KEEPING MOTHERHOOD SAFE

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SAVING LIVES BY SPACING BIRTHS
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Can health vouchers save poor women’s lives?
Profiles: Council donors George and Ann Fisher, and the council’s Dr. Placide Tapsoba
### Consider These Numbers:

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<tr>
<th><strong>343,000</strong></th>
<th><strong>6%</strong></th>
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<tr>
<td>ESTIMATED NUMBER OF WOMEN WORLDWIDE WHO DIED IN 2008 FROM PREGNANCY-RELATED CAUSES</td>
<td>PERCENTAGE OF BIRTHS IN ETHIOPIA WITH SKILLED ATTENDANTS</td>
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<th><strong>50%</strong></th>
<th><strong>99%</strong></th>
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<td>OVER HALF OF ALL MATERNAL DEATHS OCCUR IN SIX COUNTRIES: INDIA, NIGERIA, PAKISTAN, AFGHANISTAN, ETHIOPIA, AND THE DEMOCRATIC REPUBLIC OF THE CONGO</td>
<td>PERCENTAGE OF BIRTHS IN DEVELOPED COUNTRIES WITH SKILLED ATTENDANTS</td>
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<tr>
<th><strong>1 in 6,000</strong></th>
<th><strong>60%</strong></th>
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<td>A WOMAN’S LIFETIME RISK OF DYING FROM PREGNANCY-RELATED COMPLICATIONS IN NORTH AMERICA</td>
<td>PERCENTAGE OF COUPLES IN THE DEVELOPING WORLD (EXCLUDING CHINA) WHO WANT TO LIMIT OR SPACE THEIR BIRTHS, YET MORE THAN HALF OF THEM DO NOT HAVE ACCESS TO CONTRACEPTIVE SERVICES</td>
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<th><strong>1 in 7</strong></th>
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<td>A WOMAN’S LIFETIME RISK OF DYING FROM PREGNANCY-RELATED COMPLICATIONS IN NIGER</td>
<td>PERCENTAGE DECLINE IN UNSAFE-ABORTION DEATHS SIX YEARS AFTER SOUTH AFRICA LEGALIZED ABORTION</td>
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<tr>
<th><strong>68,000</strong></th>
<th><strong>1 in 3</strong></th>
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<tr>
<td>ESTIMATED NUMBER OF WOMEN WHO DIE ANNUALLY AS A RESULT OF COMPLICATIONS FROM UNSAFE ABORTION</td>
<td>NUMBER OF DEATHS RELATED TO PREGNANCY AND CHILDBIRTH THAT COULD BE AVOIDED IF WOMEN WHO WANTED EFFECTIVE CONTRACEPTION HAD ACCESS TO IT</td>
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COVER PHOTO: NADEEM IQBAL
Breaking news on maternal health has confirmed that the efforts of the Population Council and other organizations to reduce maternal mortality are paying off. The New York Times and other major media outlets recently reported encouraging data from a new study in The Lancet that indicate that the number of maternal deaths has declined by 35% since 1980. This is cause to celebrate and at the same time accelerate our efforts. We know interventions to prevent maternal death work. Yet we still have a long way to go. Many women in developing countries continue to face life-threatening complications in pregnancy and childbirth and too often they die as a result. Almost 350,000 women die each year. Millions more experience injuries or conditions leading to life-long problems. We must continue to make progress. Programs to reduce unwanted fertility rates, allow women to obtain maternity care, and widen access to skilled birth attendants have a measurable effect in saving the lives of women during pregnancy.

With your help, the Population Council and its partners worldwide give women a better chance for life by:

- providing governments solid evidence to develop health care policies that benefit families with the greatest need,
- conducting research to determine the best ways to improve the quality of and access to care, and
- developing products to promote women’s health and control over childbearing.

You are helping us save lives by improving maternal health services and increasing access to family planning. Family planning saves lives because it helps women avoid the potentially deadly risks that come from unplanned pregnancy. The Council is dedicated to increasing access to quality
family planning services so that women who wish to delay or avoid pregnancy can do so safely. Our FALAH initiative, for example, covering 26 districts in Pakistan (page 4), improves family planning services and educates women and men about the benefits of birth spacing to both mother and infant.

Council staff members advise governmental and nongovernmental organizations that help women during pregnancy and postpartum. In Kenya (page 6), we work with local partners to develop, test, and expand a program that allows women to obtain comprehensive maternity care, particularly labor and delivery attended by a skilled midwife. In Mexico and Nigeria (page 8), we explore the use of an inexpensive drug, magnesium sulfate, that combats pre-eclampsia, a common, sometimes deadly, pregnancy-related complication. In several countries in Africa and Asia (page 12), we are assessing innovative approaches to financing and increasing access to high-quality maternity care. For women who choose it, we support access to safe abortion, where legally available, and post-abortion care (page 10). We provide the evidence that enables health workers to provide quality services and policymakers to advocate for changes in policies and programs that benefit women.

In this issue, the Fisher family discusses why they joined supporters like you in contributing to the Council (page 14). You will also meet Placide Tapsoba (page 15), a Population Council physician who is tackling public health issues in West Africa.

With your contribution, we can save more lives and improve the health of women worldwide. Thank you for your generous support.
SAVING LIVES BY SPACING BIRTHS

Mothers can reduce their risk of pregnancy-related complications by waiting at least 24 months between births.

THE PROBLEM  Allowing sufficient time between pregnancies not only gives a woman the opportunity to take better care of herself and her family, it can save her life or the life of her infant. In Pakistan, almost one quarter of women want to postpone or avoid childbearing, but have an unmet need for family planning. One fifth of pregnancies end in induced abortion. As a result, an estimated 30,000 women die every year of complications from unsafe abortion or childbirth.

THE PROGRESS  Through the Family Advancement for Life and Health project (FALAH), the Population Council and its partners are addressing the main causes of unintended pregnancy in 26 of the 125 districts in Pakistan. These include lack of accurate information on contraceptive use and related health consequences, lack of access to family planning services, and poor quality of care. Through group meetings organized by trained mobilizers who provide accurate information on birth spacing and contraception and through free consultations at mobile clinics, FALAH has provided family planning and services to more than half a million people in three years. To improve the quality of available services, FALAH
staff members train local clinic and community outreach staff to provide information to clients on healthy timing and spacing of pregnancies and on contraceptive use. FALAH has also contributed to the much-needed revision of the national standards for family planning and developed a curriculum on family planning for medical and paramedic students.

GLOBAL IMPACT  FALAH’s impact has gained significant recognition in the government and communities in a very short time. The Ministry of Population Welfare is shifting its focus to birth spacing when delivering family planning services. This is groundbreaking, especially given Pakistan’s cultural and religious conservatism. As FALAH expands into new districts in Pakistan, it will provide an invaluable example for other countries to follow in reducing the risks from pregnancies that are too early, too closely spaced, or too late in women’s reproductive lives.


“In the meeting today, when [the mobilizers] told us the story ‘better health leads to a happier life,’ it helped me to understand the reasons for the ill-health of my wife and children. It seemed that [they] are telling the story of my own life.”

—Mohammad Sarwar Bozdar, 32, FALAH participant
DElIVERiNG BiRTHS AND CARE THROUGH SKiLLED HANDS

Skilled attendance at birth by a trained midwife, doctor, or nurse is unavailable for many women in rural Africa and Asia.

THE PROBLEM  A skilled birth attendant at delivery can save a woman’s life by treating complications or quickly referring the mother for emergency obstetric care. According to the World Health Organization, another 700,000 skilled birth attendants will be needed to serve the 600 million young women in developing countries as they enter their reproductive years. Lack of transportation and distance from a health facility contribute to the high proportion of home births (over 50%) in these regions. Many women or their families seek care when it is too late.

THE PROGRESS  The Population Council and our Kenyan partners developed a pilot project in Western Province to expand the roles and skills of community midwives (CMs). The goal is to increase access to skilled delivery and newborn care and post-delivery family planning.
THE RETRAINING OF PROFESSIONAL MIDWIVES CAN MAKE A SIGNIFICANT CONTRIBUTION TO LOWERING MATERNAL DEATHS WHERE THEY ARE HIGHEST.

services for women in remote or resource-poor areas. The pilot project proved so successful that Kenya’s Ministry of Health (MOH) worked with the Council to expand the program and adopt the model as a national policy.

We documented the sustainability of the community-based midwifery approach and assisted the MOH in identifying maternal and newborn health services that could be provided by CMs working from home. The Council and Kenyan partners developed guidelines and training materials and worked with CMs to connect them to MOH services. Sixty CMs received refresher training on family planning and obstetrics, bicycles to expand their coverage, and supplies and commodities to encourage home visits. They also received business training so they could become self-employed health care providers and serve women in their community.

GLOBAL IMPACT In four years, our partners have trained CMs in 24 districts in Kenya, with a steady increase in the proportion of attended deliveries. The CMs also deliver a range of contraceptive methods. This CM approach has potential in other countries with similarly high levels of under-utilized qualified and experienced midwives. CMs gain skills that increase a woman’s chances of having a safe delivery, and their services are widely accepted within the community.

THE PROBLEM
One of the most common causes of maternal death in the developing world is severe eclampsia during pregnancy. Pre-eclampsia, characterized by high blood pressure and protein in the urine, can lead to severe eclampsia identified by seizures. Other complications include cerebral hemorrhage, kidney and liver damage, and death. Because eclampsia is most common in first pregnancies and young mothers, it is the third leading cause of death in developing countries where early marriage and childbirth are prevalent. Eclamptic seizures can be prevented or treated with the relatively low-cost drug magnesium sulfate. However, many health care providers in developing countries either do not know about the drug or do not have access to it in medical facilities.

PROVIDING A LIFE-SAVING DRUG

The maternal mortality rate from eclampsia is as high as 14% in developing countries.

IN NIGERIA, WE SUPPORT THE GOVERNMENT IN EXPANDING ACCESS TO MAGNESIUM SULFATE AND OTHER HIGH-IMPACT INTERVENTIONS TO REDUCE MATERNAL DEATHS NATIONALLY.
THE PROGRESS  Council researchers and country partners conducted studies in Kenya, Mexico, and Nigeria to examine barriers to providing and using magnesium sulfate and to increasing its availability. In Nigeria, maternal mortality due to eclampsia decreased by two thirds in the hospitals adopting this innovation, and overall maternal mortality was reduced by 40% in the ten research sites. In Kenya, the Council’s study identified barriers to scaling up availability of magnesium sulfate. The Kenyan government used the study results to integrate magnesium sulfate into the country’s essential drugs list, which will increase the drug’s availability at medical facilities. In Mexico, the Council is investigating why, despite widespread availability and good provider knowledge, magnesium sulfate is inconsistently used.

GLOBAL IMPACT  Magnesium sulfate has the potential to dramatically reduce the unacceptably high number of maternal deaths during pregnancy or childbirth. As these three projects demonstrate, research is critical to identifying barriers to using the drug effectively and helping programs increase its availability and use. By increasing availability of treatment, the Council is helping ensure a future where no woman dies of this easily treatable condition.

DONORS AND PARTNERS  DFID; Federal, Mexico City, and Oaxaca State Ministries of Health; Kenyan Ministry of Health; The John D. and Catherine T. MacArthur Foundation; Nigerian Ministry of Health
SAVING LIVES BY SUPPORTING WOMEN’S REPRODUCTIVE OPTIONS

In Mexico, complications from unsafe abortion remain the fifth leading cause of maternal deaths.

THE PROBLEM  Restrictive abortion laws do not necessarily prevent women from obtaining abortion services, only from obtaining them safely. In April 2007, Mexico City passed a watershed law that legalized first-trimester elective abortion while also increasing support for family planning programs. However, 18 of Mexico’s 32 states have passed legislation aimed at making abortion entirely illegal, even for the few previously allowable conditions, such as saving a woman’s life. Even in states where abortion remains legal for specific circumstances, women face many obstacles, such as bureaucratic hurdles, a shortage of doctors willing to perform abortions, hostile opposition by conservative groups, and stigma.

THE PROGRESS  Without rigorous evidence documenting unsafe abortion rates and abortion-related complications in legally restricted settings, there is little chance of policy change in support of women’s sexual and reproductive health and rights. Council researchers have collaborated on studies to estimate national rates of unsafe abortion and to document the costs of treating resulting health complications. The Council conducts informative surveys on abortion and related reproductive health topics among a variety of groups, including youth, practicing Catholics, physicians, lawyers, and the general public. Also, the Council supports the Mexico City CATÓLICAS POR EL DERECHO A DECIDIR, A.C.
SAViNG livES bY SUPPORTiNG womEN’S REPRODUCTivE OPTiONS

ministry of health’s reproductive health services program, through research, monitoring, and data management.

GLOBAL IMPACT The Council is supporting efforts to decrease maternal mortality from unsafe abortion by targeting the specific needs of key populations. In Ghana, where abortion is legal to protect a woman’s life and her mental and physical health, and in cases of rape, the Council supports government efforts to make comprehensive abortion care routinely available in health clinics. In India, where abortion is legal, the large majority of women obtain their abortions from unregistered facilities and uncertified providers. We aim to increase access to safe abortion in India by testing new models of abortion care and providing evidence that abortions can be safely performed by non-physicians and in non-traditional health centers.

DONORS AND PARTNERS Católicas por el Derecho a Decidir (Mexico); El Colegio de México; Equidad de Género: Ciudadanía, Trabajo y Familia; Grupo de Información en Reproducción Elegida (GIRE); Guttmacher Institute; Gynuity Health Projects; Ibis Reproductive Health; Ipas; Ipas-Mexico; MacArthur Foundation; Macro International, Inc.; Marie Stopes International; Ministry of Health, Mexico City; Ministry of Health of India, National Institute of Public Health (INSP); Packard Foundation; PATH; Swedish International Development Cooperation Agency; Willows Foundation
THE PROBLEM  Vouchers for reproductive and maternity services have the potential to help poor women get access to better quality care and thereby address problems during pregnancy and delivery. Potential clients are provided vouchers for free or at a low and subsidized cost; these vouchers are then redeemed for health services at facilities accredited to provide high-quality care. The facilities are reimbursed for each voucher at a rate that covers their costs and are also given a small profit as a performance incentive. This new concept shows great possibility, but few studies have been done to determine whether the approach improves the quality of care, increases health care access, especially for vulnerable and high-risk populations, and reduces mortality and morbidity.

THE PROGRESS  The Council is evaluating reproductive health voucher programs in Bangladesh, India, Kenya, Uganda, and other countries to determine whether the programs should be scaled up to a national level, what services can be offered most effectively, or whether other financing models would be more effective. Results from a study in rural Bangladesh illustrate the potential of voucher programs; over a nine-month period, the
proportion of pregnant women not accessing antenatal care decreased from 21% to 11%, the proportion of women delivering with a skilled attendant increased from 22% to 65%, deliveries at health facilities increased from 2% to 18%, and the proportion of women getting post-natal care increased from 45% to 60%.

GLOBAL IMPACT  By working closely with governments and ministry of health staff, the Council is conducting analyses that policymakers can use to determine whether the voucher programs meet the reproductive health needs of the most vulnerable women. If effective, voucher programs could be expanded to reach women who would otherwise never receive family planning, prenatal, or post-natal care.


"I FEEL VERY GRATEFUL TO THE HEALTHY BABY [VOUCHER] SCHEME . . . THERE ARE MANY MORE MOTHERS WHO ORDINARILY WOULD FIND IT DIFFICULT TO ACCESS SUCH FACILITIES WHEN DELIVERING, SIMPLY BECAUSE THEY LACK THE MONEY."

—Jeninah Komugisha, a 35-year-old mother in Uganda who delivered her baby girl in a private facility
George and Ann Fisher live in Phoenix, Arizona and are the proud grandparents of Mimi and Myles Fisher (shown in photo). Mr. Fisher is the retired Chief Executive Officer of Motorola and Eastman Kodak.

For the last several years our family has focused our philanthropic efforts on educational projects throughout the developing world—scholarship programs for girls and young women in Vietnam and Senegal, libraries and schools in Ethiopia and Laos, and vocational training projects for women in Afghanistan. We believe that one of the best ways to address global poverty is to help educate young people, specifically girls, and give them a chance to create better lives for themselves and their families.

Recently, we have started to direct a large part of our giving toward the country of Ethiopia, because in 2006 our granddaughter, Mimi, was born in southwestern Ethiopia. Sadly, Mimi’s birth mother was unable to care for her and died of dysentery soon after dropping Mimi off at an orphanage. We feel truly blessed that Mimi has become a part of our family, and this blessing, we believe, carries with it a responsibility to give back to the people of Ethiopia. So, we do our best to find meaningful projects that are truly making a difference in the lives of Ethiopians.

We have followed the progress of the Population Council for many years, always impressed by the variety and depth of the Council’s programs. When we heard about the Council’s work with adolescent girls in Addis Ababa, we felt it was a perfect fit for our family giving. The Council’s “Biruh Tesfa” (“Bright Future”) project gives the most vulnerable population—teenage girls in urban slums, most of whom have lost one or both of their parents—a chance to create meaningful relationships, learn valuable life and literacy skills, and receive education on HIV/reproductive health issues. Every girl who is touched by the Council’s work in Ethiopia has the opportunity to create a brighter future for herself. The simple, yet very powerful ingredients of support and education are changing lives for the better.

As a family we are convinced that the “Biruh Tesfa” project is making an immediate positive impact on the lives of thousands of Ethiopian girls, and we are so honored to be a small part of making it possible. For a relatively modest amount of money, by U.S. standards, donors like us can help the Population Council make dramatic, positive changes in the lives of young women around the world.
How did you decide to enter public health?

Since childhood, I wanted to be either a priest or a nurse. During my seminary training in my country, Burkina Faso, I learned that the country had over 667 priests but only 65 physicians. I left the seminary and received a fellowship to study medicine at the University of Padua, Italy. I then chose to focus on public health and earned a Master’s in public health and a Master’s degree in medical anthropology from the University of California/Los Angeles. As a nurse in a clinic, you serve suffering people as they come in, but nothing changes and the people keep coming. I went into public health so I could work on long-term solutions.

What do you like about the Population Council?

I’ve had many opportunities to pursue emerging public health issues at the Council. I specialized in reproductive health for years, but with the Council I also work on HIV/AIDS and malaria. I am able to start ground-breaking programs. For example, I have involved Muslim religious leaders in promoting family planning, spearheaded new models of post-abortion care, and developed HIV-prevention programs for men who have sex with men. These were not easy issues to address in our conservative society but we have made remarkable progress.

What motivates you most in your job?

In the early 1990s, I took the lead in introducing post-abortion care (PAC) services in Francophone Africa. Now, as the Council’s Country Director and Director of the Reducing Maternal Mortality and Morbidity Program in Ghana, I coordinate a consortium of international partners to eliminate maternal mortality and morbidity due to unsafe abortion by reducing unwanted pregnancies. Seeing the encouraging data and positive impact on policy change concerning PAC has been extremely fulfilling.

Are you hopeful that maternal health in West Africa will continue to improve?

There is improvement, but it is slow. Out of seven girls who I grew up with in my neighborhood, five of them died due to complications of pregnancy and childbirth. Maternal health today is much better in many places in Africa and it is gratifying to have played a part in that. We have a stable government in Ghana, which is necessary for a strong health care system. The headway we are making here will ultimately serve as examples to other countries in the region, so I am optimistic. If you have no hope, then there is no need to be here.
NO WOMAN SHOULD DIE BECAUSE SHE BECOMES PREGNANT.

We must accelerate our efforts to prevent the hundreds of thousands of unnecessary deaths that take place each year as a consequence of pregnancy-related complications.

Recent encouraging data have shown that efforts to reduce maternal deaths throughout the developing world are succeeding, but we still have much work to do. Population Council researchers collaborate with our country-based partners to strengthen maternity care, safe post-abortion and abortion care where abortion is legal, and quality family planning services. With your support, the Council identifies the core reasons for delays in getting care, strategies to improve the quality of care in community health and clinical settings, and methods to reduce the costs of providing those services.

If all women who wanted to space or avoid pregnancy were to use safe and effective contraception, maternal mortality could be reduced by up to 30 percent. Your involvement helps us identify solutions that increase access to family planning services for all those women and men who want to space or limit pregnancy. It also helps us to improve adoption of new technologies to prevent hemorrhage, eclampsia, and other leading causes of death.

We count on your support to identify the factors that contribute to maternal mortality, find concrete ways to save lives, and influence policymakers to scale up innovations in the poorest countries. With your help, we will see the day when having a child is no longer one of the most dangerous risks a woman can take. Thank you for your generous support.

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The Population Council conducts research worldwide to improve policies, programs, and products in three areas: HIV and AIDS; poverty, gender, and youth; and reproductive health.

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