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CONSIDER THESE NUMBERS:

**APPROXIMATELY 830 WOMEN** die every day from preventable causes related to pregnancy and childbirth.

99% of these deaths occur in developing countries.

60% OF WOMEN in developing countries do not receive adequate antenatal care, and 49% give birth without skilled care during labor and delivery.

50,000–100,000 WOMEN each year suffer from obstetric fistula—a preventable birth-related injury caused by labor complications.

EVIDENCE-BASED PROGRAMS AND POLICIES CAN HELP END PREVENTABLE MATERNAL AND CHILD DEATHS.

Expanding access to proven treatments for pre-eclampsia/eclampsia can save the lives of more than **42,000** pregnant women and their babies every year.

Increasing delivery of respectful, high-quality maternity care increases the likelihood that pregnant women will access antenatal, skilled birth, and postnatal services.

Meeting women’s family planning needs and ensuring that all pregnant women and newborns receive adequate care would reduce maternal deaths by 68% and newborn deaths by 77%.

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**SOURCES:**


BUILDING THE EVIDENCE: WHAT WORKS TO IMPROVE MATERNAL AND NEWBORN HEALTH

by Julia Bunting, OBE

Improving access to quality maternal and newborn health (MNH) services

National governments and the global health community have made great strides in saving the lives and safeguarding the health of mothers and babies. These efforts continue under the Sustainable Development Goals and other major international commitments, and today the focus is on ending preventable maternal and newborn deaths—that is, those deaths that occur as a result of treatable complications related to pregnancy, childbirth, and the postnatal period. This means ensuring that pregnant women, new mothers, and their infants have access to quality MNH services and to proven interventions when things go wrong—particularly in low-resource settings, where nearly all of these preventable deaths occur.

Leading the way in researching and promoting lifesaving interventions

For decades, the Population Council has identified and addressed some of the biggest barriers to delivering safe, effective, and high-quality MNH services in developing countries. In this issue of Momentum, you will read about how we are increasing the use of lifesaving interventions for managing pre-eclampsia/eclampsia (page 4) and reducing unsafe abortion (page 10)—two of the leading preventable causes of maternal death in developing countries today. We are also helping to improve women’s access to treatment for fistula, a complication of childbirth that has devastating consequences for affected women (page 8).

Shifting the global conversation on MNH

The Council’s MNH work, led by Charlotte Warren (whom you will meet on page 14), is helping to shift the global conversation to highlight the importance of quality MNH care. Our groundbreaking research has led to the development of proven, replicable strategies for promoting the delivery of respectful care to women seeking MNH and other health services (page 6). As you will read on page 15, the links between delivering quality health care and empowering women and girls is what inspires Anna Nordberg to support the Council. We are also working to define reliable indicators for monitoring the quality of MNH services, which in turn will enable the global community to more effectively track MNH goals such as declines in maternal and neonatal morbidity and mortality (page 12).

Today, 30 years after the Safe Motherhood Conference in Nairobi, there is still much to do. Worldwide, approximately 830 women die every day during pregnancy and childbirth from preventable causes—and when a mother dies, her baby is at increased risk of dying, too. The Council is generating ideas and rigorously testing solutions to make pregnancy, childbirth, and the postnatal period safer for women and their infants.

As a mother of three young children, I know the value of having access to skilled care and quality, respectful services. It’s something every woman in the world has a right to.

That’s why I’m so proud that the Population Council is working across the world to build the evidence for what works to improve MNH outcomes, and to translate this evidence into action.
The Population Council is helping to improve the detection and management of pre-eclampsia/eclampsia—a leading preventable cause of maternal death in low-resource settings.

THE ISSUE  Pre-eclampsia (PE) involves an unhealthy rise of blood pressure during pregnancy and can proceed to a life-threatening condition that, without proper management, results in seizures (eclampsia) and death. Eclampsia (E) remains the second leading cause of maternal death worldwide, accounting for 14% of the 300,000 maternal deaths that occur each year. PE/E is also a leading cause of preterm birth. The majority of these deaths can be prevented with early detection and appropriate management—but in many low-resource settings, health providers do not know how to identify women at risk for PE/E or how to manage the condition due to a lack of training and national guidelines. In addition, although the World Health Organization recommends magnesium sulfate (MgSO₄) as the safest, most effective, and lowest-cost treatment for PE/E, its availability and correct use in developing countries varies widely.

THE PROGRESS  For almost 10 years, the Council has been working to increase health providers’ ability to identify and manage PE/E with MgSO₄ and other drugs in regions where access to lifesaving maternal and newborn health (MNH) care is limited. Efforts are multifaceted and conducted in partnership with health ministry officials, national health professional societies, and other stakeholders to identify and address critical policy, program, and cost barriers to expanding the use of MgSO₄ and other lifesaving commodities. Under the Ending Eclampsia project, which began in 2014, the Council and partners in Bangladesh, Ethiopia, Nigeria, and Pakistan are scaling up successful strategies and strengthening the capacity of public facilities to identify women at risk for PE/E, manage high blood pressure during pregnancy to prevent maternal and newborn deaths, and use MgSO₄ and other drugs to treat PE/E and improve MNH outcomes.

THE IMPACT  The Council and partners identified and addressed barriers at multiple levels in Nigeria—including working with policy champions to get MgSO₄ included on the country’s essential medicines list and developing a training curriculum that is now used in more than 160 schools of nursing, midwifery, and health technology nationwide—leading to a 40% reduction in maternal deaths due to PE/E in intervention zones. In Bangladesh, the Council trained service providers to identify and manage PE/E and established a functional referral system to improve timely treatment. In addition to scaling up these and other strategies in project countries, the project is raising awareness about the importance of antenatal care by engaging with key stakeholders including community leaders, health workers, ministry officials, and families of pregnant women. The project also facilitates knowledge-sharing through a global coalition to inform strategies for improving detection and management of PE/E as part of routine maternal health care.

PARTNERS  National and State Ministries of Health and professional associations for obstetricians/gynecologists, nurses, and midwives within project countries; “Eclampsia Network” international partners

DONORS  USAID Office of Health, Infectious Diseases, and Nutrition; John D. and Catherine T. MacArthur Foundation
THE ISSUE  Women in low-resource settings face many barriers when seeking maternal and reproductive care in health facilities. One such barrier is mistreatment or disrespect and abuse (D&A) by health providers and other staff. This can include discrimination, detention, nonconfidential care, procedures performed without a woman’s consent, abandonment or denial of care, and physical or verbal abuse. Not only do these practices violate women’s human rights, they also increase the risk of poor health outcomes by discouraging women from giving birth at a health facility or obtaining other needed health services. While D&A appears to be widespread, its prevalence and contributing factors are not well documented, making it difficult to design and implement effective interventions.

THE PROGRESS  Population Council researchers in Kenya and Senegal developed tools for assessing D&A and understanding what drives these practices in different settings. In Kenya, the Heshima project (meaning “dignified” in Kiswahili) found that one in five women experienced some form of D&A during childbirth in a health facility. The Council and partners then developed and implemented the Respectful Maternity Care (RMC) resource package, which includes informational materials and tools for leading workshops with health providers and communities to raise awareness and change attitudes and behaviors. In Senegal, Council researchers conducted an exploratory study examining D&A among women seeking reproductive health services in urban public health facilities to identify possible areas for intervention.

THE IMPACT  Council research raised awareness about D&A and health rights in Kenyan and Senegalese communities and increased cooperation in health facilities for improved care. Use of the RMC resource package in Kenya led to a 40–50% reduction in D&A among women during childbirth at health facilities. Findings also informed revisions to Kenya’s national guidelines for nursing and maternal and newborn health (MNH), and Council researchers worked with policymakers to develop a new maternal health bill to advocate for better MNH service delivery. Internationally, the RMC resource package has been adapted for use by other partners including USAID’s flagship Maternal and Child Survival Program and White Ribbon Alliance–Nigeria. In Senegal, the Council’s study identified key areas where future interventions could be targeted to reduce D&A in reproductive health settings. The Council’s research was instrumental in the development of the RMC Charter on the Universal Rights of Childbearing Women and informed the World Health Organization’s 2014 statement on the Prevention and Elimination of Disrespect and Abuse during Childbirth.

PARTNERS  Kenya Ministry of Health; Kenya Federation of Women Lawyers; National Nurses Association of Kenya–Midwives’ Chapter; Senegal Ministry of Health; White Ribbon Alliance

DONORS  USAID, through URC’s Translating Research into Action (TRAction) Project; International Development Research Centre; William and Flora Hewlett Foundation

PROMOTING RESPECTFUL MATERNAL AND REPRODUCTIVE HEALTH CARE

Population Council research is shedding light on disrespectful and abusive care in maternal and reproductive health settings and identifying low-cost, replicable strategies to address this problem.
TIMELY TREATMENT FOR OBSTETRIC FISTULA: IMPROVING MATERNAL HEALTH OUTCOMES

The Population Council is conducting research and testing solutions to reduce barriers for women seeking treatment for obstetric fistula.

THE ISSUE  Obstetric fistula is a complication of prolonged obstructed labor without timely medical intervention that opens a hole between the vagina and the bladder or rectum, or both, through which urine and/or feces continuously leak. It is most common in low-resource settings with limited access to emergency obstetric services, and pregnant adolescents are at greater risk. An un repaired fistula can lead to lifelong ostracism and even death for affected women. While fistula is preventable and treatable, it is estimated that 1–2 million women worldwide are living with this devastating condition, and at least 50,000–100,000 new cases occur every year. There are many reasons why women may not seek treatment for their fistula—they may lack resources to pay for repair or for transportation to a clinic. There may not be a skilled fistula repair surgeon nearby, or women may not even know repair is possible.

THE PROGRESS  As a partner on the Fistula Care Plus (FC+) project, the Population Council is working to identify and reduce barriers for women seeking fistula repair in Nigeria and Uganda. In 2014, Council researchers conducted a systematic review of the barriers to fistula treatment in these settings. In general, women, their families, and even health providers had very limited awareness about obstetric fistula—its causes, characteristics, the fact that treatment is available, and where to access care. The review suggests that to increase access to fistula care, interventions must be holistic and target multiple barriers simultaneously—for example, women who feel stigmatized because of their condition may be less likely to seek treatment regardless of whether they are able to access care at a nearby facility.

THE IMPACT  Following recommendations from the Council’s review, and building on formative research conducted through FC+, targeted interventions are being developed and tested in Nigeria and Uganda to determine the most effective strategies for increasing women’s access to fistula repair. For example, can mobile phone technology make it easier to identify women living with fistula and provide transportation vouchers to facilitate their access to care? Will women be more likely to accept referrals and vouchers to fistula care centers from health providers trained to sensitively discuss the subject? By raising awareness about fistula symptoms and treatment availability among women, health providers, and the community, this project is helping to reduce stigma and increase support for affected women—thereby increasing the likelihood that women living with fistula will seek treatment for their condition.

PARTNERS  EngenderHealth; Dimagi; Direct Relief; Fistula Foundation; Nigeria Ministry of Health; Maternal Health Task Force; TERREWODE; Uganda Ministry of Health

DONOR  United States Agency for International Development (USAID)
MENSTRUAL REGULATION WITH MEDICATION: REDUCING MATERNAL MORTALITY IN BANGLADESH

The Population Council is working with the Bangladesh Directorate General of Family Planning and other partners to reduce complications of unsafe abortion by identifying and scaling up a safe, acceptable alternative.

THE ISSUE  In Bangladesh, nearly one in three pregnancies is unintended, a rate that has remained the same for more than 20 years. Each year, an estimated 1.2 million of these pregnancies are terminated either through illegal induced abortion—a key driver of maternal morbidity/mortality and associated poor outcomes for women and families—or via menstrual regulation, a government-approved method for establishing nonpregnancy up to 12 weeks after a missed period. Menstrual regulation is typically performed using manual vacuum aspiration (MVA), a procedure that is safe and low risk when performed by trained providers in hygienic conditions. Yet, over one-third of Bangladeshi women who seek menstrual regulation with MVA suffer complications due to untrained providers and unhygienic conditions—leading to preventable injury or death for thousands of women each year.

THE PROGRESS  Menstrual regulation with medication (MRM) is a safe, noninvasive alternative to MVA that has been approved in Bangladesh but has not yet been introduced in the public health system. Under the Strengthening Evidence for Programming on Unintended Pregnancy (STEP UP) project, the Council worked with the Bangladesh Directorate General of Family Planning and other partners to conduct research at 13 urban and rural health facilities to assess the safety, acceptability, and feasibility of introducing MRM in Bangladesh using the World Health Organization-approved combined regimen of mifepristone and misoprostol. Of the nearly 3,000 women who visited the intervention facilities seeking menstrual regulation services during the study period, about two-thirds opted to receive MRM versus the MVA procedure, and nearly all MRM acceptors said they would recommend MRM to others. Overall quality of services provided at the facilities was high, as was women’s compliance with the MRM regimen including follow-up care.

THE IMPACT  This study shows that women and health providers find it safe, acceptable, and feasible to introduce MRM in urban and rural health facilities in Bangladesh. Encouraged by these findings, the process is now underway to obtain approval to introduce and scale up MRM in the national family planning program. The Population Council and STEP UP partners have developed service-delivery guidelines and teaching and educational materials on MRM, and are now working to strengthen the capacity of public health facilities to roll out MRM across the country.

PARTNERS  Directorate General of Family Planning, Ministry of Health and Family Welfare, Bangladesh; Marie Stopes Bangladesh; Obstetrical and Gynecological Society of Bangladesh; and STEP UP Research Program Consortium partners: African Population and Health Research Center; International Center for Diarrhoeal Disease Research, Bangladesh; London School of Hygiene & Tropical Medicine; Marie Stopes International; and Partners in Population and Development

DONORS  UK Department for International Development; World Health Organization
Population Council researchers are developing better indicators to measure and monitor the quality of maternal and newborn health care delivery worldwide.

THE ISSUE  Delivering quality maternal and newborn health (MNH) care during childbirth and the early postnatal period is essential for reducing preventable maternal and child deaths. Researchers and decision-makers routinely track several health indicators to measure progress on global MNH goals and to identify for financing and scale-up those MNH programs that will produce the greatest impact. The health indicators most widely used to measure the quality of MNH care—births that occur in a health facility and births attended by a skilled health worker—present several challenges. First, while these indicators tell us whether women had contact with the health system, they don’t provide information about which MNH services women received (content of care) or how well the services were provided (quality of care). Also, since little is known about whether health system contact directly results in better MNH outcomes, we don’t know how helpful the indicators are for actually monitoring the factors that affect MNH globally. Finally, as current approaches to monitoring MNH care rely on women’s reports from the time of birth—which can be as long as five years prior to the interviews—women’s recall of events may not be accurate. To address these challenges, there is a growing call to change how MNH services are measured and monitored worldwide—mainly by focusing on direct measurement of the content and quality of MNH care.

THE PROGRESS  Council-trained researchers interviewed women who gave birth in public-sector health facilities in Kenya and Mexico from 2013 to 2014 to collect information about the content and quality of MNH care received during labor/delivery and the early postnatal period. By comparing these reports to the observations made by separate research teams that recorded the care women received in real-time, the Council can assess the validity of women’s self-reports at the individual level (i.e., how accurately do women self-report on care received?) and at the population level (i.e., how accurately does the indicator estimate true prevalence of the practice in the population?). The Council is also investigating other key MNH indicators focused on postnatal care through 2016.

THE IMPACT  Findings from these and related studies clarify which aspects of MNH care women are able to accurately self-report and where changes to data collection procedures may be warranted. Improved indicators will help the global community better track the delivery of quality MNH services in diverse settings to inform the financing and scale-up of programs designed to reduce preventable maternal and child deaths.

PARTNERS  Ministries of Health

DONORS  Bill & Melinda Gates Foundation via the Maternal Health Task Force of Harvard University; Johns Hopkins University
How did you get started in the maternal and newborn health (MNH) field?

Between my mother being a pediatric nurse and my childhood travels to Africa, I knew at a young age that I wanted to follow in her footsteps and work in countries that needed assistance in improving child health. That was my primary focus at first, not maternal health. I am a registered sick children’s, general, and obstetric nurse in the UK, and hold a Masters in Primary Health Care and a PhD in Health Sciences.

How has being a registered nurse helped shape your work?

My first job in Africa was in a refugee camp in Eastern Sudan, where I established a pediatric unit and managed feeding centers for over 1,000 malnourished babies and children. At the unit for pregnant and lactating women there was one tiny baby whose mother didn’t have enough milk, and the other mothers were donating their breast milk to feed the baby. That’s when I really understood that for babies to survive, mothers must survive—that child and maternal health are innately linked.

After that I moved to Kenya, where I ran a clinic on the shores of Lake Victoria for two years providing antenatal and postnatal care, immunizations, and other primary health care services. My experiences living and working in very rural, remote areas helped me understand the everyday challenges health workers face in low-resource settings, and the importance of supporting health workers providing MNH services.

What brought you to the Population Council?

In 2000, I was seconded to the Council from the UK Department for International Development to work on DFID’s Safe Motherhood Demonstration Project in Kenya. At that time there were no national guidelines for obstetrics, so we worked very closely with the Ministry of Health and the University of Nairobi to develop the “Essential Obstetric Care Manual for Health Care Providers in Kenya,” which launched in 2002. When the DFID appointment ended, I joined the Council’s Nairobi office and became very engaged in scaling up our safe motherhood work.

What are some of the Council’s most important contributions to MNH?

The Council was one of the first to document the prevalence of disrespect and abuse (D&A) during childbirth and then to demonstrate a significant reduction in D&A as a result of our respectful maternity care materials (see page 6). There is now a groundswell to address D&A globally. I also feel very connected to our Ending Eclampsia work (see page 4). Soon after we introduced MgSO4 in Kenya, I heard about a pregnant woman having convulsions at the local market. She was rushed to the hospital and treated for eclampsia, and both she and her baby survived. This showed me how the Council really is making a difference for women and their families around the world.

My connection to the Population Council is personal and ideological. My mother served as Head of Information Services at the Council in the early 1970s, and my godmother, Judith Bruce, has worked there for almost four decades, doing pioneering research and advocacy for women and girls.

Twenty years ago our family, together with the Council, established an award in my mother’s memory that honors excellence in writing and editing in the population sciences. For the two decades I’ve served on the award committee, I’ve met the people who work at the Council, seen their dedication, and learned about the research they support.

I still remember one lively trip I took with Judith right after college to India and Bangladesh. We started in Calcutta, touring women’s health clinics. One morning we walked for about a mile through tiny, muddy streets, too narrow for cars to pass, before arriving at a spotless two-room clinic about the size of a shipping container.

The female doctor there greeted us so warmly and spoke about the Council staff as if they were celebrities. It wasn’t until this trip that I understood what kind of impact the Council had, and that it achieved this influence not from research conducted at a thousand-foot level, but from work carried out on the ground. As if to drive this point home, the next day we met with a union of sex workers, two concepts I had never put together before this trip.

Several years later, when I was an editor at the parenting magazine Cookie, I covered women’s health and did a story on contraception, focusing on the Mirena IUS (intrauterine system). I didn’t know at the time that the Council had helped design the Mirena, one of the most effective long-term birth control methods and, incidentally, the one most frequently used by female ob/gyns themselves. I was surprised again by the breadth of the Council’s reach and influence.

The Population Council is on the frontlines. It goes where other institutions and policy groups aren’t able to go, and it understands the facts on the ground. And the facts are these: You cannot have equality for women and girls without reproductive rights, reproductive health, and maternal health services. If you want to improve outcomes in the developing world, dollar for dollar, one of the best ways to do it is to educate and empower women and girls. The Council figured this out a long time ago, and it’s why I’m proud to continue supporting the organization today.
WITH YOUR HELP, WE CAN CONTINUE TO GENERATE THE IDEAS AND EVIDENCE THAT WILL HELP IMPROVE MATERNAL AND NEWBORN HEALTH WORLDWIDE.

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For additional information, contact:
development@popcouncil.org
877-339-0500

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