



EVENT REPORT

Global Maternal Newborn Health Conference

(18th - 21st October 2015, Mexico)



Acknowledgements

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Summary

October saw the first-ever [Global Maternal Newborn Health Conference](#) (GMNHC) take place in Mexico. Technical implementers, policymakers, researchers and practitioners from global maternal and newborn health (MNH) communities in more than 50 countries came together to discuss strategies for reaching every mother and newborn with high-quality health care in the Global Goals era.

The landmark conference was centred on three themes: integration, equity and quality of care. In this vein, SHARE was delighted to host the only panel discussion on water, sanitation and hygiene (WASH) and MNH integration.

WASH and MNH – using what we know to accelerate progress on WASH access and MNH outcomes

Nowhere at the GMNHC was ‘integration’ – different sectors working together – more aptly demonstrated than in a panel session on WASH and MNH, a topic that incorporates both Global Goal 3 (to ensure healthy lives and promote well-being for all at all ages) and Global Goal 6 (ensure availability and sustainable management of water and sanitation for all).

This lively session was moderated by Professor Wendy Graham, of [the Soapbox Collaborative](#) at the University of Aberdeen, and consisted of presentations from six panellists including: two epidemiologists, an obstetrician, two health and hygiene specialists and a water specialist. Between them they represented academic research institutes, government organisations, non-governmental organisations and donor agencies.

The first four speakers gave us a picture of the current state of WASH in health care facilities in low- and middle-income countries:

Oona Campbell, Professor of Epidemiology and Reproductive Health at [LSHTM](#), outlined the evidence that exists about the impact of WASH on MNH analysed using a framework that showed gender inequalities and a life course perspective. While more evidence is needed (and thus more research), her main message was that we have [enough evidence to know that we need to act](#). WASH interfaces with quality of care and other MNH issues. As the number of pregnant women delivering in health facilities increases, the quality of MNH services is becoming increasingly important in all its aspects, including: inter-personal relationships, staff training and skills, the availability of supplies and infrastructure. Professor Campbell proposed that ‘access to WASH’ should become a tracer indicator under Global Goal 3 to support the provision of facility-based WASH.

Dr Kranti Vora, Associate Professor at the [Indian Institute of Public Health](#), described a [situation analysis](#) of the labour rooms of health facilities in India and Bangladesh that was conducted using the [WASH & CLEAN Toolkit](#). This toolkit, developed by SHARE and the [Water Supply and Sanitation Collaborative Council](#), comprises a number of tools to assess both the visual and bacteriological cleanliness of delivery rooms in health facilities through observation, swab analysis and semi-structured interviews with health facility managers, staff (including medical staff and cleaners) and clients. The study found that visual cleanliness could not be relied upon for infection prevention and control and that staff at all levels, including cleaners, needed to be trained in all aspects of WASH. Since the study, the State Government in Gujarat, where the Indian facilities that took part in the study were based, has ordered that WASH is monitored in all health facilities.

Alison Macintyre, a health researcher with [WaterAid Australia](#), described a tool that has been developed, to assess WASH in health care facilities (HCFs) in Cambodia. Working with [Emory University](#), WaterAid undertook a [situation analysis of HCFs and referral hospitals](#). Around one quarter of HCFs did not have access to an improved water supply and not all delivery rooms had a water supply. All the referral hospitals surveyed had access to an improved water supply, although none met water quality standards. There was no drinking water and the infrastructure for WASH and accessibility to it were poor. Moreover, while in some cases there was soap for doctors and staff to use, no soap was available for patients and their care givers, and not all delivery rooms had a water supply. It is intended that these

assessments will provide information for advocacy and to spur the Ministry of Health to make improvements to health care facilities.

Fabrice Fotso, a water specialist with [UNICEF Senegal](#) outlined the findings of a review of water and sanitation access in obstetric facilities in 14 countries in West and Central Africa. Emergency obstetric and newborn care needs assessments covered WASH-related infrastructure, health and safety and the motivation of staff. Not only does the lack of water and WASH facilities affect patient care, but often there are no wash room facilities or running water for staff as well. Fotso suggested that there should be global standards for WASH in health facilities with set criteria. While the World Health Organization (WHO) has set out environmental health standards for health facilities in 2008, what is missing is a set of basic minimum standards, he said.

The last two speakers looked at innovations to improve hand cleaning behaviours, particularly among mothers and other family members in households where there is a newborn baby. Many communities do not have access to an improved water source, or even to any water source at all within their homes. One opportunity to promote behaviour change around hygiene practices for the care of newborns is when women visit health clinics for antenatal visits. **Merri Wenger**, from [USAID](#), described a [project in Malawi](#) which is training clinic staff to deliver training to pregnant women in the use of safe hygiene practices to prevent infection, using water hygiene kits. Each pregnant woman was given a storage container, a bottle of water treatment solution, soap and education materials. They received top-up supplies in subsequent antenatal and postnatal visits. The programme was assessed nine months after being implemented and again after 3 years to assess its sustainability in improving hand washing techniques. The results were promising with around two thirds of women continuing to use the correct handwashing technique and some continuing to buy the water treatment solution, with wider benefits for the whole family.

For households without a water supply in the home, another innovation being tested to help prevent infections in babies during the perinatal period is waterless hand cleaning with chlorhexidine. Chlorhexidine is an antiseptic antibacterial agent, recommended by WHO for umbilical cord care. **Professor Pavani Ram**, from the [University of Buffalo](#), has conducted a [randomised control trial in Bangladesh](#) to promote chlorhexidine for waterless hand cleansing to mothers before contact with their baby. Pregnant women who received a bottle of chlorhexidine during their antenatal visits were found to have increased their hand cleansing compared with women in the control arm, and the other family members of women in the intervention arm also increased their hand cleansing behaviour.

When summing up, Professor Graham noted that the congruence of increased facility deliveries and the launch of the Global Goals presented a timely opportunity to improve access to WASH in HCFs' delivery rooms and save mothers and babies from falling ill or dying from preventable infections.

Presentations from the session can be viewed here:

<http://www.sharereseach.org/research/global-maternal-newborn-health-conference-presentations>



Research for sanitation and hygiene solutions

The SHARE Research Consortium comprises eight organisations that have come together to generate rigorous and relevant research for use in the field of sanitation and hygiene. The purpose is to join together the energy and resources of these partners in order to make a real difference to the lives of people all over the world who struggle with the realities of poor sanitation and hygiene.

SHARE is led by the London School of Hygiene & Tropical Medicine (LSHTM) and includes the following partners:

- Centre for Infectious Disease Research, Zambia
- Great Lakes University of Kisumu, Kenya (GLUK)
- International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B)
- International Institute for Environment and Development (IIED)
- Mwanza Interventions Trial Unit, Tanzania
- Shack/Slum Dwellers International (SDI)
- University of Malawi (College of Medicine and Polytechnic)
- WaterAid

The SHARE core team work from LSHTM.

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