Newsletter - December 2024

Dear friends and supporters of HDI

HDI's work to help the Ministry of Health in Togo eliminate and control "Neglected Tropical Diseases" continues to go well thanks to our dedicated team and USAID funding.

Otherwise, 2024 has been a frustrating year. But it looks to be ending well, and with a nice story.

When the article with results from almost 1.4 million births in health facilities in Niger, in West Africa were published in respected *The Lancet Global Health* in early 2023, we celebrated a little and then started working to get other countries and their supporters to repeat the "experiment". Actually, we had tried for several years. But this now became our main aim.

In all science, in physics, chemistry, medicine, and otherwise, when an experiment succeeds the next step is ALWAYS to repeat it in other settings, especially if results are "better than expected".

A reduction of 70% in the world's main cause of maternal mortality, and well over 50% fewer within two years in one of the world's poorest countries is definitely "better than expected". Technically, it is perfectly reasonable given the science behind it. "But seriously, ... ! "

Better than expected. But checked each month for aberrant numbers, and with a system to check numbers against underlying documentation on individual births and deaths in health facilities in all of the regions through all 72-months. Also, nobody put magic drops in the Niger River.

Even so. The results are not considered "true", worth doing, until the same approach gives exceptionally impressive results in other countries too.

And many are therefore eager to repeat the experiment, so women in their country also have a better chance of surviving childbirth? For some, that was obviously true. We worked with people in different countries, also in health ministries, planning how much medicine and supplies need to be procured, based on how many health centers and hospitals have deliveries. Then things went silent. In country after country after country. Completely. Silent.

In part we think people were unable to get the information needed. And they may have been embarrassed. But we believe a very different reality is also blocking the way. When all manner of UN-agencies, bilateral development agencies, universities at home and abroad, and NGOs provide a steady stream of good ideas, "cake recipes" I call them, for how to get one delicious result after the other on one important topic after the other, but budgets barely cover a measly salary for insufficient staff, one is unlikely to plan for anything where money is not already on the table.

No money, no budget. No budget, no funding proposal.

In other words, new initiatives in the global "south" mostly address things which large-donor countries are focused on, currently environment including rain-forests, education, to some extent

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agriculture, stimulating business creation, and diseases that may threaten us too, such as HIV, influenza, any virus that can unleash global pandemics, initiatives to limit population growth in other parts of the world, etc. All of this also, of course, because of the considerable benefits to populations in "the south"!

Ensuring that more women survive childbirth seems, currently, to be "the wrong kind of project", also because it is considered "vertical", which is to say focused on particular outcomes rather than building a whole health system.

The latter view is strongly held but based on a small misconception. "Somebody must do the surgery", also in integrated health systems, also in the poorest of countries. Results are better when those who do, do *lots* of surgery. Besides. When a health system achieves really good results on issues that people care greatly about, even with limited resources in a poor country, that strengthens the health system by building trust with the community, thus increasing the probability that health workers work conscientiously with what meagre resources they have. When something saves lives, quickly, and brings cash benefits several times the running-cost, and for example reduces overall maternal mortality by 34.5% as in Niger, it ought to be "worth it" to let 2-3 people focus on this. And worth it to repeat the experiment in a handful of countries.

Encouraging news. And a nice story.

The day after Thanksgiving brought exciting news. Niger has decided! Niger asked partners to help prevent deaths due to eclampsia (hypertensive catastrophe with convulsions), the world's second most common cause of maternal mortality, and to prevent obstructed labor deaths. Combatting obstructed labor deaths should also prevent obstetric fistula among its survivors.

That is what we are suggesting countries do, to get the most out of an investment to prevent women from bleeding to death, also in "new" countries because "all that is needed" is to buy one additional medication, magnesium sulphate (cheap!), which health workers in Niger already know how to use. The stock-out-prevention component that handles misoprostol can handle one additional drug - not all drugs needed for reproductive health - but one. Niger also decided to address maternal deaths due to infection.

Their plan is to test this in four of their eight regions, where over 17 million, over 70% of the population lives. World Bank Results-Based Financing already supports a maternal mortality project in the two most populous of those four regions.

We in HDI will do what we do best, support the overall planning and implementation in a low-key manner - important that the national health system gets the credit - help ensure the quality of numbers collected each month, and analyze those numbers. We have hope for 2025.

A nice story, from Congo **(The Democratic Republic of Congo, DRC)**

This fall, in October a woman in labor arrived at a remote rural Congolese health center staffed by one very young doctor. She gave birth as she had many times, then bled profusely and went into shock. Misoprostol tablets did not stop it. The nearest hospital is 35 kilometers away. No road. So, no ambulance. Evacuation by motorcycle was impossible. He knew she would be dead within the hour that would take. Desperate, he called a senior doctor at another hospital. "Do a hysterectomy!" Impossible. He had never been trained in that operation. Even more desperate, and disappointed, he called another senior doctor, this time in a really remote health center like his own. That doctor was doing surgery, could not leave now but advised his young colleague to find

a condom, a piece of string, a catheter; tie the condom onto the catheter. Put the catheter into the uterus; fill with lots of water in hopes of it being a temporizing measure until he could get there in case hysterectomy was needed. Young doc did as instructed. When the senior colleague arrived three hours later, the woman had received two blood transfusions, was stable. The experienced physician removed the condom. Through one hour's observation she did not bleed, at all.

Where did the senior doctor learn this?

He was present during a one-hour training on preventing and managing PPH for doctors, nurses, and midwives at the hospital in Vanga,* over the internet from HDI's office in Niamey 2,500 km away, and from a kitchen floor in Norway. Teaching without practicing, but with demonstrations. Three years later, he successfully explained how to do an intrauterine condom tamponade, by phone. A woman was saved. And many were spared from growing up as a motherless child.

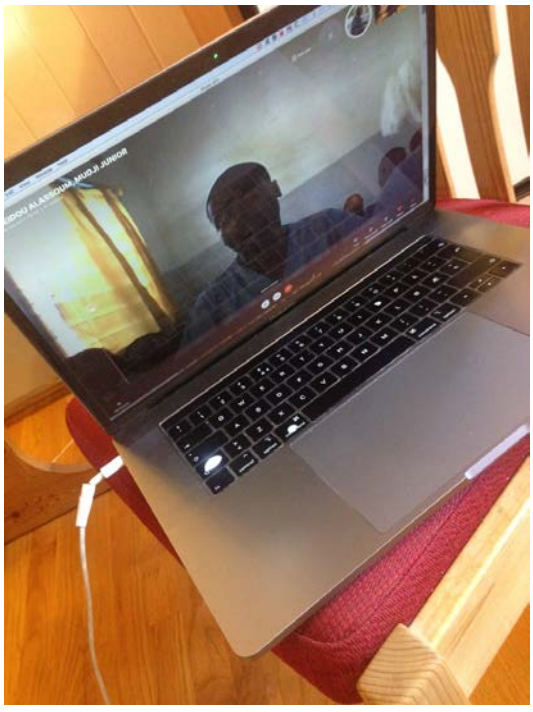
I and everyone at HDI greatly appreciate your support, friendship, and encouragement, all of which make these results possible !!

Warmest wishes for lovely Holidays, a fine new year, and for peace where tragedy is still unfolding.

Anders

* Vanga Evangelical Mission Hospital

Demonstration:
How to apply "anti-shock pants"



Participants in Vanga hospital, Congo. Picture of the demonstration in upper right corner, April 17,2021.