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2 Making “Invisible Deaths” Count Launching Maternal and Newborn Programs

The Challenge

Deaths during the most precarious month of life go virtually uncounted in many developing countries. Around four million babies die every year during their first 28 days—amounting to more than 40 percent of all child deaths. Yet another four million babies every year are estimated to be stillborn. (See figures 2.1 and 2.2 on the next page.)

Most newborn deaths take place in the home and many are not even recorded by the health system. Until recently, the medical establishment believed vulnerable babies could only be saved through sophisticated interventions, so the cause seemed futile wherever resources were scarce. The 1990 World Summit on Child Health did not even include newborn health among its goals.

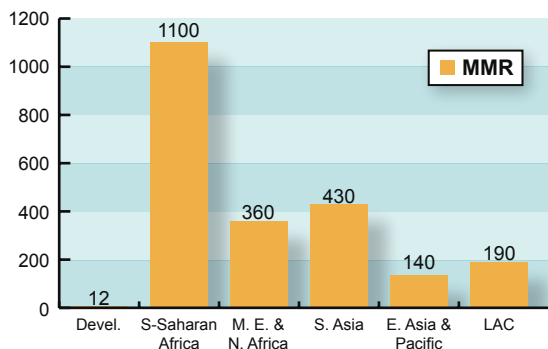
Every time a woman in the developing world becomes pregnant she risks not only losing a child but her own life as well. More than half a million women die every year from complications of pregnancy and childbirth. Yet maternal health is still a low priority in many health budgets.

Often, ministries—as well as donors—do not recognize how high the costs are of failing to invest in proven interventions for both mothers and newborns.

The Academy has created tools that actually demonstrate these costs, and also help policy makers translate local data into local solutions. In many countries, these have been the first crucial steps to reducing unacceptable deaths among both mothers and newborns.

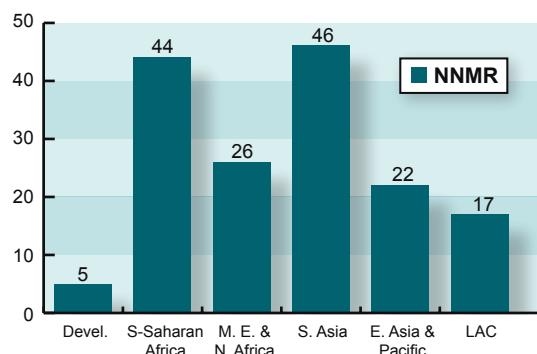


Figure 2.1: Maternal mortality* for 2000



*Note: Maternal mortality ratio is the number of maternal deaths per 100,000 live births.
Source: UNICEF/WHO 2004

Figure 2.2: Neonatal mortality* for 1999



*Note: Neonatal mortality is the number of newborn (<28 days) deaths per 1000,000 live births.
Source: State of the World's Newborns 2001

The Numbers Can Speak

REDUCE and ALIVE are complex statistical spreadsheets.¹ More importantly, they are advocacy processes that stimulate policy dialogue and strategic planning.

At the heart of both REDUCE and ALIVE are interactive computer models that estimate the impact, in a specific region, of poor maternal and newborn care on maternal and infant deaths; on short-and long-term illnesses, injuries, and disabilities; and on economic productivity. The models essentially

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REDUCE looks at specific health factors that contribute to maternal mortality and morbidity. These include tetanus, infections, hemorrhage, unsafe abortions, pregnancy-related high blood pressure, obstructed labor, malaria, and anemia.

ALIVE adds factors that affect the newborn. These are congenital syphilis, maternal iodine deficiency, low birth weight, and essential newborn care.

Typically a multi-disciplinary team of around 15 high-level health professionals, economists, demographers, and sociologists are invited to attend a two-week workshop. Their first task is to reach consensus on what population-based surveys and health services information will be fed into the spreadsheets.

Ownership of the data makes the tool much more powerful than the example of some other country, or projections based on international averages, for example.

The model then projects the *consequences*, or *costs*, of improving outcomes through specific interventions or, alternately, of maintaining the status quo. The model also provides a statistical framework for discussing what would be the most appropriate program for a given setting.

¹ Initial development of REDUCE was funded by USAID through the Support for Analysis and Research in Africa (SARA) Project. ALIVE was developed with funding from The Gates' Foundation Saving Newborn Lives Initiative (managed by Save the Children) and the SARA Project. The Academy has also developed interactive computer advocacy processes in support of nutrition interventions (PROFILES) and the reduction of tariffs and taxes on Insecticide Treated Nets (MoreNets).



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And the numbers do speak. They supply sound arguments for giving higher priority to maternal and newborn programs and resource allocations. Participants are asked to reach at least preliminary consensus on strategies and develop computer-generated presentations to “make the case” for their proposals. Each REDUCE or ALIVE workshop ends with a major advocacy event carried out by the participants for government and international officials, and often for members of the media. In more than ten countries, these events have galvanized national attention.

Measuring Advocacy Outcomes

The Academy has supported this process in Burkina Faso, Burundi, Ethiopia, Ghana, Mali, Mauritania, Mozambique, Nigeria, Senegal, Uganda, and Viet Nam, as well as a special regional effort in sub-Saharan Africa. Funders have ranged from national governments, to the World Health Organization, the World Bank, USAID, and others.

In each case the success of a REDUCE or ALIVE process is measured in outcomes: new policies, new funding, and plans for improved programs.

Mauritania

In 2002 the World Health Organization sponsored the REDUCE/ALIVE process in Mauritania in order to help the Ministry of Health and donors coordinate their advocacy plans and move forward. Representatives from the government, WHO/AFRO, WHO/Mauritania, USAID, and Centre de Formation et de Recherche en Santé de la Reproduction (a regional organization) participated. Following the workshop, the Ministry of Health and UN agencies adopted a six-year framework for reducing maternal, neonatal, and infant mortality.

The Ministry also launched a project to reduce maternal mortality in Wilaya Region. To promote specific interventions, they conducted a national seminar on Islam and reproductive health, incorporating data and materials produced as part of the REDUCE process. The next year, the First Lady of Mauritania inaugurated the first annual National Safe Motherhood Day.

Mozambique

A REDUCE workshop held during the early advocacy phase for safe motherhood in Mozambique helped catalyze action by donors. The in-country team made a formal REDUCE presentation to representatives of the World Health Organization, UNICEF, the UNFPA, USAID, the Irish Government, the Department for International Development (DFID), and others. The Ministry of Health used the meeting as an opportunity to appeal for funds for maternal health and safe motherhood interventions, and received pledges of \$10 million towards the Ministry’s safe motherhood plans.

Viet Nam

Newborn advocacy models were first incorporated into the REDUCE process in Viet Nam in 2002. After a workshop in Hanoi, the Ministry of Health developed a five-year Master Plan for Safe Motherhood with help from several donors. The Royal Netherlands Embassy provided funds for the Master Plan and preparation of an operational plan. They also funded a two-year pilot phase of the Safe Motherhood initiative, through the UNFPA. The World Health Organization supported research on maternal mortality.

REDUCE and ALIVE are especially powerful tools for mobilizing decision makers “at the top.” But the process can also engage the district and the community. (See box.) Advocacy for giving priority to mothers and newborns is equally critical at the level of every village chief.

An Advocacy Tool for All Levels

REDUCE and ALIVE are powerful at the district and community level, as well as “at the top.”

Senegal

The REDUCE process was conducted at both the national level and district levels in Senegal. National data were first presented at an advocacy workshop for Parliamentarians. The model was then translated into Wolof and used as the basis for district-level advocacy among religious leaders, traditional opinion leaders, members of women’s and youth networks, and the media. Training of trainers workshops on advocacy for maternal and newborn health were conducted for participants from 15 districts and 113 rural communities.

Data from the REDUCE model were translated into an array of communication tools. These included debates, newspaper features, discussions, and a 90-minute radio call-in program on maternal health.

Nigeria

After an initial workshop at the national level, the Federal Ministry of Health in Nigeria took complete ownership of the REDUCE process and disseminated information materials to all 31 State Directors of Primary Health Care and reproductive health focal persons in the 774 Local Government Authorities (LGAs) throughout the country. In a number of LGAs, REDUCE helped increase resource allocation for maternal health.



A majority of deliveries throughout the developing world take place in the home rather than in a facility.

Another Level of Data, Another Kind of Tool

REDUCE and ALIVE focus on the causes of morbidity and mortality. But they do not open the “black box” of any health problem to reveal what happens in homes and *why*. This deeper level of information is needed to *design programs* that will make a difference.

In many countries little is known about family and community practices surrounding childbirth. A survey by the World Health Organization in four African countries showed that 76-94 percent of rural deliveries take place in the home, and 70-75 percent of urban deliveries are in the home.² Even in health facilities, the quality of delivery and newborn care is still poor. Only about 40 percent of births are assisted by trained health professionals. To improve care at the community level, we need to understand key factors that affect local practices.

AED has developed a set of tools to help countries gather this community-level information. WHO/AFRO and USAID have provided funding to prepare a package of assessment tools that can be adapted to local contexts. In Zambia, AED worked through the WHO office with a team of local researchers to test and revise the tools and collect information on community and health worker practices in two districts. The next step will be a strategy workshop for

² Presentation by Dr. Andrew Kosia, WHO Regional Office for Africa (Brazzaville), at the second meeting of the WHO Africa Regional Reproductive Health Task Force, October 20-24, 2003, Dakar, Senegal.

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program managers and policy makers to translate these locally-relevant findings and recommendations into programmatic steps to reduce barriers to improved maternal and newborn health.

This process will be duplicated in Tanzania, incorporating lessons from Zambia. As part of the exercise in Zambia, the Academy also gave hands-on training to raise the skills of a core cadre of maternal/newborn health researchers. The local coordinator and the lead researcher for the up-coming Tanzania activity also participated, providing them with crucial field experience.

Based on lessons from these two countries, AED will revise the package of tools and guidelines. These tools will assist many countries with little experience in newborn or maternal research to gather critical information and plan appropriate ways to reduce maternal and newborn mortality.■