Women and Children First (UK)
CEO ROS DAVIES TALKS TO INTERNATIONAL INNOVATION ABOUT THE MANY DANGERS AND INJUSTICES FACED BY MOTHERS AND INFANTS IN LOW-RESOURCE SETTINGS, AND HOW COMMUNITIES CAN WORK TOGETHER TO CREATE EFFECTIVE INTERVENTIONS AND REDUCE PREGNANCY-RELATED MORTALITY AND MORBIDITY

Women and Children First work in some of the world’s poorest communities to prevent maternal and infant mortality. Can you outline some of the organisation’s priority areas for action?

In general, our priority areas are marginalised communities in countries that still suffer from high rates of maternal and newborn mortality. Our main body of work focuses on populations in rural settings, who often have great difficulties in accessing health services because of distance, poor transport links or unaffordable costs.

The ‘Countdown to 2015: Maternal, Newborn & Child Survival’ has highlighted that there are still 75 countries with unacceptably high maternal and/or newborn death rates. As we’re a small organisation with limited resources and funding to work internationally, we focus on a small number of countries – currently, Bangladesh, Ethiopia, Malawi and Uganda. We’ve also got plans to work in Sierra Leone, Guatemala and Nicaragua. As we are not in the business of building our partners’ organisational capacity, we endeavour to find strong and stable organisations on the ground with a good reputation with which we can share our tried and tested women’s group approach. We’ve chosen these specific countries because, in addition to them having high maternal and newborn mortality rates, we have identified suitable local partners there. Our history of collaborating closely with colleagues at University College London’s Institute for Global Health led us to organisations with which they had established good working relations, and others were identified because Women and Children First’s staff had worked with them previously.

Why did you decide to dedicate your career to advocating for the health and safety of mothers and children?

I haven’t been in this field all my working life; half of it was spent on community development and women and children’s issues in London. It was initially by luck that I became involved with international development issues. I was doing a Master’s degree, and took on a part-time job at Marie Stopes International to look after their office administration. As I was specialising in Latin America, and nobody else on the team could speak Spanish, I started working on some of the programmes.

Much of the work was on family planning, and I soon realised how grossly unfair it is that women in Western countries have access to family planning and fertility services, while those in many developing countries face constant barriers, and do not often have knowledge about or access to health services – or even contraception. As time went on and I gained more experience, I began to look further into maternal and child health and the dangerous and exhausting cycle of pregnancy, wherein families have more children than they wish to have or can afford to look after, which can limit educational opportunities and damage women’s health. So my general interest is in international development, but I specifically focus on women’s issues, such as empowering them to be able to control their own fertility and improve their economic circumstances.

What are some of the biggest risk factors affecting mothers and infants during pregnancy, childbirth and in the following weeks and months?

There are a wide range of factors that can affect mothers and babies across these time scales. I’ve talked about family planning, and related to that is the fact that pregnancies become more risky when women can’t control their fertility. It is particularly dangerous for young girls (often as young as 10) and older women to become pregnant. Risks are also involved when pregnancies occur too closely together; the ideal spacing is three years, but without contraception, there are women who fall pregnant year after year. In addition, conditions that may not be life threatening in a non-pregnant woman, such as malaria, can result in severe problems for both mother and baby. Pregnancy-related conditions, including pre-eclampsia, can also be fatal where health services cannot be reached.
Many women don’t have access to antenatal or postnatal care, or skilled attendants to deliver the baby. This can result in an increase in complications, leading to mortality or morbidity. Often, mothers must live with physical disabilities, pain and stigma – as in the case of obstetric fistula (characterised by incontinence), which is difficult to manage and can lead to them being ostracised by their families and the community.

In brief, there are three delays that contribute to increased risk in childbirth: delay in deciding to get skilled care when ready to give birth or during pregnancy (no antenatal care in the first trimester); delay in reaching a health facility when in labour (which can lead to serious complications); and delay in assessing the pregnant woman once she arrives at the clinic (wherein she may not receive the exact care required).

Over 70 per cent of infant deaths occur within the first year of life, many of them in the first 28 days. Could you describe some of the most effective interventions to safeguard newborns?

In areas where there are still very high rates of newborn mortality, small changes can make quite a big difference in reducing deaths. As mentioned, antenatal care is vital so that any problems are flagged up as early as possible, particularly for those with high-risk pregnancies. Postnatal care, often recommended within the first 48 hours of birth, is also essential to detecting any suffering in the newborn. Skilled practitioners will identify danger signs, such as the risk of maternal exhaustion in a prolonged labour or a blockage, which can affect a baby’s airway – but parents should also be given the knowledge to recognise risk factors, such as fever, which can be life threatening in a newborn.

Practices that people might think are a good idea, like washing a newborn, can result in problematic decreases in body temperature, so something as simple as keeping the baby warm is an effective intervention. In terms of traditional customs, some populations put dung on an umbilical cord because they think that will protect it, but it is far more likely to cause an infection. Others may feed infants cow’s milk, which they can’t digest. We would recommend immediate and exclusive breastfeeding for newborns. In Kangaroo mother care, the newborn baby is wrapped skin-to-skin against the mother and can easily breastfeed and be kept warm. This is particularly effective for premature babies.

Moreover, getting timely treatment for any infections from a skilled medical practitioner is very important. Even though attendance at medical centres has not increased significantly in our programmes, newborn death rates have reduced quite dramatically. Addressing these simple, basic habits and changing behaviour can be extremely effective with very low to no cost, as we have shown with our work.

What are the greatest benefits of running self-help community groups for women?

The groups provide women with an environment in which to learn all about how to look after themselves properly during pregnancy, including getting skilled care for themselves and their newborn babies, as well as going to a health centre for the delivery. More generally, the groups empower women because their awareness is raised. Although the focus is on running women’s groups, we mobilise the communities and bring on board husbands, brothers, fathers and mothers-in-law – those who can help but are often also the gatekeepers, and prevent women from attending the clinic or hospital because of the cost of transport or medicines, or due to local customs. The groups are designed to create positive, sustainable change within the local communities, empowering them to address what they themselves see as the biggest problems faced during pregnancy, childbirth and the newborn period. They work together to devise solutions, such as lobbying for a bicycle ambulance to overcome the obstacles created by distance from a health facility, or setting up a village fund to address lack of financing to travel there. In order to tackle poor nutrition or anaemia, they might set up a communal vegetable garden or keep domestic animals like pigs or chickens. If more knowledge is required, they may organise health education talks and spread the word. We estimate that for every one woman who is in a women’s group, around two or three more will benefit because they talk to each other, especially intergenerationally.

I’ve been at several open days in Malawi where they have brought together the communities and women’s groups in the area and involved the local district officials and Members of Parliament, so the whole community can really work together. Once a women’s group has been set up in a community, it is very low cost to run and it is likely to carry on after project funding comes to an end. In Nepal, for example, many groups have been meeting for seven years without any external financial inputs. Looking from the outside, the main benefit is that this approach has been demonstrated to reduce newborn mortality. Seven randomised control trials have been conducted in Nepal, Bangladesh, India and Malawi and a meta-analysis of the results has been accepted by the World Health Organization (WHO), which recommends women’s groups to improve maternal and newborn health, particularly in rural settings with poor access to services. On average, we have shown that the groups are reducing newborn mortality rates by 33 per cent and maternal mortality rates by 49 per cent.