

validation studies²⁻⁴ in three languages; these studies showed that a high SOMS score (reflecting high ICU mobility levels) was associated with short hospital length of stay and low hospital mortality, as referred to by Guohui Li. Results from our randomised controlled trial¹ showed that an intervention designed to increase the SOMS through early, goal-directed mobilisation supported by an implementation facilitator, decreased patients' length of hospital stay and improved functional independence at hospital discharge.

Our study¹ was neither powered for, nor did we observe a statistically significant difference in mortality. Thus, it is very difficult to interpret subtle differences in the frequency counts of this outcome. For example, Li and Ayako Tada and colleagues have highlighted that a higher frequency of patients died in the intervention group. However, in the intervention group, a higher frequency of patients also had excessive APACHE scores (>35) compared with the control group (two patients vs no patients), and mean procedure severity score and Charlson Comorbidity Score admission scores tended to be higher (although not significant) as well; all of which might explain a proclivity towards higher mortality independent of the intervention in this sample. We have done extensive analyses to assess the effect of mortality on intervention effects, and these results are confirmatory. We used missing data imputation with death at 28 days imputed, and several additional sensitivity models. Importantly, our main outcomes did not change in sensitivity analyses, as shown in the appendix of our Article.¹

Li also highlights the importance of optimal pain treatment to balance analgesia and opioid-induced side-effects. In our randomised study,¹ opioid consumption did not differ between intervention and control groups.

Early after stroke, very early and aggressive mobilisation can affect neurological outcomes in patients.⁵ By

contrast, our data¹ show that in surgical patients who are critically ill with varying levels of impaired conscious state (as quantified by the Glasgow Coma Scale), SOMS-guided early, goal-directed mobilisation improved relevant outcomes such as SICU and hospital length of stay, number of delirium free days, functional mobility at hospital discharge, and the number of patients who could be discharged back home. On the basis of our data, we encourage clinicians to consider implementing a protocol for early, goal-directed mobilisation in surgical patients who are critically ill to improve patient outcomes.

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Setting maternal mortality targets for the SDGs

The Global Burden of Disease (GBD) 2015 Article on maternal mortality by Nicholas Kassebaum and colleagues (Oct 8, p 1775)¹ contains a serious error reflecting a basic misunderstanding of the Sustainable Development Goal (SDG) target for maternal mortality, one that is potentially very dangerous to the lives of childbearing women and to the vital programmes around the world that support them.

The report states that "only ten countries achieved MDG 5, but 122 of 195 countries have already met SDG 3.1". This is a dangerous and inaccurate interpretation of the global goal. The SDG target is a global target, not a country target. The SDG target states: "By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 livebirths". The 2015 global maternal mortality ratio was estimated to be 216 maternal deaths per 100 000 livebirths (80% UI 207-249) by the Maternal Mortality Estimation Interagency group led by WHO;² and 196 maternal deaths per 100 000 livebirths (95% UI 173-224) by the GBD 2015 report.¹

The SDG target is a global average maternal mortality ratio of less than 70 maternal deaths per 100 000 livebirths by 2030. To achieve the global target for maternal mortality reduction requires every country to reduce its national maternal mortality ratio from baseline by two-thirds in that timeframe. It is probably safe to assume that no country has succeeded in reducing its maternal mortality ratio by two-thirds since the SDGs were launched in September, 2015.

A similar error appears in the discussion section of a paper in *The Lancet* Maternal Health Series³ by Campbell and colleagues, which reads: “Countries where hospital births are nearly universal are approaching, or are already below, the new 2030 maternal mortality ratio target of 70 per 100 000 livebirths or less, irrespective of the front-line cadre”.

The maternal mortality ratio targets adopted by both the SDGs and the Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–30 come from the goal-setting maternal health report, “Strategies toward Ending Preventable Maternal Mortality” published in 2015. The targets and detailed guidance about their implications for national target-setting are available in that report.⁴

Understanding the distinction between the global and national targets is crucial. The global target alone is not useful for bringing about country-level change. Countries need to set national targets to achieve at least a reduction by two-thirds in maternal deaths and thus contribute to meeting the global goal.

The erroneous suggestion that over 60% of countries in the world have already achieved the SDG target for maternal mortality ratio when in fact none has, and when there remains much to be done to improve maternal survival and equity in the risk of death in even some of the highest-income countries, has potentially catastrophic implications. If country decision makers and global development partners mistakenly decide that maternal health and survival are no longer a high priority based on this misinterpretation of the SDG target for maternal mortality reduction published in the prominent report of the GBD 2015, women’s lives will be compromised. It is imperative that *The Lancet* publish a correction of these serious errors.

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Authors’ reply

A vast unfinished agenda in maternal and reproductive health remains. Tremendous inequity in maternal mortality is evident as maternal mortality ratios range from less than one death per 100 000 livebirths in Iceland to 1763 (95% UI 351–4693) in the Central African Republic.¹ Development of the Sustainable Development Goals (SDGs) specifically focused on reducing this inequity, based on the notion that sustained and focused investment toward specific targets could facilitate progress toward a grand convergence in health. The SDG declaration preamble states that, “as we embark on this collective journey, we pledge that no one will be left behind.”² SDG targets were

carefully chosen based on reaching convergence with health outcomes found in select member countries of the Organisation for Economic Co-operation and Development with substantial improvement.³ For maternal mortality ratio, this resulted in a shift from a relative target of the Millennium Development Goals (MDGs) (reduce maternal mortality ratio by three-quarters between 1990 and 2015) to an absolute target (reduce maternal mortality ratio to less than 70 deaths per 100 000 livebirths) that all countries, at minimum, should achieve. The natural endpoint of the SDG ethos is that no single woman should be confronted with an individual risk of death of more than 70 per 100 000 livebirths from maternal causes.

The alternative interpretation suggested by Jolivet and colleagues—that a global maternal mortality ratio target of 70 should be subsequently reframed (with little supporting documentation) as a relative country-level target (of two-thirds reduction)—is dangerously anti-equity and one with which we profoundly disagree. A global relative target could lead to worsening inequity. Indeed, although the global maternal mortality ratio during the MDG era declined from 282 (95% UI 264–300) in 1990 to 196 (95% UI 173–224) in 2015, the proportion of global maternal deaths in the two lowest quintiles of socio-demographic index rose from 68% to 80%.¹ The use of an absolute national-level target appropriately emphasises the worst off, which rightfully should help to focus international attention and resources on those countries who have the farthest distance to go. Reaching the absolute target does not preclude countries from continuing to improve. For example, the 2013 Declaration of Panama urges countries to do just that by ensuring that the target is met within each state or district to reduce subnational inequity.⁴

In addition to the equity repercussions, a global relative target

For the *Lancet* Series on maternal health see <http://www.thelancet.com/series/maternal-health-2016>



Panama