United Nations' goal that is lagging more than any other.

We are applying our science and business expertise to implement a strategy that focuses on postpartum hemorrhage and preeclampsia, the two leading killers. And we are increasing access to family planning.

We are looking to speed up the development of technologies that can save women's lives. These include temperature stable oxytocin or a noninvasive screening test for anemia.

We want to accelerate access to maternal health products and care.

We also want to raise awareness about maternal mortality and make it a household topic like breast cancer and HIV/AIDS.

I am excited to share that I was Uganda last month to announce a new public-private partnership led by the U.S. Government to rapidly reduce the number of women who die during pregnancy and childbirth called *Saving Mothers, Giving Life* along with Merck, the Government of Norway, the American College of Obstetricians and Gynecologists, and the advocacy organization Every Mother Counts. We are beginning on-the-ground programs in Uganda and Zambia. The goal is to prove to the world that we can save women's lives if our efforts are focused and coordinated – and there is political will.

Let me close by applauding all of your work.

Merck is inspired by your dedication to increasing access to affordable, quality health care and eliminating health disparities.

Let's remember that a maternal death is a sentinel event – a sobering sign that a health system – in Nigeria or Washington, D.C. – is not working as it should. A maternal death is a sign that health providers, policy makers and advocates must act – urgently.

I look forward to collaborating with all of you to make the tragedy of a woman who dies while giving life a memory, rather than a crisis.

Thank you.