Delivering Success:

Scaling Up Solutions for

Maternal Health

Wilson Center

By Margaret E. Greene, Omar J. Robles, Sandeep Bathala, *and* Lauren Herzer Risi

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Maternal Health Task Force

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Maternal Health Task Force

Cover Photo: A mother and her newborn child, beneficiaries of a UK-funded maternal health and family planning program in Orissa, one of India's poorest states. Photo courtesy of flickr user Pippa Ranger/ Department for International Development

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A mom and her newborn baby at the Maternal & Child Health Training Institute for medically needy in Dhaka, Bangladesh. Photo courtesy flickr user UN Photo/Kibae Park.

Foreword

We know a great deal about what it takes to prevent most pregnancy-related deaths and complications. This collective knowledge, coupled with political commitment and action, has led to a global reduction in maternal mortality of 47 percent since 1990 (WHO, 2012). Yet, despite this achievement, improvements have not been universal—many countries and areas within countries remain behind. The most underserved communities and marginalized women are still too often unable to access the resources, information, and services that ensure safe pregnancy, delivery, and recovery.

The rate of decline in maternal mortality is just over half of what is needed to achieve Millennium Development Goal 5—a 75 percent reduction in the maternal mortality ratio between 1990 and 2015 (United Nations, 2013b). No single investment will eliminate the stark differences in access to quality maternal care that currently exist, but there is much to be learned from improved dialogue between practitioners and policymakers. The Wilson Center's *Advancing Dialogue on Maternal Health* series identifies strategies to support policymakers and practitioners around the world in improving these outcomes.

While common approaches to improving maternal health exist, implementation must account for local contexts. As a representative from the Rwandan Ministry of Health stressed at a series event, "it is very difficult to do copy-paste; we should do and think according to the reality in the field" ("Learning From Success," 2012). A collaboration among the Wilson Center's Global Health Initiative (GHI), Maternal Health Task Force (MHTF), and United Nations Population Fund (UNFPA), the *Advancing Dialogue on Maternal Health* series is rooted in this perspective, acknowledging that policymakers and practitioners must adapt effective approaches to meet country-specific challenges. From 2009 to 2011, the initiative highlighted priorities for policies, programs, and research to overcome barriers in social, economic, and health systems through a series of events in Washington, DC, and around the world.

Recognizing the need to delve deeper into key issues and to identify opportunities to maximize the scope and scale of national responses, GHI hosted 15 additional events from 2012 to 2013 and participated on a panel at the Global Maternal Health Conference and in a Congressional Study Tour preceding the Women Deliver Conference. This second phase in the *Advancing Dialogue on Maternal Health* series convened a diverse cross-section of panelists from a number of government agencies, research institutions, NGOs, and private foundations. Over the course of the meetings, panelists drew on their collective experiences in more than 10 countries to engage in participatory dialogue to identify pathways for making quality maternal care a reality for all women.

This report reflects on these dialogues to complement the momentum of recent years and continue raising the profile of the global maternal health challenge.

What do a diverse group of stakeholders believe will maximize efforts to reduce disparities and accelerate progress in maternal health?

STRENGTHEN DATA COLLECTION, MANAGEMENT, AND USE:

- Track maternal mortalities *and* morbidities
- Investigate maternal deaths, act on findings
- Mandate reporting and collecting data to a multidisciplinary group of stakeholders
- Monitor use of referral mechanisms

PRIORITIZE EQUITY IN HEALTH SYSTEMS RESPONSE TO MATERNAL HEALTH:

- Identify and respond to disparities by geography, urban vs. rural locale, and socioeconomic status
- Include maternal health services in social protection plans and safety net programs that expand primary care services
- Tailor information and services for the most vulnerable girls including married adolescents, minorities, and other marginalized groups

EMPHASIZE ACCOUNTABILITY FOR, AND QUALITY OF, MATERNAL HEALTH POLICY AND PROGRAMMING:

- Seek community input in design of national quality standards and ensure accountability
- Promote principles of respect, non-violence, and non-discrimination
- Provide continuing education opportunities for health workers, including midwives

ENSURE A RELIABLE SUPPLY OF ESSENTIAL MEDICINES AND HEALTH WORKERS:

- Procure life-saving medicines (i.e., oxytocin, misoprostol, magnesium sulfate, and manual vacuum aspirators) from certified manufacturers
- Train and assign lead agency to forecast the supply, demand, and use of maternal health medicines

- Train physicians in how to identify key maternal morbidities, such as obstetric fistula and uterine prolapse and, where possible, build the health systems support, technical capacity, and resources required to treat these conditions
- Expand responsibility, such as reporting and aligning incentives, to a broader cadre of workers (e.g., midwives, community health/social workers, and community leaders)
- Integrate mHealth technologies

INTEGRATE MATERNAL HEALTH SERVICES ACROSS SECTORS:

- Strengthen links between maternal health information and services and: (1) sexual and reproductive health, (2) newborn and child health, with an emphasis on nutrition, (3) and HIV

INVEST IN EMPOWERING WOMEN AND GIRLS AND ENGAGING MEN AND BOYS:

Women and girls

- Ask women and adolescent girls about their maternal health needs and the barriers to care that they face; address these barriers
- Invest in girls' education, in child marriage prevention, and in already-married girls
- Inform women and adolescent girls about their right to live free from violence and the services available to them

Men and boys

- Work with men and boys to define constructive roles in maternal care, and demonstrate the life-saving benefits that accrue to their partners, children, and themselves
- Partner with religious leaders and other influential male members of a community

In Nigeria, after losing two children through complications during childbirth when delivering at home, Hauwa'u, 25, gave birth safely to a baby boy, Muktar, after a skilled birth attendant recognised a headache and fever—two of the key danger signs—and got Hauwa'u to a hospital where she gave birth with the help of a midwife. Photo courtesy flickr user Lindsay Mgbor/DFID

INTRODUCTION:

Advancing Dialogue on Maternal Health Series

Since 2009, the Wilson Center's Global Health Initiative (GHI) has collaborated with the Maternal Health Task Force (MHTF) and the United Nations Population Fund (UNFPA) to facilitate dialogue around what is needed to improve maternal health, with an emphasis on reducing maternal health disparities. The *Advancing Dialogue on Maternal Health* series identifies strategies to support policymakers and practitioners in maximizing efforts to improve maternal health outcomes.

Despite having reduced maternal mortality by nearly half since 1990, global gains in maternal health outcomes have been uneven across and within countries. The information, services, and resources that ensure safe pregnancy, delivery, and recovery are too often not reliably accessible for the most underserved communities and marginalized women. Nearly 80 percent of all maternal deaths are concentrated in 21 countries, and six countries account for more than half of all maternal deaths: India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of Congo (World Bank, 2013).

Between 2009 and 2011, the *Advancing Dialogue on Maternal Health* series addressed critical and neglected maternal health topics. This earlier iteration of the series raised awareness about the social, economic, and health systems factors that must receive increased attention in policy and programming, including critical maternal health topics that are often overshadowed by the resources and attention earmarked for reducing maternal mortality. These first 25 events produced specific recommendations, highlighted research gaps, and reinvigorated the focus on maternal health in Washington, DC, and globally.

The second installment of the *Advancing Dialogue on Maternal Health* series continued to convene experts who work in maternal health, health systems strengthening, donor, and policymaking communities. The events in this series delved deeper into key issues, identifying opportunities to maximize national responses to pressing maternal health challenges. The aim was to leverage participants' collective knowledge and identify common strategies or priorities that might be adapted across settings to prevent pregnancy-related deaths and complications. The events complemented recent international meetings aimed at improving the access to and quality of care for women worldwide.

This report consolidates key findings from this latest installment of the *Advancing Dialogue on Maternal Health* series and ties them to discussions taking place in global forums. The findings are organized around six major categories:

- Strengthen data collection, management, and use
- Prioritize equity in health systems' response to maternal health
- Emphasize quality and accountability for maternal health policy and programming

» Ensure a reliable supply of essential medicines and health workers

» Integrate maternal health services across other sectors

» Invest in empowering women and girls and engaging men and boys

This report is intended for policymakers and development practitioners to use based on their specific needs, interests, or priorities. As such, each major category is written as a stand-alone brief that both contextualizes and explores key findings in greater detail.

Even though it is unreasonable to conclude that investment in any one area will solve the maternal health challenges, the collective objective of all series participants and this report is to call attention to the steps that key stakeholders—donors, policymakers, development practitioners, NGOs, and communities—should consider taking to accelerate the progress.

> “We are likely to see commonalities that are featured in the success of these programs. These are important because [they] can really inform the work in other countries. But I’m also confident that we are going to see considerable differences in the pathways to successes based upon the special situations inherent in [all] countries.”

Mary Ellen Stanton, Senior Maternal Health Adviser, U.S. Agency for International Development (“Learning From Success,” 2012)

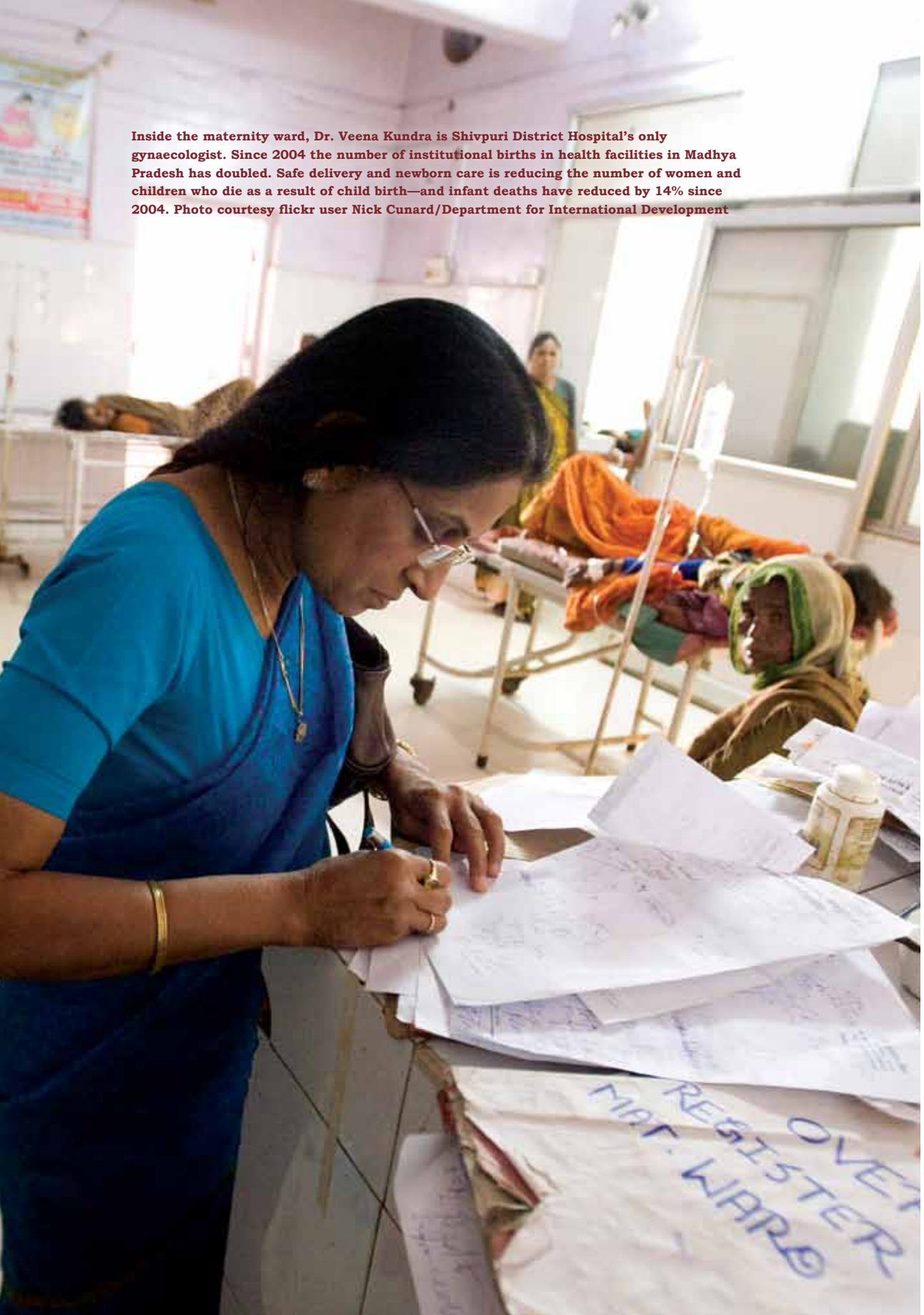
Global gains in maternal health are uneven

When the international community engages in dialogue about maternal health, a consensus emerges: a great deal is known about what it takes to prevent almost all pregnancy-related deaths and complications. Some key steps include expanding access to basic, life-saving primary care with standardized policies and guidelines; making essential medicines reliably available; increasing the number of trained practitioners, especially recruiting and training midwives at the community level; integrating emergency obstetrical care; and introducing community-based interventions that involve communities in defining quality standards. Despite what we know, high quality maternal information and services is not a reality for all women.

Every woman is at risk for experiencing sudden and unexpected complications during pregnancy, childbirth, and following delivery. Investing in initiatives that expand women’s—and communities’—knowledge of, access to, and use of quality antenatal, obstetric, and post-natal care can reduce the risk of maternal death and morbidities. Millennium Development Goal 5—improving maternal health—has helped leverage political support and financial resources.

And yet, disparities across and within countries are alarming. The fact that 99 percent of maternal deaths and morbidities occur in developing countries indicates that these resource-constrained settings lack adequate and accessible resources and services (WHO, 2012). Additionally, it is estimated that for every woman who dies of pregnancy-related causes, an estimated 20 women experience acute or chronic morbidity—maternal health outcomes such as obstetric fistula and uterine prolapse that, while not resulting in death, can have severe health, social, and livelihood consequences for women, their children, and their families (Firoz et al., 2013). A narrow focus on the prevention of maternal deaths misses the opportunity to reduce the number of maternal morbidities.

One principle of the post-2015 development framework is that actions that reinforce other development goals should receive particular emphasis. Maternal mortality and morbidity are not only health issues, they are core to a host of other aspects of development. The consequences of maternal death and illness can ripple through families for years. Studies in many low-income countries have found that poor families who have maternal health–related expenses may use savings or incur debt to make payments, which reduces their ability to purchase food or invest in education. Investments and actions to improve maternal health also safeguard these other areas. For these reasons, maternal health must remain central to the post-2015 development framework.



Inside the maternity ward, Dr. Veena Kundra is Shivpuri District Hospital's only gynaecologist. Since 2004 the number of institutional births in health facilities in Madhya Pradesh has doubled. Safe delivery and newborn care is reducing the number of women and children who die as a result of child birth—and infant deaths have reduced by 14% since 2004. Photo courtesy flickr user Nick Cunard/Department for International Development

Strengthen *data* collection, management, and use

Quality data are a prerequisite for targeted, cost-effective action to improve maternal health outcomes. Throughout the series, representatives from government and the public sector repeatedly stressed the importance of strengthening the collection, management, and use of data to inform national policies and programming. To ensure that resources, personnel, and medicines are equitably allocated across a population requires that a national health information system be able to track, analyze, and use local data in a timely manner. Data tracking and analysis should be conducted not only on maternal deaths, but also near-miss morbidity, rates of caesarean section, contraceptive prevalence rates, unmet family planning need, and proportion of births handled by skilled birth attendants. For relevant indicators, these data should be disaggregated by key characteristics including age and location.

Track maternal mortalities and morbidities. Establishing a comprehensive surveillance system is a critical step for improving maternal health. At the local level, governments should (and in many cases have) set up this system to track and monitor maternal deaths. Yet additional information is needed to drive improvements in maternal care.

Drawing from national efforts to improve maternal care in Afghanistan, the Dominican Republic, Cambodia, and Rwanda, policymakers emphasize the importance of concurrently collecting data on maternal mortality and morbidities ("Learning From Success," 2012). Some sample indicators include those listed above: rates of caesarean section, contraceptive prevalence rates, unmet need for family planning, and proportion of births handled by skilled birth attendants. Additional data can help illuminate gaps in maternal care that exist, even where maternal deaths have been averted. These indicators are among the most closely aligned with maternal mortality outcomes.

Mandate reporting across disciplines. Collecting quality data is important for guiding a government's response to meet women's maternal health needs, but policies must also establish mechanisms that drive the use of these data. In the context of competing priorities within health information systems at both the local and national levels, policies should support mandatory reporting across a standard set of indicators. Systems should include a broader cadre of workers, such as midwives and social workers, into tracking and reporting systems. Even though no consensus emerged about the appropriate timing of mandatory reporting—some countries require local clinics to report data to national agencies on a weekly basis—panelists highlighted its importance ("Learning From Success," 2012).

CIDA supports a wide range of projects that are improving maternal and child health care, especially in areas with high needs in southern Afghanistan. Photo courtesy flickr user Canada in Afghanistan.

Investigate maternal deaths and act on findings. "Data just to have data is not the point," emphasized Dr. Bautista Rojas Gómez, the Minister of Health of Dominican Republic, as he described in detail how the country acts on the data it collects ("Learning From Success," 2012). Dr. Bautista was among several participants who described how their countries investigate maternal deaths—a step that requires a timely national response to local-level outcomes.

Despite the fact that virtually all (97 percent) of women in the Dominican Republic receive prenatal care and births occur in hospitals attended by skilled health professionals, in 2009 the Dominican Republic reported a maternal mortality rate (MMR) of 215 per 100,000 live births. According to Dr. Bautista, a combination of real-time tracking, mandatory reporting, follow-up investigations, and government commitment to act on the findings helped to lower MMR to 140 per 100,000 live births in 2012.

Monitor use of referral mechanisms in complementary ways. Experts not only highlighted the role that community-to-clinic referral mechanisms play in improving maternal health outcomes, but also the need to monitor and track their use. Young and adult women who live in rural, hard-to-reach areas often cannot rely on timely transportation to and from health clinics. The integration of referral systems has helped to connect many women to essential, life-saving services during the prenatal phase, and most especially, during labor and recovery. As countries establish referral mechanisms, they should feed into data collection systems that track outcomes.

> "Information is power… and what gets monitored, gets done."
>
> *Dr. Abhay Bang, Director, Society for Education, Action and Research in Community Health ("Maternal Health in India," 2013)*

Women and their children wait to receive maternal child health services at a health center in Tanzania. Photo courtesy flickr user Nathan Golon/ICAP.

LINK TO GLOBAL DIALOGUE

UN General Assembly

In December 2012, the UN General Assembly adopted a resolution urging governments to move towards providing *all* people with access to affordable, quality healthcare services, including primary care and maternal health services. Primary care saves lives—from maternal care, immunizations, and newborn health to a consistent supply of sexual and reproductive health services (United Nations, 2013c).

Prioritize *equity* in health systems' response to maternal health

Women at higher risk of dying or experiencing pregnancy-related complications often also face the pressures of poverty, poor infrastructure, and restrictive gender norms that undermine their ability to care for their health (Smith et al., 2009). These women often lack access to maternal health information that resonates with the realities of their lives. By prioritizing equity in health systems response to maternal health, governments can support policies and programs that address key barriers. Equity in health highlights, for example, access to maternal care *across* social groups and geographic regions *within* a country. Accelerating progress in maternal health requires that governments disaggregate maternal outcomes in ways that provide the data for better, more targeted resource allocation.

Identify and respond to disparities by geography, urban vs. rural locale, and socioeconomic status. During the *Advancing Dialogue on Maternal Health* series, panelists identified sub-populations with consistently poor maternal outcomes and suggested that targeted actions to make maternal information and services available to the most in-need, underserved communities is essential to meeting development goals.

In most countries, women from the poorest households in rural communities are less likely to benefit from life-saving maternal health care. Even as countries progress with their economic development, disparities in maternal health outcomes between urban and rural areas often persist. Moreover, rural to urban migration has led to rapid urban growth, and the growth of large, poorly-planned and poorly-served peri-urban communities. Governments have a responsibility to channel resources in accordance with needs on the basis of data disaggregated by age, geography, wealth quintile, and ethnicity.

Include maternal health services in social protection plans and safety net programs that expand primary care services. All government representatives who participated in the *Advancing Dialogue on Maternal Health* series linked their gains in improving maternal outcomes with the expansion of primary care services.

Experts noted the critical role that social protection schemes have played in expanding essential services to sub-populations who might not otherwise be able to access or afford services. Social protection schemes generally aim to reduce out-of-pocket expenditures—a key barrier to services. For example, a multi-sectoral group of stakeholders that outlined priorities to reduce the high levels of maternal mortality and morbidities in India discussed the need for greater integration of maternal health into social protection schemes ("Maternal Health in India," 2013). In the Dominican Republic, social protection schemes decreased out-of-pocket expenditures

for maternal care by almost 25 percent in 10 years. In Cambodia, health equity funds for low-income families cover the cost of transportation, prenatal and delivery care, transportation, and a food allowance for expectant mothers and an accompanying person ("Learning from Success," 2012).

Tailor information and services for the most vulnerable girls, including married adolescents, minorities, and other marginalized groups. Governments should publish and deliver reproductive health and maternal health information and services in ways that both resonate with specific high-risk population groups and reduce stigma and discrimination. Promoting adolescent-friendly services in South Africa, for example, improved provider attitudes, quality of services and outcomes among a population at a relatively higher risk of experiencing pregnancy-related complications (Dickson et al., 2007).

LINK TO GLOBAL DIALOGUE

International Day of the Girl Child

Child marriage was the main theme for the United Nations' first "International Day of the Girl Child" (October 11, 2012).

Worldwide, the United Nations hosted events that raised awareness of the prevalence of child marriage, the harmful consequences for child brides, and the need to end the harmful practice. In New York City, UNFPA Executive Director Dr. Babatunde Osotimehin highlighted the maternal health risks that young married girls face.

During the *Advancing Dialogue on Maternal Health* series, the magnitude of these links received considerable attention. More than 16 million girls (15–19) in developing countries give birth every year, and nine out of ten of them are married. Compared to their non-married, older peers, these girls face greater risks of maternal death and complications.

Emphasize *quality* and *accountability for* maternal health policy and programming

Even though the scale and reach of maternal health services have increased in recent years, the quality of those services has not necessarily kept pace with international guidelines and standards. Efforts to improve maternal health cannot focus solely on expanding services. Safe motherhood programs must also improve and standardize the quality of information and services that women receive. Quality of care in countries that have increased the number of skilled health personnel to achieve MDG 5 continues to vary considerably without improved information and services (United Nations, 2013b). As governments work to ensure that women enter health facilities or deliver their infants in the presence of a skilled birth attendant, a concurrent focus must be the content and quality of care that young and adult women receive before, during, and after labor. This focus on quality extends beyond preventing maternal deaths; it includes enforcing national standards that make the health system (institutions and staff) respectful and accountable to all persons during labor and delivery, as well as able to address maternal morbidities.

Seek community input in design of national quality standards and ensure accountability. Establishing national standards and guidelines for quality of maternal care makes clear to all stakeholders (institutions and staff) the expectations to which they are held accountable. A lesson learned from Afghanistan's push to improve maternal health is the inclusion of communities in the development of these national standards ("Learning From Success," 2012). Over the last ten years, the Ministry of Public Health reviewed international concepts and best practices and developed an Afghanistan-specific form of community-based health care. Volunteer Community Health Workers (CHWs) are the backbone of this effort, each supporting about 150 households and promoting healthy behaviors, referring the sick to the closest health clinic, and providing life-saving health services including family planning, information on essential maternal and newborn care, including the importance of birth spacing.

Community-level participation, coupled with good governance, can increase the likelihood that national standards on paper will translate into real-life improvements in the care that women receive. Good governance structures can elevate accountability by incorporating quality indicators into data collection systems. These steps help ensure that institutions and health workers are held accountable to national guidelines and standards of quality maternal care.

Provide continuing education opportunities for health workers, including midwives. Educating and training health professionals is an ongoing endeavor that requires timely and consistent investment. As maternal health guidelines,

LINK TO GLOBAL DIALOGUE

Global Maternal Health Conference January 2013, Arusha, Tanzania

The 2013 Global Maternal Health Conference brought together researchers, scientists, and policymakers to build on progress toward eradicating preventable maternal mortality and morbidity. The conference was organized around five themes:

- Implementing program approaches and tools to improve the quality of maternal health care
- Measuring the quality of maternal health care
- Strengthening health systems for improving the quality of maternal health care
- Providing access to and utilization of quality maternal health care
- Supporting evidence-informed policy and advocacy for quality maternal health care

Key points that emerged from this meeting:

1. ***There is a huge gap in reliable information on maternal deaths and health outcomes.*** The lack of data creates a gap in measurement, information, and accountability and must be prioritized in the coming years.
2. ***How to position and track maternal health in the post-2015 sustainable development framework.*** The "Manifesto for Maternal Health" proposed at the meeting, and subsequently co-authored by MHTF Director Ana Langer, *Lancet* Editor Richard Horton, and the Executive Director of Management and Development for Health, Guerino Chalamilla, highlights the connections between maternal health and women's human rights: political, economic, and social. One key element of this is to make women's rights central to reproductive, maternal, newborn and child health—an effort that will contribute to improvements in quality.
3. ***The importance of respectful maternity care.*** Relating to the connections between maternal health and women's human rights, the conference emphasized how important it is to reach women who are socially excluded by virtue of their culture, geography, education, disabilities, or other aspects of their experience and identity. As part of this effort, the voices of women themselves "must be incorporated into writing the future of maternal health" (Langer et al., 2013).

Source: Langer et al., 2013

methods, and medicines to ensure safe pregnancy and labor change, the health system must ensure that the full cadre of health workers is informed about the latest policies and best practices.

Continuing education for professionals, including midwives, through national professional associations has helped fill this need in India and Bangladesh ("Preventing Injuries During Childbirth," 2012). In Guatemala and El Salvador, the use of in-service training curricula for professional and volunteer health care providers, community health workers, and other health sector professionals has helped to ensure quality maternal health at facilities and within communities (USAID, 2009).

Promote principles of respect, non-violence, and non-discrimination. Not all women who see a medical provider during pregnancy and labor have an opportunity to interact with a provider who creates a supportive environment where women can make informed decisions about their health. Caring, empathetic, supportive, trustworthy, respectful, and empowering are among the adjectives that would describe the ideal skilled birth attendant. Far too many women and adolescent girls do not receive care that matches these terms, despite the fact that every woman has the right to privacy and confidentiality.

In a series event on disrespect and abuse during childbirth, Charlotte Warren, an associate for the Population Council, spoke about a project she's involved in to understand maternal health care conditions. "In Kenya, we are working in 13 private, public, and faith-based facilities to gain a deeper story of women's experiences." To establish a clearer picture of maternal health care conditions, they surveyed women "from admission all the way through to post-natal care." The results were dramatic ("Address Disrespect and Abuse During Childbirth," 2013).

Warren reported that women were consistently subjected to non-confidential, non-consensual, and non-dignified care. For example, Kenyan women recalled being scolded for screaming during childbirth, slapped by the medical staff, and forced to walk around the ward naked. Further, only 38 percent of providers responded that women have the right to be informed of the procedures being performed and only 37 percent responded that information confidentiality was important ("Address Disrespect and Abuse During Childbirth," 2013).

In 2010, a landscape report by Diana Bowser and Kathleen Hill, *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth*, summarized the available knowledge and evidence on this topic. Disrespect and abuse of women seeking maternity care is becoming an urgent problem. The imbalance of power between women and their providers is often a barrier to respectful, quality care. In some countries, providers may feel that women have no recourse. The lack of oversight and accountability also fuels apprehension among women who might access services, and mistrust of providers among women do access maternal care. In addition to greater government oversight, partnering with professional associations to link guidelines with consequences for their violation could promote more respectful patent-provider interaction.

However, in an event at the Wilson Center Hill cautioned against an oversimplified explanation of poor service, noting that abuse often arises when providers and staff are

themselves feeling overwhelmed by workforce shortages, scarcities of essential supplies, or a lack of promotional opportunities. "There are multiple points of suffering and complexity here," she said ("Address Disrespect and Abuse During Childbirth," 2013).

"How do you expect a midwife to be in a good mood if she works with no breaks and has many clients to attend to in a dirty working environment?" asked Warren. These conditions lay the groundwork for disrespect and help explain why patient neglect is so prevalent, particularly in countries that lack enforceable national laws and oversight over health services, said Hill.

One Kenyan nurse told Hill, "by the ninth, tenth, eleventh delivery of the night, I would have been rated minus zero. If you care for the nurses, they will care for the patients" ("Address Disrespect and Abuse During Childbirth," 2013).

To address such issues, the White Ribbon Alliance works to improve the quality of care provided to Nigerian women by training medical staff on the "ethics and etiquette" of health care work ("Woman-Centered Maternity Care," 2013). "Health workers should see their jobs as a call to service," said Philippa Momah, board director of Nigeria's White Ribbon Alliance. "We have started a three-year campaign to advocate for policymakers and health workers to provide respectful maternity care to all women." To date, the White Ribbon Alliance has trained 85 percent of rural health workers in Nigeria in right-based maternity care.

Similarly, the Last Ten Kilometers Project has worked since 2007 to strengthen interactions between Ethiopian women and their primary health care units. "Project workers convene community members and health workers to identify barriers to improving quality care and train providers to improve interpersonal skills," Project Director Wuleta Betemariam said. Working in Ethiopia's four most populous regions, she said they have reached an estimated 3.5 million women of reproductive age ("Woman-Centered Maternity Care," 2013).

IMPROVE QUALITY

A key finding from a cash-incentive scheme in India

The Government of India initiated a cash-incentive scheme called, *Janani Suraksha Yojana* (JSY). The scheme was designed to reduce maternal deaths by promoting institutional deliveries, particularly among the rural poor. Several studies have concluded that JSY achieved its stated goals: increased antenatal care and in-facility births. JSY, however, has not necessarily improved the quality of care that women receive as measured by maternal morbidities and qualitative studies. A lesson learned from JSY is that, in addition to creating incentives for people to access healthcare at facilities, making sure health workers are trained to deliver quality care when women arrive is key.

LINK TO GLOBAL DIALOGUE

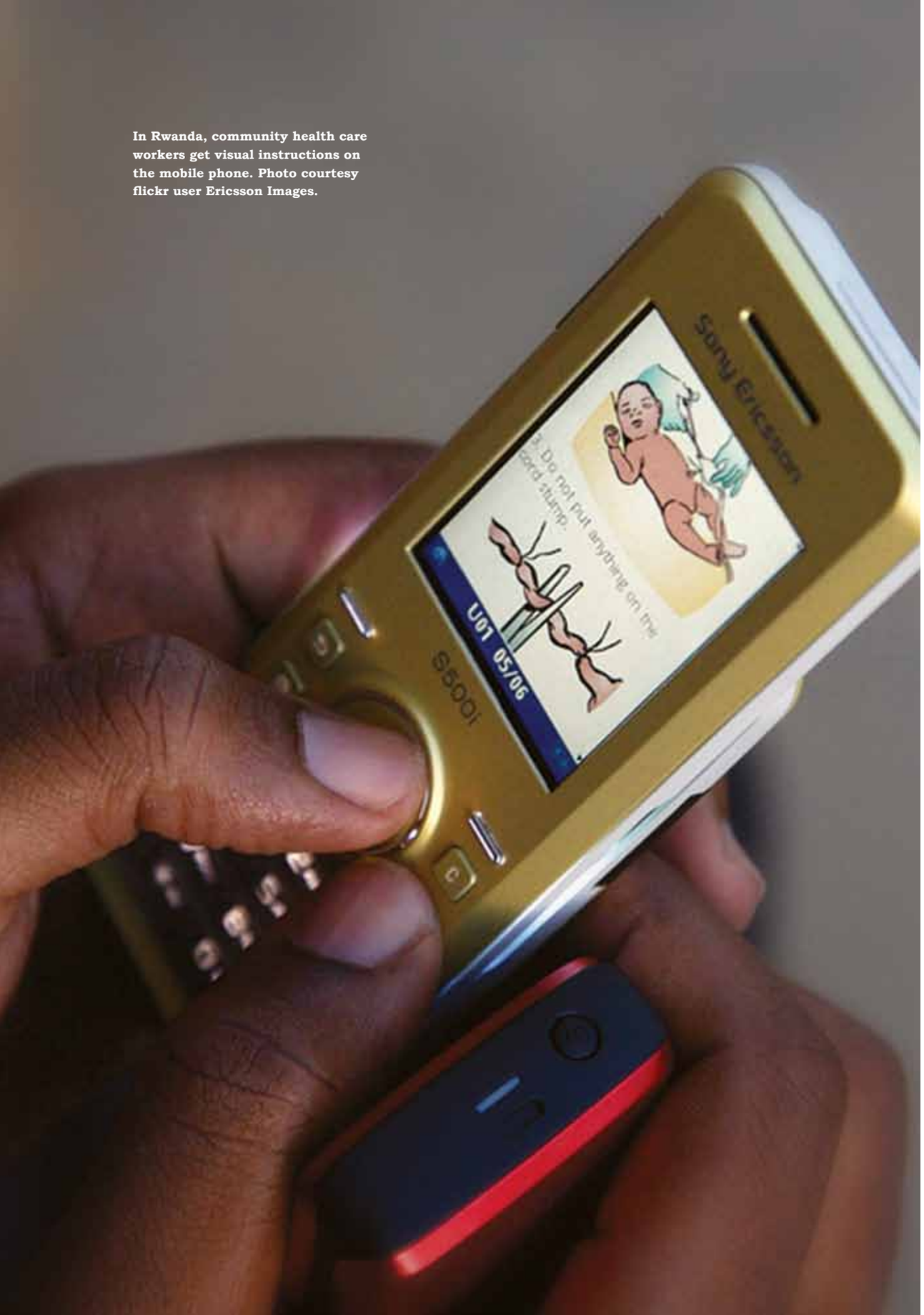
Women Deliver

The Women Deliver 2013 Conference was one of the largest gatherings ever of policymakers, advocates, and researchers focused exclusively on women's health and empowerment, bringing together over 4,500 participants from 149 countries in Kuala Lumpur. At the conference, UN representatives noted that disempowerment of women and girls is the single biggest driver of inequality and poor health outcomes.

As noted in Wilson Center staff blogs from the conference participants reaffirmed the critical role that midwives play at the frontlines of service delivery. Their contributions are often undervalued and the opportunities to scale up their positive contributions are underfunded. "Midwives are the frontline and backbone" of maternal health, said Pat Brodie of the Papua New Guinea Maternal and Child Health Initiative and WHO Collaborating Center for Nursing, Midwifery, and Health Development (Bathala, 2013). For midwives, and for other diverse staff who have a role in reducing maternal mortalities and morbidities, there is a need for improved training and certification; for quality services and medicines; and for adequate investment to expand upon what is already known to end what are largely preventable outcomes.

In addition to underscoring the benefits for women and girls, the Women Deliver Conference linked poor maternal health to the harmful consequences for individual women and girls themselves and also to economic and human development.

Both the conference and the *Advancing Dialogue on Maternal Health* series have called attention to the need for maternal health to feature prominently in the in the next round of development frameworks: the post-2015 development agenda and the ICPD Beyond 2014 process.



In Rwanda, community health care workers get visual instructions on the mobile phone. Photo courtesy flickr user Ericsson Images.

Ensure a *reliable supply* of essential medicines and health workers

A key determinant of whether a woman will survive childbirth is *where* she gives birth. Nearly 80 percent of all maternal deaths are concentrated in 21 countries, and six countries account for more than half of all maternal deaths: India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of Congo (World Bank, 2013).

The availability of essential medicines and skilled birth attendants can determine a woman's fate. Despite the increased availability of essential medicines and health workers, almost 300,000 women die each year. Most of these deaths occur in developing countries. In most circumstances, such poor maternal health outcomes are preventable. In addition to governments having recruited more community health workers to expand services to underserved areas, manufacturers have also developed affordable, effective medicines to treat and prevent the leading causes of maternal deaths—excessive bleeding after childbirth and seizures during pregnancy. During the *Advancing Dialogue on Maternal Health* series, panelists identified some specific priorities to align the supply of essential maternal heath medicines and workers with the national demand for care.

Procure life-saving medicines from certified manufacturers. Estimates suggest that making oxytocin and misoprostol available to all women during delivery could avert 41 million cases of postpartum hemorrhage and save 1.4 million lives. Magnesium sulfate is the most effective medicine for preventing and treating pre-eclampsia and eclampsia, which are the second leading causes of maternal death (WHO, 2011b).

Government policy should encourage the purchase of essential maternal health medicines from certified manufacturers. At the national level, governments can lead national certification efforts. "Innovation and rapid increases in product development and market opportunities…could rapidly improve the affordability, availability and use of selected medicines, medical devices and supplies. But [governments] don't have enough pre-qualified manufacturers," said Jagdish Upadhyay, UNFPA Chief of the Global Program to Enhance Reproductive Health Commodities Security ("Strategic Steps for Global Action," 2012).

Since many national and local governmental and NGO procurement organizations purchase medicines in their country, it is important to identify and strengthen the capacity of smaller, local manufacturers. At the international level, representatives from NGOs and academia encouraged government and international agencies to certify a select number of manufacturers able to produce quality maternal health medicines on a global scale.

Train and assign a lead agency to forecast the supply, demand, and use of maternal health medicines. Four major commodities—oxytocin, misoprostol, magnesium sulfate, and manual vacuum aspirators—address the three leading causes of maternal mortality. We know this, yet demand for these drugs outpaces supply

within and across countries. A lead agency must be trained and held responsible for forecasting (and budgeting for) the supply, demand, and use of maternal health medicines at the national and local levels. This requires integrating data tracking and analysis of maternal health medicines into existing national logistics management information systems.

Train physicians on how to identify key maternal morbidities, such as obstetric fistula and uterine prolapse, and, where possible, build the health systems support, technical capacity, and resources required to treat these conditions. In addition to collecting data on maternal morbidities, governments must train medical personnel to identify and treat pregnancy-related complications. Especially important are efforts to build the knowledge and skills of skilled birth attendants to refer cases of obstetric fistula and uterine prolapse for surgical treatment.

The UN End Fistula Campaign, the Fistula Foundation, and the USAID-funded Fistula Care initiative are all working to reduce the shortage of medical staff who are equipped to treat these and other conditions that significantly impact women's health, reduce women's quality of life, and leave women vulnerable to stigma and discrimination. Most physicians in resource-poor countries have been exposed to fistula or uterine prolapse, though they do not always have the knowledge and tools necessary to treat it.

Expand responsibility to a broader cadre of workers. A common theme throughout the *Advancing Dialogue on Maternal Health* series was the importance of leveraging the use of midwives, community health workers, and female community leaders to extend the coverage and reach of maternal health services. In addition to formal midwifery training curricula, governments can expand community-based midwifery training programs. These community-based reforms should be careful to not overwhelm already weak systems, coupling their referral with equipped staff that can deliver high-quality maternal care.

Integrate "mHealth" technologies. The use of mobile technologies, such as cell phones, has helped with real-time health information exchange. In general, the benefits and consequences (intended and unintended) of using mHealth technologies remain uncertain. However, mHealth applications include their use to strengthen tracking of patients through referral systems, to improve the dissemination of up-to-date dosage information and health records, and to expand community access to health information hotlines.

LINK TO GLOBAL DIALOGUE

Every Woman, Every Child

The "Every Woman, Every Child" Campaign is a global movement to improve the health and well-being of women and children. "Every Woman Every Child" aims to save the lives of 16 million women and children by 2015. The movement recognizes that a strong focus on reproductive, maternal, child, and newborn health (RMCNH) is integral to improving global health. Working with a broad cadre of national and international stakeholders, "Every Women Every Child" supports integrated service delivery for mothers and children—from pre-pregnancy to delivery, the immediate postnatal period, and childhood (United Nations Foundation, 2012).

This campaign, and the *Advancing Dialogue on Maternal Health*, series call attention to the importance of providing quality maternal health services along a continuum of care.

Two publications that describe effective interventions and priority medicines along the continuum of care include that can reduce maternal mortalities and morbidities are: (1) "The Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health—A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health" (Partnership for Maternal, Newborn & Child Health, 2011), and (2) "Priority Medicines for Mothers' and Children's Health, 2011" (WHO, 2011a), which also identify medicines that are in need of enhanced attention and utilization in order to avoid preventable deaths of women and children.

LINK TO GLOBAL DIALOGUE

Essential medicines for maternal health

A short list of essential medicines would make a huge difference to improving maternal health, yet these affordable, effective medicines and simple health supplies are not readily available to the women who need them the most. The United Nations Commission on Life-Saving Commodities for Women and Children, part of the "Every Woman Every Child" movement, was created to highlight these important supplies and to remove barriers to accessing them. The Commission developed 10 recommendations clustered under three key themes:

- Improved markets for life-saving commodities
- Improved national delivery of life-saving commodities
- Improved integration of private sector and consumer needs

In support of the Commission, PATH brought together over 100 "maternal health experts—including health professionals, program implementers, advocates, donor country representatives, and ministry of health officials—to identify and prioritize common challenges and potential solutions to specifically improve the quality of and access to maternal health medicines, which have often been overlooked" (Kade & Moore, 2012, p. 5). Coming together from around the world, they participated in five roundtable events in Bangladesh, Tanzania, and the United States, including one event at the Wilson Center.

Their findings focused particularly on three medicines:

- Oxytocin, for the prevention and treatment of excessive bleeding after childbirth;
- Misoprostol, for the prevention and treatment of excessive bleeding after childbirth when oxytocin is unavailable; and
- Magnesium sulfate, for the prevention and treatment of pre-eclampsia and eclampsia.

Removing the barriers to access these three medicines must happen through actions in four main areas:

- Data collection
- Effective use
- Safety and efficacy
- Systems strengthening

Sources: United Nations, 2012; Kade & Moore, 2012; Maternal Health Task Force, 2012.

Integrate maternal health services across other sectors

As a concept, integration is not new nor does the term mean the same thing to all stakeholders. According to the World Health Organization, integrated service delivery refers to "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money" (WHO, 2008). In general, there is consensus that many health-related challenges, including those related to maternal health, cannot be tackled in isolation from each other. Initiatives that support better health, from sexual and reproductive health (SRH) and HIV prevention, to infant and child nutrition, are logically linked and affected by similar constraints, such as financing and skilled physicians.

While integration is not a panacea for limited capacity and resources, it might help to save lives, money, and time. Dialogue around integration, however, arouses skepticism that important, issue-specific expertise and nuance is compromised when institutions integrate services under the rationale that improved "health systems" will help countries achieve their development goals. More research on the effectiveness of integration, particularly what factors influence maternal health outcomes, is needed.

During the *Advancing Dialogue on Maternal Health* series, participants discussed links between maternal health and:

SRH services. Making it standard practice to offer women a broad set of family planning and maternal and child health services during the same appointment, at the same service delivery site, and from the same provider improves maternal health outcomes from a prevention *and* treatment perspective. This was strongly emphasized at the India consultation in April 2013. A woman's ability to control her pregnancy intentions—to access contraception, to prevent unintended pregnancies, and to have access to safe and legal abortion services—is associated with better outcomes for mothers and newborns.

Governments and organizations working to reduce the number of high-risk pregnancies, especially among married and unmarried adolescent girls, are focused on ending child marriage, and on delaying pregnancy intervals. Efforts to delay very early marriage and to mitigate its effects on the lives of young girls have become much more common in recent years ("Vision, Innovation, and Action to Address Child Marriage," 2013). Since lengthening the interval between pregnancies could greatly reduce the newborn deaths, promoting birth-spacing has received increased attention. A consensus has developed around the need for all women to wait 36 months after a live birth before becoming pregnant again (Rutstein, 2005); if this goal were achieved, governments could prevent an estimated 1.8 million deaths among children under 5 years of age (Rawe, 2012).

Newborn and child health, with emphasis on nutrition. Capitalizing on opportunities to empower women with information and options to attain sexual

and reproductive health has helped health systems prevent maternal mortalities and morbidities. Also, whether health systems fail to provide primary and maternal care to expectant mothers affects infant survival. The level of quality care that mothers receive is often linked to the availability and quality of newborn and child health. Taken together, poor maternal health and limited services for newborns, especially nutrition, can have intergenerational implications, affecting children's long-term development.

HIV. A 2012 Cochrane Review of more than 10,000 research articles concluded that integrated maternal health and HIV/AIDS services are feasible to implement and show promise towards improving a variety of health and behavioral outcomes (Lindegrin et al., 2012). Global investments in HIV prevention, particularly as they relate to promoting knowledge about HIV transmission (e.g., prevention as related to women's health and mother-to-child transmission), and safe-sex practices provide opportunities to address maternal health issues.

> "When we don't have community participation and community involvement, we fail in many of our health indicators."

Dr. Fidele Ngabo, Director of Maternal and Child Health, Ministry of Health, Rwanda ("Learning From Success," 2012)

LINK TO GLOBAL DIALOGUE

Family Planning 2020 Summit

The Family Planning 2020 Summit (FP 2020) in July 2012 mobilized global interest and increased funding to provide contraception to the millions who currently want to use it but do not have access to it.

At both the FP 2020 Summit and throughout the *Advancing Dialogue on Maternal Health* series, stakeholders framed family planning as a valuable, cost-effective tool for improving maternal health at scale through the prevention of unplanned pregnancy. During the maternal health series, several panelists underscored the barriers that women, especially adolescent girls, have to overcome in order to plan and space their pregnancies. Barriers include provider bias, social norms, and limited access to tailored health information and services.

USAID supports maternal and child health through training and technical assistance to government health extension workers. Pictured here is a mother and baby outside a health post in Oromia Region. Photo courtesy flickr user Nena Terrell/USAID Ethiopia.

LINK TO GLOBAL DIALOGUE

Maternal health in India: policy dialogue to outline emerging priorities

"The collective vision emerging from the dialogue is to expand existing frameworks, create new paradigms. We want to see a future that views maternal from the perspective of overall health and well-being. Women's empowerment, dignity, rights, justice, are values integral to this approach."
Poonam Muttreja, Executive Director, Population Foundation of India

"If you have good governance, we can have quite a jump in the health outcomes in India."
Dr. H. Sudarshan, Honorary Secretary of Karuna Trust

"All of these ideas lead us back to an over-arching notion of how we might be accountable to quality."
Dr Gita Sen, Professor of Public Policy at the Indian Institute of Management Bangalore (IIM-B), and Adjunct Professor of Global Health and Population, Harvard School of Public Health

As part of the *Advancing Dialogue on Maternal Health* series, the Wilson Center, MHTF, and UNFPA collaborated with Population Foundation of India to convene a multi-sectoral group of stakeholders to outline emerging priorities—the steps the government should make to reduce its high levels of maternal mortality—in India, where 20 percent of the world's maternal deaths occur each year. This private workshop, held on April 3, 2013, brought together leading development practitioners, senior government officials, and a wide range of donors and media representatives. Following the private workshop, participants publicly shared their recommendations during a three-city videoconference between Boston, New Delhi, and Washington, DC on April 4, 2013.

Emerging priorities included:

- Promote a life-cycle approach to maternal health, which builds upon calls for greater integration of maternal health across other sectors such as family planning
- Support sexual health education, with a focus on reaching adolescents
- Account for social determinants of women's and girls' health in India, including the gender norms and harmful practices that shape the social realities girls face

Kabita gives advice on contraception to mother-of-two, Tuni, so she can plan the size of her family. Local community health workers—or 'ashas'—like Kabita are trained to give care and support to mums-to-be in every village across the state of Odisha, India. They are also on hand to give advice on family planning. Photo courtesy flickr user Pippa Ranger/Department for International Development

- Strengthen governance structures, inclusive of combating corruption and improving data collection for improved decision-making, quality of care, and accountability
- Emphasize the importance of *quality of care* as related to preventing both maternal deaths and maternal morbidities, e.g., disproportionately high rates of complications due to anemia during pregnancy, among others
- Champion maternal health as an integral piece of national and international development agendas, including its role in the post-2015 framework

Bishop Earl Bledsoe gently touches a tiny preemie baby girl while her mother watches in the maternity ward of Mpassa Hospital in Kinshasa. Photo courtesy flickr user Lynne Dobson/United Methodist New Service.

Invest in *empowering* women and girls and *engaging* men and boys

Women and girls who are empowered with quality education, life skills, and social networks are more likely to use contraception, less likely to marry young, and are at lower risk of experiencing pregnancy-related complications (Temin & Levine, 2009; Lloyd, 2009). While complex, these associations are strong. Investing in young women, who face a higher risk of death and pregnancy-related complications, is critical. The barriers that girls face are especially prominent during adolescence. As girls approach adulthood they can find that their lives are constrained by a lack of early learning foundations, harmful gender norms, violence, inadequate nutrition and anemia, poor sexual and reproductive health (SRH), and discriminatory treatment at school. For their part, maternal health policies and programming can encourage women's participation and work in coordination with broader initiatives that promote gender equality, women's agency, and their decision-making.

Policies and programs should concurrently engage men and boys—family members, and community and religious leaders. Many initiatives regarding women's empowerment, maternal health, and education tend to focus on women and girls in isolation of the male stakeholders who influence their lives, directly or indirectly. However, men and boys can adopt gender-equitable attitudes and behaviors that are associated with better maternal health outcomes, less violence against women, and higher school enrollment and achievement for girls.

Ask women about their maternal health needs and the barriers to care that they face and address them. Data are good for identifying key associations and gaps in maternal health coverage. As important is an understanding of how adolescent girls and women perceive their roles in their families, in their schools, and in society. Collecting this information requires asking questions about their routines, attitudes, and practices as they relate to their health and well-being. This information helps to strengthen maternal health programs in ways that consider women's daily roles, responsibilities, and opportunities to access services.

From Afghanistan and the Dominican Republic to Cambodia and Nigeria, government representatives stressed the importance of directly asking women about their maternal health needs. Numerous countries—India, for example—have reported on the benefits of community monitoring and the solicitation of women's views via focus group discussions and local advocacy NGOs to inform national maternal health priorities and service-delivery standards ("Maternal Health in India," 2013).

Invest in girls' education, in child marriage prevention, and in already-married girls. Educating girls and delaying marriage are avenues through which governments can leverage their investments into women's health and well-being

across their lifetimes. Girls' level of education is one of the most important factors associated with good health, including their SRH and the maternal care they receive. Greater numbers of girls in schools is also associated with a higher median age at first marriage.

Policies and programs cannot overlook millions of girls who are already married, divorced or widowed. Programs such as *Tesfa* in Ethiopia are demonstrating that tailored interventions aimed at these girls—out-of-school education initiatives, life skills training, peer and adult counseling—can significantly improve their well-being, self-esteem, and livelihoods ("Vision, Innovation, and Action to Address Child Marriage," 2013).

Inform women and adolescent girls about the services available to them and their right to live free from violence. Pregnant women who experience intimate partner violence are less likely to access the information and services that ensure safe pregnancy and delivery. Compared to women who do not report suffering from violence, these expectant mothers have higher rates of miscarriages and low-birth weights, and are less likely to receive comprehensive antenatal care.

Physical, sexual, or psychological harm by a spouse or partner is a major factor in maternal and reproductive health, said Jay Silverman at a series event ("The Impact of Violence Against Women on Maternal Health," 2013).

Silverman, a professor of medicine at the University of California, San Diego, cited a 15-country study of both developed and developing countries that found 25 to 75 percent of women have suffered from intimate partner violence at least once (Garcia-Moreno et al., 2006). The effects are very significant, both in terms of the health of mothers and their children.

According to Silverman, abusive partners are 83 percent more likely to coerce a pregnancy, through forced intercourse or birth-control sabotage. Women suffering from abuse are twice as likely to have a miscarriage and their children are 3.9 times more likely to have a low birth weight, while infant diarrheal diseases are 38 to 65 percent more common in children born to mothers suffering from abuse ("The Impact of Violence Against Women on Maternal Health," 2013).

Efforts to reduce maternal mortality and morbidity should not sidestep broader efforts to empower women with knowledge about the legal and health services that can support them and their rights to live free from violence. For example, health professionals, including midwives, should be trained in how to identify and confidentially refer victims of gender-based violence to appropriate services.

Work with men and boys to redefine their roles in maternal care and demonstrate the life-saving benefits that accrue to their partners, children, and themselves. Men and boys have a key role to play in changing the negative impact of gender norms on maternal and child health; four out of five men worldwide will be fathers at some point in their lives (United Nations, 2011). National efforts to reduce maternal mortality have supported newlywed counseling that prepares couples for pregnancy-related health needs. Some countries have launched campaigns that promote engaged fatherhood and equality in caregiving.

LINK TO GLOBAL DIALOGUE

Some Rights Won, but More Challenges Ahead

The UN Commission on the Status of Women (UN CSW) met for its 57th session in March 2013. The title of the event—"Some Rights Won, but More Challenges Ahead"—highlighted the fact that while there have been advancements in how governments and communities work to eliminate violence against women, there is still more to be done. The same holds true for global efforts to improve maternal health.

During the *Advancing Dialogue on Maternal Health* series, featured topics included the disrespect and abuse some women face when they access health facilities, and the impact of intimate partner violence on maternal health. A consensus emerged from these discussions: (1) improving maternal health outcomes will require greater accountability to ensure health workers provide respectful treatment to *all* persons, independent of age, ethnicity, disability, or any other social characteristic that may marginalize a woman, and (2) improving maternal health requires substantial commitments to reduce violence against women, through programming that empowers women and girls with the information and education to assert their rights, as well as through initiatives that give providers the tools and training to confidentially identify and refer pregnant women and adolescent girls to the appropriate services.

Among its list of agreed conclusions, the 57th Session of the UN CSW includes strong language against violence and for greater integration between efforts to end violence and improve maternal health: "Expand the availability of health-care services, and in particular, strengthen maternal and reproductive health centers, as key entry points that provide support, referrals to services and protection to families, women and girls at risk of violence, especially sexual violence, and which provide support to adolescents in order to avoid early and unintended pregnancies and sexually-transmitted infections, through education, information, and access to sexual and reproductive health-care services." The *Advancing Dialogue on Maternal Health* series affirmed and expanded upon why these links matter.

Partner with religious leaders who are often influential male members of a community. When religious leaders speak, communities tend to listen; their buy-in makes men's constructive involvement in girls' and women's lives credible. Working with religious leaders, often men, to support women's health and to champion attitudes and behaviors in support of women's and girls' health, rights, and well-being is integral to longstanding social change. "Religious leaders have tremendous power of speech," Nigerian Urban Reproductive Health Initiative's Kabir Abdullahi said. "Because they speak the same language, they understand them, they know them, [and] they have trust in them" ("Nigeria Beyond the Headlines," 2012).

Relying on tradition, customs, and faith does not justify the perpetuation of harmful practices, human rights violations, and the lower social status of women and girls relative to men and boys. Ayscha Hamdani, former special adviser and chief of staff to the European Union special representative to Afghanistan, said at the Wilson Center that for the sustainability of women's health programs—and international development programs in general—it's important to work within Afghanistan's cultural parameters. "We ought to use the very religion of Islam, that is currently being used against women, to actually reinforce the position of women," she said, "Let's talk about the rights that woman have according to Islam and use this in a positive manner, to give women a greater access to education, to health, and to the basic provisions that they require" ("Afghanistan Beyond the Headlines," 2013).

A skilled birth attendant travels three hours from the Mawa Village in Nepal to deliver babies and check on her pregnant patients. Photo courtesy flickr user Gates Foundation.

LINK TO GLOBAL DIALOGUE

Bali Global Youth Forum

In December 2012, the UN convened youth in Bali, where they outlined priority issues, needs, and recommendations in the Bali Global Youth Forum Declaration. Collecting more data and supporting targeted health services for young people feature prominently in the declaration, which will inform the implementation of the Program of Action of the International Conference on Population and Development (ICPD) beyond 2014 (United Nations, 2013a).

During the *Advancing Dialogue on Maternal Health* series, policymakers, advocates, and attendees routinely referenced the need to ensure that the catch-all phrase "community participation" was inclusive of youth, women, and other marginalized groups. It is understood that substantive participation by different social groups is linked to greater accountability.

LINKS TO GLOBAL DIALOGUE

Vision, Innovation, and Action to Address Child Marriage

On June 17, 2013, GHI collaborated with USAID and the Interagency Gender Working Group Task Force on Gender-Based Violence, and its co-chairs Population Reference Bureau and CARE, to lay out key actions that can help end child marriage—a practice that UNFPA estimates will affect more than 140 million girls between 2011 and 2020 (UNFPA, 2012). These numbers translate into an estimated 14.2 million young girls marrying before their 18th birthday every year, or 39,000 daily. The majority of these girls do not receive access to education or reproductive health services. Moreover, the sexual and reproductive health consequences of child marriage for girls are many: girls are more likely to get pregnant early, more likely to die during pregnancy, and more vulnerable to HIV.

A combination of primary and secondary education, life-skills training, and positive reinforcement though social and peer networks can build girls' resilience to becoming brides before they can freely consent to marry. In Egypt, a program called *Ishraq*, which means "sunrise" in Arabic, is focused on reducing girls' vulnerability to child marriage by encouraging communities to prioritize girls' education. Reaching hundreds of girls through its 18-month curriculum, *Ishraq* currently teaches literacy, life skills, and recreational activities (Program implementers: Save the Children and Population Council).

Community engagement and investment in girls themselves is key. A foundation in Ethiopia called *Tèsfa* (meaning "hope" in Amharic) has reached more than 5,000 married, divorced, and widowed girls between the ages of 10 and 19. In Ethiopia—where 41 percent of girls marry by age 18, and 14 percent of girls marry by age 15—policies and programs often overlook already-married girls. This is common in many countries, and *Tèsfa* has been able to demonstrate these already- and once-married girls, when given access to "life skills and education," are measurably more able to resolve conflicts, discuss money, use contraception, and work for pay (Program implementers: CARE and ICRW).

Panelists affirmed that laws are insufficient for preventing child marriage. Countries like Bangladesh, India, and Indonesia, for example, passed minimum age at marriage laws decades ago but still have high rates of child marriage (66.2, 44.5, and 22.0 percent, respectively). Program evidence finds that working with communities and girls themselves to shift cultural norms and to champion girls' education is key to ending child marriage. Leveraging additional resources to monitor policy implementation and build upon what works will require greater political will and attention.

Families' economic concerns around child marriage also merit attention. Since families often marry their girls young to offset economic burdens, one program has worked to demonstrate how empowering girls need not be an economic drain on families. In Ethiopia, the program *Berhane Hewan* (Amharic for "light of Eve") offers families a goat to off-set the short-term benefits of marrying girls, followed by two chickens, 12 months later, and another two chickens, another 12 months later—always on the condition that their daughters remain in school (Population Council). This approach calls attention to the importance of addressing parents' concerns, while making sure to keep young girls at the center of program design, implementation, and evaluation.

A midwife treating a patient in Parwan Province, Afghanistan. Photo courtesy flickr user Graham Crouch/World Bank

Conclusion

The *Advancing Dialogue on Maternal Health* series seeks to stimulate discussion to help leverage collective knowledge and reduce the disparities we see in maternal health. Greater investment in documented solutions is needed to ensure that millions of women and girls do not suffer largely preventable complications and deaths related to pregnancy and childbirth.

Every woman is at risk for experiencing unexpected complications during pregnancy, childbirth, and following delivery. The risks of pregnancy, labor, and delivery exist everywhere; despite increased investment in maternal health, persistent disparities across and within countries are of great concern.

Like the report on the first series, this report of the second wave of discussions that were part of *Advancing Dialogue on Maternal Health* highlights key actions that need to be taken to overcome social, economic, and cultural barriers and gender inequality, strengthen health systems, and improve research and data collection. One key difference between the first and second reports, however, is the emphasis in the first on the need to make the case for investing in maternal health. That case has largely been made in the development field; certainly, the focus among advocates in the maternal health field has moved on, since the evidence for investing in maternal health is so clear.

The second series has therefore gone into more detail on *how* to bring about change and the practical steps required to improve maternal health and reduce maternal morbidity and mortality. This report strongly emphasizes the specific ways in which services can become more responsive, including expanding access to basic, life-saving primary care with standardized policies and guidelines; making essential medicines reliably available; expanding human resources, especially recruiting and training midwives at the community level; integrating emergency obstetrical care; and introducing community-based interventions and improving service quality, with community engagement in defining standards. In recognition of the persistent social constraints to maternal health, the series again highlights the need to invest in women and girls, while at the same time engaging men and boys to be supportive partners and agents of change for women and girls in their communities.

What direction should the next iteration of the *Dialogue* take? One important emphasis could be on the establishment of the systems of accountability that make these concrete steps possible. How are budgets allocated and who is accountable for ensuring they are spent in the right way? How can maternal health and the programs to improve it best be monitored, and by whom? How is maternal health addressed in the global trend toward universal health coverage? Where does maternal health fit into the post-2015 development framework so that it is consistently and systematically prioritized in national investments?

Preventable maternal morbidity and deaths are violations of the human rights of girls and women and a measure of their low status around the world. Investing in pathways the world knows to be effective—and ensuring the level and consistency of that investment—is the measure of our humanity.

UK aid is funding breastfeeding counsellors like Varshna (right) in nutrition rehabilitation clinics across Madhya Pradesh, as part of efforts to educate pregnant women and new mothers about the importance of breastfeeding from birth to combat malnutrition. Photo courtesy flickr user Russell Watkins/Department for International Development

ANNEX A

Advancing Dialogue on Maternal Health, Panel Series (2012–2013)

APRIL 23, 2012: "Learning From Success: Ministers of Health Discuss Accelerating Progress in Maternal Survival" with **Mary Ellen Stanton**, Senior Maternal Health Adviser, U.S. Agency for International Development; **Honorable Dr. Suraya Dalil**, Minister of Public Health, Afghanistan; **Honorable Dr. Mam Bunheng**, Minister of Health, Cambodia; **Honorable Dr. Bautista Rojas Gómez**, Minister of Health, Dominican Republic; **Dr. Fidele Ngabo**, Director of Maternal and Child Health, Ministry of Health, Rwanda

APRIL 25, 2012: "Nigeria Beyond the Headlines: Population, Health, Natural Resources, and Governance" with **Scott Radloff,** Director of Population and Reproductive Health, USAID; **Bolatito Ogunbiyi,** Atlas Fellow, Population Action International; **Volker Treichel**, Lead Economist, Operations and Strategy, World Bank; **Anthony Carroll,** Vice President, Manchester Trade, Ltd.; **Jacob Adetunji**, Lead Technical Officer, Office of Population and Reproductive Health, U.S. Agency for International Development; **Peter Lewis,** Fellow Associate Professor and Director of the African Studies Program, Johns Hopkins University, School of Advanced International Studies; **Judy Asuni**, Director, Academic Associates PeaceWorks; **Akwe Amosu**, Africa Policy Analyst, Open Society Institute; **Pauline Baker**, President Emeritus, Fund for Peace

MAY 21, 2012: "Family Planning and Results-Based Financing Initiatives: Opportunities and Challenges" with **Ben Bellows**, Associate, Reproductive Health, Population Council Kenya; **Beverly Johnston**, Senior Policy Advisor, USAID; **Lindsay Morgan**, Senior Health Analyst, Broad Branch Associates

JUNE 07, 2012: (PRIVATE ALL-DAY MEETING) GHI co-hosted a private working meeting with 20 participants from the policy, donor, research, and NGO communities to strategize on how the UN Commission on Life-Saving Commodities can move the maternal health agenda forward. The action steps identified at this meeting and other similar dialogues in the U.S. and abroad were presented to the UN Commission in Sept 2012 and during the series' public event on October 23rd (referenced below).

AUGUST 28, 2012: "Adolescent Reproductive Health: The Challenge and Benefits of Delaying Sex" with **Laurette Cucuzza**; Senior Technical Advisor for Reproductive Health, CEDPA; **Cate Lane**, Youth Health Advisor, USAID; **Gene Roehlkepartain**, Vice President of Research and Development, Search Institute

SEPTEMBER 17, 2012: "Maintaining the Momentum: Highlights from the 2012 London Summit on Family Planning" with **Julia Bunting**; Department for International Development; Reproductive Health Supplies Coalition; **Karen Hardee**, Senior Fellow, Futures Group; **Win Brown**, Senior Program Officer, Family Health Program, Bill and Melinda Gates Foundation; **Jill Sheffield**, President and Founder, Women Deliver; **Scott Radloff**, Director of Population and Reproductive Health, USAID

SEPTEMBER 27, 2012: "Preventing Injuries During Childbirth: Programmatic and Policy Recommendations for Addressing Obstetric Fistula and Uterine Prolapse" with **Kate Grant**, Executive Director, Fistula Foundation; **Gillian Slinger**, Technical Specialist Obstetric Fistula and Coordinator of Campaign to End Fistula, UNFPA; **Dr. Luc de Bernis**, Senior Maternal Health Advisor, Technical Division, UNFPA; **Dr. Lauri Romanzi**, Clinical Associate Professor, New York University Langone Medical Center; **Celia Pett**, Medical Associate, Fistula Care, EngenderHealth

OCTOBER 23, 2012: "Strategic Steps for Global Action on Maternal Health Medicines" with **Deborah Armbruster**, Senior Maternal and Newborn Health Advisor, USAID; **Dr. Kennedy Chibwe**, Deputy Director of Promoting the Quality of Medicines Program, United States Pharmacopeial Convention (USP); **Ann Starrs**, Executive Vice President, Family Care International; Chair, Global Partnership for Maternal and Newborn Health; **Kristy Kade**, Family Health Advocacy Officer, PATH; **Jagdish Upadhyay**, Chief of the Global Program to Enhance Reproductive Health Commodities Security, UNFPA

JANUARY 17, 2013: [Arusha, Tanzania] "The role of policy in efforts to improve maternal health care" with **Sandeep Bathala**, Senior Program Associate for GHI, WWICS; **Crystal Lander,** Director, Policy and Advocacy , Management Sciences for Health; **Steve Solter**, Global Technical Lead for Fragile States, Management Sciences for Health; **Ruthpearl Ng'ang'a,** Communications Manager at African Population and Health Research Center

APRIL 03, 2013: [New Delhi, India] "Maternal Health in India" with Population Foundation of India. The in-country meeting brought together more than 70 experts from the maternal health, health systems, donor, and policymaking communities to identify best practices, gaps, and areas requiring focused interventions in maternal health. After plenary discussions on "**Maternal Health in India**," "**Neglected Areas in Maternal Health**," and "**Maternal Health: Making Strategies More Effective**," the participants broke out into roundtable discussions for more focused conversation on the following topics:

» Quality of care, moderated by **Dr. Sharad Iyengar,** ARTH Society

» Connecting maternal health, family planning and reproductive health, moderated by **Dr. Leela Visaria,** Gujarat Institute of Development Research

» Social determinants and maternal health, moderated by **Dr. Abhay Bang,** SEARCH

» Knowledge gaps and research needs, moderated by **Dr. Priya Nanda,** ICRW

» Accountability of the public health system on maternal health, moderated by **Dr. H. Sudarshan,** Karuna Trust

Following the roundtable discussions, moderators shared the recommendations that emerged from each roundtable in a plenary session.

APRIL 04, 2013: "Maternal Health in India: Emerging Priorities (New Delhi, Boston, Washington DC)" with **Dr. Abhay Bang**, Director, Society for Education, Action and Research in Community Health; **John Townsend**, Vice President Reproductive Health Programs, Population Council; **Mary Nell Wegner**, Executive Director, MHTF, Women and Health Initiative, Harvard School of Public Health; **Poonam Muttreja**, Executive Director, Population Foundation of India; **Leela Visaria**, Honorary Professor, Gujarat Institute of Development Research; **Michael Kugelman**, Senior Program Associate for South and Southeast Asia, Asia Program; **Dr. H. Sudarshan**, Honorary Secretary of Karuna Trust.

APRIL 18, 2013: "The Impact of Violence Against Women on Maternal Health" with **Anita Raj**, Professor of Medicine and Global Public Health, University of California, San Diego, and Co-Director, Program on Gender Inequities and Global Health; **Cari J. Clark**, Assistant Professor of Medicine, University of Minnesota Medical School; **Jay G. Silverman**, Professor of Medicine and Global Public Health, University of California, San Diego, and Co-Director, Program on Gender Inequities and Global Health.

MAY 02, 2013: "Addressing Disrespect and Abuse During Childbirth" with **Charlotte Warren**, RH/MNH Associate, Population Council; **Kathleen Hill**, Senior Technical Advisor, U.S. Agency for International Development Translating Research into Action (TRAction) Project; **Lynn Freedman**, Director, Averting Maternal Death and Disability Program; Professor of Clinical Population and Family Health, Mailman School of Public Health, Columbia University; **Mande Limbu**, Maternal Health Technical Advisor, White Ribbon Alliance; **Kathleen McDonald,** Project Manager, Hansen Project on Maternal and Child Health, Maternal Health Task Force.

MAY 26, 2013: [Kuala Lumpur, Malaysia] "Regional Briefing on Health in South and Southeast Asia" (part of a Congressional briefing prior to the Women Deliver Conference) with **Sandeep Bathala**, Senior Program Associate for GHI, WWICS; **Amie Batson,** Chief Strategy Officer, PATH; **Caroline Crosbie**, Senior

Vice President of Programs, Pathfinder International; **Maheen Malik**, Senior Technical Advisor, Management Sciences for Health; **Rachel Cintrón**, Maternal and Child Health, Indonesia Regional Mission Office, U.S. Agency for International Development

JUNE 11, 2013: "Woman-Centered Maternity Care, Family Planning, and HIV: Principles for Rights-Based Integration" with **Wuleta Betemariam**, Project Director, Last Ten Kilometers Project, JSI Ethiopia; **Philippa Momah**, White Ribbon Alliance Nigeria Board of Directors; Former Director, Family Health Department, Ministry of Health, Nigeria; **Sarah Craven**, Chief of Washington Office, UNFPA; **Mary Beth Hastings**, Vice President, Center for Health and Gender Equity (CHANGE); **Louise Dann**, Partnerships Specialist, UNFPA

JUNE 17, 2013: "Vision, Innovation, and Action to Address Child Marriage" with **Carla Koppell,** Senior Coordinator for Gender Equality and Women's Empowerment, USAID; **Jennifer Redner**, Senior Program Officer, U.S. Foreign Policy at International Women's Health Coalition, Co-Chair, Girls Not Brides US Coalition; **Anju Malhotra**, Principal Adviser, Gender and Rights, UNICEF; **Feven Tassew**, CARE Ethiopia; **Jeff Edmeades**, Social Demographer, International Center for Research on Women; **Patrick Crump**, Associate Vice President, Program Quality and Impact, Save the Children; **Annabel Erulkar**, Senior Associate & Country Director, Population Council; **Margaret Greene**, Co-Author, *Delivering Solutions*, and Director, GreeneWorks; **Michal Avni**, Senior Gender Adviser, U.S. Agency for International Development

JUNE 26, 2013: "Afghanistan Beyond the Headlines: Women, Youth, and War" with **Dr. Linda Bartlett**, Associate Scientist, Johns Hopkins Bloomberg School of Public Health; **Richard Cincotta**, Political Demography Consultant, Environmental Change and Security Program; Demographer-in-Residence, The Stimson Center; **Ayscha Hamdani,** Independent International Affairs Consultant; Former Special Adviser and Chief of Staff to the European Union Special Representative, European Union Delegation to Afghanistan; **Karen Hardee,** Senior Fellow, Futures Group; **Razia Jan**, Founder and President, Razia's Ray of Hope Foundation; **Palwasha Kakar,** Director, Women's Empowerment and Development for Afghanistan, The Asia Foundation; **Michael Kugelman**, Senior Program Associate for South and Southeast Asia, Asia Program; **Ratha Loganathan**, Senior Health Adviser for Afghanistan, Office of Afghanistan and Pakistan Affairs, U.S. Agency for International Development; **Maiwand Rahyab**, Deputy Country Director, Programs, Counterpart International, Afghanistan; Founding Member, Afghanistan 1400; **Mary Ellen Stanton**, Senior Maternal Health Adviser, U.S. Agency for International Development.

ANNEX B

Advancing Dialogue on Maternal Health Experts (2012–2013)

Adetunji, Jacob; Lead Technical Officer, Office of Population and Reproductive Health, USAID

Amosu, Akwe; Africa Policy Analyst, Open Society Institute

Armbruster, Deborah; Senior Maternal and Newborn Health Advisor, USAID

Asuni, Judy; Director, Academic Associates PeaceWorks

Avni, Michal; Senior Gender Adviser, USAID

Baker, Pauline; President Emeritus, Fund for Peace

Bang, Dr. Abhay; Director, Society for Education, Action and Research in Community Health

Bartlett, Linda; Associate Scientist, Johns Hopkins Bloomberg School of Public Health

Bathala, Sandeep; Senior Program Associate for GHI, WWICS

Batson, Amie; Chief Strategy Officer, PATH

Bellows, Ben; Associate, Reproductive Health, Population Council Kenya

Betemariam, Wuleta; Project Director, Last Ten Kilometers Project, JSI Ethiopia

Brown, Win; Senior Program Officer, Family Health Program, Bill and Melinda Gates Foundation

Bunheng, Mam; Minister of Health, Cambodia

Bunting, Julia; Department for International Development; Reproductive Health Supplies Coalition

Carroll, Anthony; Vice President, Manchester Trade, Ltd.

Chibwe, Kennedy; Deputy Director of Promoting the Quality of Medicines Program, United States Pharmacopeial Convention

Cincotta, Richard; Political Demography Consultant, Environmental Change and Security Program; Demographer-in-Residence, The Stimson Center

Cintrón, Rachel; Maternal and Child Health, Indonesia Regional Mission Office, USAID

Clark, Cari J.; Assistant Professor of Medicine, University of Minnesota Medical School

Craven, Sarah; Chief of Washington Office, UNFPA

Crosbie, Caroline; Senior Vice President of Programs, Pathfinder International

Crump, Patrick; Associate Vice President, Program Quality and Impact, Save the Children

Cucuzza, Laurette; Senior Technical Advisor for Reproductive Health, CEDPA

Dalil, Suraya; Minister of Public Health, Afghanistan

Dann, Louise; Partnerships Specialist, UNFPA

de Bernis, Luc; Senior Maternal Health Advisor, Technical Division, UNFPA

Edmeades, Jeff; Social Demographer, International Center for Research on Women

Erulkar, Annabel; Senior Associate & Country Director, Population Council

Freedman, Lynn; Director, Averting Maternal Death and Disability Program; Professor of Clinical Population and Family Health, Mailman School of Public Health, Columbia University

Gómez, Bautista Rojas; Minister of Health, Dominican Republic

Grant, Kate; Executive Director, Fistula Foundation

Greene, Margaret; Co-Author, *Delivering Solutions*, and Director, GreeneWorks

Hamdani, Ayscha; Independent International Affairs Consultant; Former Special Adviser and Chief of Staff to the European Union Special Representative, European Union Delegation to Afghanistan

Hardee, Karen; Senior Fellow, Futures Group

Hastings, Mary Beth; Vice President, Center for Health and Gender Equity (CHANGE)

Hill, Kathleen; Senior Technical Advisor, USAID Translating Research into Action (TRAction) Project

Iyengar, Sharad; ARTH Society

Jan, Razia; Founder and President, Razia's Ray of Hope Foundation

Johnston, Beverly; Senior Policy Advisor, USAID

Kade, Kristy; Family Health Advocacy Officer, PATH

Kakar, Palwasha; Director, Women's Empowerment and Development for Afghanistan, The Asia Foundation

Koppell, Carla; Senior Coordinator for Gender Equality and Women's Empowerment, USAID

Kugelman, Michael; Senior Program Associate for South and Southeast Asia, Asia Program, WWICS

Lander, Crystal; Director, Policy and Advocacy, Management Sciences for Health

Lane, Cate; Youth Health Advisor, USAID

Lewis, Peter; Fellow Associate Professor and Director of the African Studies Program, Johns Hopkins University, School of Advanced International Studies

Limbu, Mande; Maternal Health Technical Advisor, White Ribbon Alliance

Loganathan, Ratha; Senior Health Adviser for Afghanistan, Office of Afghanistan and Pakistan Affairs, USAID

Malhotra, Anju; Principal Adviser, Gender and Rights, UNICEF

Malik, Maheen; Senior Technical Advisor, Management Sciences for Health; McDonald, Kathleen; Project Manager, Hansen Project on Maternal and Child Health, Maternal Health Task Force

Momah, Philippa; White Ribbon Alliance Nigeria Board of Directors; Former Director, Family Health Department, Ministry of Health, Nigeria

Morgan, Lindsay; Senior Health Analyst, Broad Branch Associates

Muttreja, Poonam; Executive Director, Population Foundation of India

Nanda, Priya; ICRW

Ngabo, Fidele; Director of Maternal and Child Health, Ministry of Health, Rwanda

Ng'ang'a, Ruthpearl; Communications Manager at African Population and Health Research Center

Ogunbiyi, Bolatito; Atlas Fellow, Population Action International

Pett, Celia; Medical Associate, Fistula Care, EngenderHealth

Radloff, Scott; former Director of Population and Reproductive Health, USAID

Rahyab, Maiwand; Deputy Country Director, Programs, Counterpart International, Afghanistan; Founding Member, Afghanistan 1400

Raj, Anita; Professor of Medicine and Global Public Health, University of California, San Diego, and Co-Director, Program on Gender Inequities and Global Health

Redner, Jennifer; Senior Program Officer, U.S. Foreign Policy at International Women's Health Coalition, Co-Chair, Girls Not Brides US Coalition

Roehlkepartain, Gene; Vice President of Research and Development, Search Institute

Romanzi, Lauri; Clinical Associate Professor, New York University Langone Medical Center

Sheffield, Jill; President and Founder, Women Deliver

Silverman, Jay G.; Professor of Medicine and Global Public Health, University of California, San Diego, and Co-Director, Program on Gender Inequities and Global Health

Slinger, Gillian; Technical Specialist Obstetric Fistula and Coordinator of Campaign to End Fistula, UNFPA

Solter, Steve; Global Technical Lead for Fragile States, Management Sciences for Health

Stanton, Mary Ellen; Senior Maternal Health Adviser, USAID

Starrs, Ann; Executive Vice President, Family Care International; Chair, Global Partnership for Maternal and Newborn Health

Sudarshan, H.; Honorary Secretary of Karuna Trust

Tassew, Feven; CARE Ethiopia

Townsend, John; Vice President Reproductive Health Programs, Population Council

Treichel, Volker; Lead Economist, Operations and Strategy, World Bank

Upadhyay, Jagdish; Chief of the Global Program to Enhance Reproductive Health Commodities Security, UNFPA

Visaria, Leela; Gujarat Institute of Development Research

Visaria, Leela; Honorary Professor, Gujarat Institute of Development Research

Warren, Charlotte; RH/MNH Associate, Population Council

Wegner, Mary Nell; Executive Director, MHTF, Women and Health Initiative, Harvard School of Public Health

References

"Addressing Disrespect and Abuse During Childbirth" [Webcast]. (2013, May 2). *Advancing Dialogue on Maternal Health Series.* Washington, DC: Woodrow Wilson Center. Available online at http://www.wilsoncenter.org/event/addressing-disrespect-and-abuse-during-childbirth

"Afghanistan Beyond the Headlines: Women, Youth, and War" [Webcast]. (2013, June 24). Washington, DC: Woodrow Wilson Center. Available online at http://www.wilsoncenter.org/event/afghanistan-beyond-the-headlines-women-youth-and-war

Bathala, Sandeep. (2013, May 30). "Midwives, the Frontline and Backbone of Maternal Health, Face Insecure Working Environments." New Security Beat. Available online at http://www.newsecuritybeat.org/2013/05/midwives-frontline-backbone-maternal-health-face-difficult-working-environments/#.Uiz1GcYqiSo

Bowser, Diana, & Kathleen Hill. (2010, September 20). *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis*. Washington, DC: USAID, Harvard School of Public Health, and University Research Co., LLC. Available online at http://www.tractionproject.org/sites/default/files/upload/RFA/Respectful%20Care%20at%20Birth%209-20-101%20Final.pdf

Dickson, Kim Eva, Joanne Ashton, & Judy-Marie Smith. (2007, February 2). Does Setting Adolescent-Friendly Standards Improve the Quality of Care In Clinics? Evidence From South Africa. *International Journal for Quality in Health Care 19*(2), 80-89. Available online at http://intqhc.oxfordjournals.org/content/19/2/80.full.pdf

Firoz, Tabassum, Doris Chou, Peter von Dadelszen, Priya Agrawal, Rachel Vanderkruik, Ozge Tunçalp, Laura A Magee, Nynke van Den Broek, & Lale Say. (2013, August 6). "Measuring Maternal Health: Focus on Maternal Morbidity." World Health Organization Perspectives. Geneva: World Health Organizations. Available online at http://www.who.int/bulletin/online_first/13-117564.pdf

Garcia-Moreno, Claudia, Henrica AFM Jansen, Mary Ellsberg, Lori Heise, & Charlotte H. Watts. (2006, October 7). "Prevalence of Intimate Partner Violence: Findings From the WHO Multi-Country Study on Women's Health and Domestic Violence." *The Lancet 368*(9543), 1260-1269. Available online at http://www.who.int/gender/violence/who_multicountry_study/media_corner/Prevalence_intimatepartner_WHOStudy.pdf

"The Impact of Violence Against Women on Maternal Health" [Webcast]. (2013, April 18). *Advancing Dialogue on Maternal Health Series.* Washington, DC: Woodrow Wilson Center. Available online at http://www.wilsoncenter.org/event/impact-violence-against-women-maternal-health-1

Kade, Kristy, & Lindsay Moore. (2012, September). *Safeguarding Pregnant Women with Essential Medicines: A Global Agenda to Improve Quality and Access.* Washington, DC: PATH. Available online at http://www.path.org/publications/files/ER_mhs_policy_rpt.pdf

Langer, Ana, Richard Horton, & Guerino Chalamilla. (2013, February). "A Manifesto for Maternal Health Post-2015." *The Lancet 381*(9867), 601-602.

"Learning From Success: Ministers of Health Discuss Accelerating Progress in Maternal Survival" [Webcast]. (2012, April 23). *Advancing Dialogue on Maternal Health Series.* Washington, DC: Woodrow Wilson Center. Available online at http://www.wilsoncenter.org/event/learning-success-ministers-health-discuss-accelerating-progress-maternal-survival

Lindegrin, Mary Lou, Caitlin E. Kennedy, Deborah Bain-Brickley, Hana Azman, Andreea A. Creanga, Lisa M. Butler, Alicen B. Spaulding, Tara Horvath, & Gail E. Kennedy. (2012, September 12). *Integration of HIV/AIDS Services With Maternal, Neonatal and Child Health, Nutrition, and Family Planning Services*. Cochrane Dabatase of Systematic Reviews 2012 (9).

Lloyd, Cynthia. (2009). *New Lessons: The Power of Educating Adolescent Girls*. New York: Population Council. Available online at http://www.popcouncil.org/pdfs/2009PGY_NewLessons.pdf

"Maternal Health in India: Emerging Priorities" [Webcast]. (2013, April 4). *Advancing Dialogue on Maternal Health Series.* Washington, DC: Woodrow Wilson Center and New Delhi: Population Foundation of India. Available online at http://www.wilsoncenter.org/event/maternal-health-india-emerging-priorities-new-delhi-boston-washington-dc

Maternal Health Task Force. (2012, May). *UN Commission on Life-Saving Commodities for Women and Children: Country Case Studies*. Cambridge, MA: Maternal Health Task Force, Global Health Visions. Available online at http://www.maternalhealthtaskforce.org/components/com_wpmu/wp-content/uploads/blogs.dir/1/files/2012/06/UN-Commission-for-Lifesaving-Commodities_Country-Case-Studies_June-2012-clean.pdf

"Nigeria Beyond the Headlines: Population, Health, Natural Resources, and Governance" [Webcast]. (2012, April 25). Washington, DC: Woodrow Wilson Center. Available online at http://www.wilsoncenter.org/event/nigeria-beyond-the-headlines-population-health-natural-resources-and-governance

Partnership for Maternal, Newborn, & Child Health. 2011. *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health.* A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH). Geneva, Switzerland: PMNCH. Available online at http://www.who.int/pmnch/topics/part_publications/essential_interventions_18_01_2012.pdf

"Preventing Injuries During Childbirth: Programmatic and Policy Recommendations for Addressing Obstetric Fistula and Uterine Prolapse" [Webcast]. (2012, September 27). *Advancing Dialogue on Maternal Health Series.* Washington, DC: Woodrow Wilson Center. Available online at http://www.wilsoncenter.org/event/programmatic-and-policy-recommendations-for-addressing-obstetric-fistula-and-uterine-prolapse

Rawe, Kathryn. 2012. *Every Woman's Right: How Family Planning Saves Children's Lives*. London: Save the Children. Available online at http://everyone.savethechildren.net/sites/everyone.savethechildren.net/files/library/Every%20Woman's%20Right%20low%20res%20FINAL.PDF

Rutstein, S.O. (2005). "Effects of Preceding Birth Intervals on Neonatal, Infant and Under-Five Years Mortality and Nutritional Status in Developing Countries: Evidence From the Demographic and Health Surveys." *International Journal of Gynecology and Obstetrics 89*, S7 - S24. Available online at http://www.factsforlife.org/pdf/BIRTH%20SPACING%20AND%20NUTRITION%20IN%20DEVELOPING%20COUNTRIES.pdf

Smith, Rhonda, Lori Ashford, Jay Gribble, & Donna Clifton. (2009). *Family Planning Saves Lives* (Fourth Edition). Washington DC: Population Reference Bureau. Available online at http://www.prb.org/pdf09/familyplanningsaveslives.pdf

"Strategic Steps for Global Action on Maternal Health Medicines" [Webcast]. (2012, October 23). *Advancing Dialogue on Maternal Health Series*. Washington, DC: Woodrow Wilson Center. Available online at http://www.wilsoncenter.org/event/strategic-steps-for-global-action-maternal-health-medicines

Temin, Miriam, & Ruth Levine. (2009). Start with a Girl: A New Global Agenda for Health. Washington DC: Center for Global Development. Available online at http://www.cgdev.org/sites/default/files/1422899_file_Start_with_a_Girl_FINAL_0.pdf

United Nations. (2011). *Men in Families and Family Policy in a Changing World*. New York: United nations Department of Economic and Social Affairs. Available online at http://www.un.org/esa/socdev/family/docs/men-in-families.pdf

United Nations. (2012, September). *UN Commission on Life-Saving Commodities for Women and Children* (Commissioners' Report). New York: United Nations. Available online at http://www.everywomaneverychild.org/images/UN_Commission_Report_September_2012_Final.pdf

United Nations. (2013a, April 10). "Bali Global Youth Forum Declaration." Follow-up to the implementation of the Program of Action of the International Conference on Population and Development beyond 2014. Available online at http://icpdbeyond2014.org/uploads/browser/files/bali_global_youth_forum_declaration_final_edoc_v3-2.pdf

United Nations. (2013b). *Millennium Development Goals Report 2013*. New York: United Nations. Available online at http://www.un.org/millenniumgoals/pdf/report-2013/mdg-report-2013-english.pdf

United Nations. (2013c, March 14). "Global Health and Foreign Policy" (Resolution 67/81 adopted by the General Assembly on 12 December 2012). New York, NY: UN General Assembly. Available online at http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/67/81

United Nations Foundation. (2012). Every Woman Every Child. Available online at http://www.everywomaneverychild.org/

United Nations Population Fund (UNFPA). (2012). *Marrying Too Young: End Child Marriage*. New York: UNFPA. Available online at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf

U.S. Agency for International Development (USAID). (2009). *Two Decades of Progress: USAID's Child Survival and Maternal Health Program*. Washington DC: USAID. Available online at http://pdf.usaid.gov/pdf_docs/PDACN044.pdf

"Vision, Innovation, and Action to Address Child Marriage" [Webcast]. (2013, June 17). *Advancing Dialogue on Maternal Health Series.* Washington, DC: Woodrow Wilson Center. Available online at http://www.wilsoncenter.org/event/vision-innovation-and-action-to-address-child-marriage

"Woman-Centered Maternity Care, Family Planning, and HIV: Principles for Rights-Based Integration" [Webcast]. (2013, June 11). *Advancing Dialogue on Maternal Health Series.* Washington, DC: Woodrow Wilson Center. Available online at http://www.wilsoncenter.org/event/woman-centered-maternity-care-family-planningand-hiv-principles-for-rights-based-integration

World Bank. (2013). "Goal 5: Improve Maternal Health." *MDGs & the Crisis.* Available online at http://go.worldbank.org/V6TU8FT1T0

World Health Organization (WHO). (2008, May). "Integrated Health Services—What and Why? Technical Brief No. 1." Geneva: World Health Organization. Available online at http://www.who.int/healthsystems/technical_brief_final.pdf

WHO. (2011a). *Priority Medicines for Mothers' and Children's Health, 2011.* Geneva: World Health Organization. Available online at http://www.who.int/medicines/publications/A4prioritymedicines.pdf

WHO. (2011b). *WHO Recommendations for Prevention and Treatment of Pre-Eclampsia and Eclampsia*. Geneva: World Health Organization. Available online at http://whqlibdoc.who.int/publications/2011/9789241548335_eng.pdf

WHO. (2012, May). "Maternal Mortality." WHO Fact Sheet No. 348. Geneva: World Health Organization. Available online at http://www.who.int/mediacentre/factsheets/fs348/en/

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