

**INITIATIVES INC. PRESENTS
REPRODUCTIVE HEALTH
INTEGRATION ISSUES**

VOLUME 1 NUMBER 3 OCTOBER 1998

FOCUS: INTEGRATING SAFE MOTHERHOOD

Reproductive Health Integration *Issues* is a new publication of Initiatives Inc. designed to support the integration of reproductive health into the portfolios of community based organizations currently addressing other development concerns. In quarterly installments, *Issues* will address the complex programmatic, managerial and evaluative questions that arise in planning and implementing RH integration strategies.

The newsletter is a by-product of the USAID-funded SEATS Project, Reproductive Health Integration Initiative (RHII), which is based on the premise that integration provides a cost-effective and efficient method of extending services, giving women and men the opportunity to make informed choices about their pregnancies, ensure their reproductive health and help their children to survive.

WHAT IS SAFE MOTHERHOOD?

Safe Motherhood is a woman's ability to have a safe and healthy pregnancy and delivery.

WHY FOCUS ON SAFE MOTHERHOOD?

Nearly 600,000 annual deaths, mostly in developing countries, occur from pregnancy related complications; 60 million women endure illness and lifelong medical problems. Pregnancy and childbirth account for 18% of death, disease and disability among women of reproductive age in developing countries, making it the most significant cause of death and disability.

Given the central role women play in supporting and caring for their families and contributing to their communities, a woman's death is not only an emotional tragedy for her family but can cause great economic and social hardships for her surviving family and the broader community. Facilitating a family's ability to seek and receive qualified obstetric care and to help ensure healthy mothers is an essential and effective development intervention.

In Asia, one out of every 65 women dies from pregnancy complications; in Africa, one out of every 16 women dies; in Northern Europe, the chances of dying are only 1 in 4000. In developed countries, 99% of women have access to maternal health services, while in developing countries only 54% are delivered by a trained attendant. These statistics reveal a public health tragedy: the rate of maternal mortality is the single largest discrepancy between wealthy countries and resource poor countries.

CAUSES OF MORTALITY AND MORBIDITY

Five conditions, known as the direct causes of maternal mortality, include hemorrhage, unsafe abortion, hypertension (eclampsia), obstructed labor and sepsis, and these either alone or in combination, account for more than 80% of all maternal deaths. A series of other conditions, or

indirect causes, anemia, malaria, hookworm, viral hepatitis, and STD/RTIs, contribute individually and collectively towards 15-20% of maternal deaths.

CONTRIBUTING FACTORS

A range of cultural factors, as well as societal and gender inequities, compromise the health and welfare of women and contribute to the direct and indirect causes of maternal complications. Poverty, unreliable food sources, poor quality, inaccessible or nonexistent health services are obvious factors; more subtle are the inadequate nutrition, education and health care available to girls rendering them weaker, and stunted (as a result of chronic energy deficiency). Such young women are less likely to seek medical care, and overcome poverty, or to resist the expectations of early marriage and early pregnancy. The practice of female genital mutilation causes death, in some cases, while in others, lifelong pain and obstacles to safe deliveries. Limited access to safe and effective family planning and pregnancy termination services increase the likelihood that women will resort to unsafe procedures to end pregnancies.

Cultural traditions and women's lack of decision-making authority often make it difficult for them to seek needed medical care during pregnancy and labor.

THE THREE DELAYS

One of the most serious reasons for maternal mortality and morbidity but one which can be best addressed by community based programs, is lack of education regarding danger signs, severity of the situation, and the need for medical care. This is compounded by difficulty in reaching medical care due to distance, lack of transport, poor roads and limited funds. Even for those women who do seek help at a facility, medical care may be slow, of poor quality, or not available. This set of factors has been referred to as the "3 delays": the *delay* in understanding the need to seek assistance, the *delay* in reaching a clinical site and the *delay* in receiving assistance from that site. (Maine)

Community Organizations Can Make a Difference:

NGOs working in sectors such as youth programs, women's rights, refugee issues, education, AIDS prevention, and food security are prime targets for integration of safe motherhood RH services. Through community based interventions, NGOs working in partnership with health institutions can reduce mortality and morbidity among pregnant women. Information, Education and Communication (IEC) Programs can provide community members with accurate information about pregnancy and health care; the danger signs that require immediate medical attention; the need for antenatal and postnatal care; the need for proper nutrition, TT immunizations, micronutrient supplementation; education; and the need for family planning including delaying the age of marriage and first pregnancy.

Mobilization activities can assist communities to develop transport plans to help women reach medical care or loan programs to assist in payment for transport and emergency care. Advocacy strategies can insist on: qualified medical care closer to people who need it; better roads; better access to safe abortion, where legal, and to services for the management of abortion complications; more education and employment opportunities for women.

Strategies to Increase Program Effectiveness:

- Involve community leaders and women's groups. Determine how women view pregnancy; how women define RH problems; how women feel about their treatment at formal health services; where/how women/families gather information about pregnancy and RH care; who influences pregnant women's decision to seek care or family planning services; where women give birth; which reference groups should be targeted for information campaigns and care, e.g. women, husbands, mothers-in-law, traditional medical personnel?
- Ensure all women have access to quality maternal health services before, during and after pregnancy. Risk screening during pregnancy has not proven to be an effective strategy for identifying which women actually develop complications during pregnancy. The best approach is to ensure ALL women have access to services. Promote family planning. Key to preventing complications is preventing unwanted pregnancies. Annually 20 million unsafe abortions are performed, of these 95% occur in developing countries, killing 200 women daily.
- Concentrate on adolescents. Reducing pregnancies will reduce the disproportionate number of deaths among adolescent mothers and their under 5 children and lessen the large number of unsafe abortions among adolescents. Reach out to formal systems (schools, clubs) and hard to reach groups (gangs, street children).
- Ensure proper nutrition for women from the in utero stage to adulthood. This will help to prevent anemia, stunted growth, immature birth canals, obstructed labor, and low birth weight babies. It will also help to stop the cycle of mothers giving birth to daughters who face the same pregnancy-related risks and complications as their mothers.
- Develop partnerships with the government, referral agencies, supply and training sources and the private sector. This will increase cooperation, resources and sustainability. Prepare written contracts with partners detailing roles, responsibilities and feedback mechanisms.

- Promote hygienic deliveries. Provide or sell clean birth kits to women who choose to give birth at home. Enlist the support of TBAs or other birth attendants in this effort.

COMMUNITY VOLUNTEERS/WORKERS/CBDS CAN:

- ⇒ treat anemia, by providing pregnant women with iron+folic acid supplements during the last two trimesters of gestation. Iron deficiency causes anemia which can increase a woman's chances of dying from hemorrhage and affect the health of the newborn.
- ⇒ treat malaria and hookworm which increase the likelihood of anemia in pregnant women. Hookworm infection contributes to anemia by causing blood loss in stools. Blood loss increases iron loss. Deworming with an antihelminthic can help to eliminate blood loss. Malaria destroys red blood cells which leads to iron loss, adding to anemia problems.
- ⇒ provide contraceptives to avoid unwanted pregnancies, that are "too many, too young and too close together."
- ⇒ provide assistance to women who need emergency care during pregnancy and delivery by contacting medical personnel, organizing transport and, where possible, providing emergency first aid.

COMMUNITY GROUPS CAN:

- ⇒ create revolving loan funds using income generation projects, social marketing or community funds for obstetric emergencies to ensure financial obstacles do not impede treatment
- ⇒ organize a transport system among existing resources, e.g., truck drivers, taxi chauffeurs, rickshaw wallahs, ferries, etc. to pre-selected hospitals and health centers
- ⇒ advocate against FGM
- ⇒ advocate for better nutrition and educational opportunities
- ⇒ work with government and private industry to develop food fortification programs such as: iodized salt; vitamin A supplemented sugar, MSG, margarine, oil, ghee; iron-supplemented noodles and wheat flour.
- ⇒ create programs to provide women with a megadose (200,000 IU) of vitamin A after delivery (not later than 6-8 weeks postpartum) to improve maternal vitamin A stores to reduce infections and pregnancy related death risk and improve the vitamin A content of breastmilk.
- ⇒ provide information about pregnancy danger signs and the need to seek medical care:

Obstetric Complications	Danger Signs
Sepsis (infection)	fever, headaches, pain in lower abdomen, foul-smelling discharge, vomiting or diarrhea
Obstructed labor	in labor for 12 hours or more; baby appearing malpresented during delivery, e.g. breech

Unsafe Abortion	fever or chills pain in abdomen, cramping or backache; bleeding from the vagina- can be heavy ;foul-smelling discharge from vagina; over 6 week delay in re-starting period
Hemorrhage prior to delivery-->	slight to severe bleeding usually in last 4 months
during or after delivery:	placenta undelivered after 30 minutes continued or severe bleeding after placenta is delivered
hypertension/ prior to delivery--> pre- eclampsia	swelling of feet, ankles, hand, face severe headaches blurred vision, spots before eyes vomiting
eclampsia	fits, loss of consciousness
post delivery-->	fainting, fits, convulsions

Women's Voices, Women's Lives: The Impact Of Family Planning . A
Synthesis of Findings from the Women's Studies Project. - Family
Health International
PO Box 13950, Research Triangle Park, NC 27709
www.fhi.org

RESOURCES

Safe Motherhood Initiative
Family Care International
588 Broadway, Suite 503 NY NY 10012
email: smi10@familycareintl.org
website: www.safemotherhood.org

MotherCare
John Snow Inc
1616 N. Fort Myer Dr.
Arlington VA 22209 USA
Attn: MotherCare publications

INTERNET CONNECTIONS

REPRO-HLTH-L is an interactive forum for discussion of reproductive health issues. To subscribe send a message to: listproc@info.usaid.gov stating only subscribe repro-hlth-l (your name).

OTHER LINKS FOR RH INFORMATION:

www.safemotherhood.org
www.reproline.jhu.edu (RH)
www.who.org
www.pathfinder.org/focus.htm (youth)
www.med.jhu.edu./ccp/ (RH materials/links)
www.rho.org

ISSUES WELCOMES CONTRIBUTIONS:

Send short articles, comments and suggestions to initiatives@worldnet.att.net or mail to: Donna Bjerregaard, Editor, RHI *Issues*, Initiatives Inc. 276 Newbury Street, Boston, MA 02116

THIS NEWSLETTER IS ENTIRELY SUPPORTED BY INITIATIVES INC.

EXPERIENCES FROM THE FIELD: Flying Squad
In 1991, a local NGO, MCWAP, organized the 'flying squad' to handle maternal emergencies in Faisalabad, Punjab. An ambulance and trained staff were prepared to deal with obstetric emergencies but a call was not received for the first 9 months. Research revealed that Pakistani women, accustomed to deliver at home with a TBA, feared financial debt from using health facilities. An educational "street camp" program was convened to address groups of people about the risks of childbirth and inform the public that emergency services would be free of charge. To gain their support, TBAs were especially targeted in this campaign. They were trained to identify high-risk pregnancies and deliveries and encouraged to accompany mothers to the health center. The service was also promoted through a popular radio program. In '91, when the program was implemented, there were 41 recorded maternal deaths; in 1995, the number decreased to 19.

MOTHER & CHILD WELFARE ASSOCIATION OF PAKISTAN

PUBLICATIONS:

The Design and Evaluation of Maternal Mortality Programs
Maine D., Akalin M., Ward, V., Karmara, A.
Center for Population and Family Health
School of Public Health, Columbia University 1997

Healthy Women, Healthy Mothers
An Information Guide
Dr. A. Arkutu, Family Care International
New York 1995

Integrating RH into NGO Programs Vol 1: Family Planning
Lyons, J.V., Huddart, J.A. SEATS Project/Initiatives Inc 1997