

WHAT HEALTH POLICYMAKERS CAN DO

FACTS

- Anemia is one of the most widely prevalent disorders, affecting the lives of almost half a billion women of reproductive age.¹
- Iron deficiency anemia (IDA), alone, contributes to over 100,000 maternal and almost 600,000 perinatal deaths each year.² Inter-generational impacts include increased risk of infant mortality, pre-term delivery, low birth weight, and reduced cognitive development in children.³
- Anemia results in reduced energy levels which affect productivity, earning power and even maternal caring practices. Economic losses due to IDA alone are estimated at approximately \$0.32 per capita or 0.6% of GDP.⁴
- Anemia has multiple causes: increased iron requirements during pregnancy, inadequate intake of micronutrients, particularly iron, and malaria, hookworm, HIV, diarrhea and other infections.

VISION

- Reduce maternal and neonatal deaths, and improve health, productivity and economic development.

ACTION

Proven, cost-effective interventions can reduce maternal anemia during pregnancy and lactation. The package of activities includes:

- In all countries: Provide iron-folic acid supplementation; promote healthy timing and spacing of pregnancy; and prevention of postpartum hemorrhage through active management of third stage of labor (AMTSL).
- In malaria endemic areas: Provide intermittent preventive treatment, long-lasting insecticide-treated bed nets, indoor residual spraying, and artemisinin-based combination therapy.
- Where hookworm prevalence exceeds 20%: Provide de-worming medication during Child Health Days and as a routine part of ante-natal care (ANC).

6 PRIORITIES



Increase political commitment.

The strong links between maternal anemia reduction and maternal and perinatal survival (MDGs 4 and 5) call for a renewed commitment to anemia control.

- Improve coordination between global stakeholders, including the private sector, to prioritize key activities.
- Provide adequate funding for scale-up and service delivery throughout the maternal health continuum of care.



Integrate with health programs.

Increased focus and attention on the multiple causes of maternal anemia will result in more harmonized and integrated implementation of prevention and treatment efforts.

- Identify and nurture champions for maternal anemia within maternal and child health and nutrition, reproductive health, malaria, HIV, TB and neglected tropical diseases communities.
- Integrate standard anemia control strategies, training, messages, and protocols across focused ANC/birth/postpartum, and infectious disease policies, guidelines and programs.



Provide pharmaceuticals and supplies.

Further work is needed to strengthen and maintain strong supply systems for the package of maternal anemia control activities.

- Ensure adequate, quality supplies of IFA for supplementation, oxytocin for AMTSL or misoprostol for community-based use, and contraceptives for birth spacing.
- Where hookworm is prevalent, ensure availability of antihelminths, and in malaria-endemic areas, locally effective antimalarial medications, bed nets, and insecticides for spraying.
- Through public-private-community linkages, increase the safety of packaging, ease of use and affordability of commodities.

FOR POLICYMAKERS

Expand roles for communities.



Communities play an important role in increasing women's access to the full package of services to prevent common causes of anemia.

- Use complementary delivery platforms, such as community based distribution, to reach pregnant women.
- Build community-clinic linkages to bridge the gap between community advocacy/support and clinical service delivery.
- Use community health networks to bring needed services, supplies and follow-up directly to the homes of pregnant women.
- Listen and take action to overcome the barriers women face in accessing anemia prevention and treatment to develop context-relevant approaches, such as the provision of the full course of IFA at first treatment.

Increase demand.



Social marketing can be further utilized to create awareness of and demand for services and supplies. Counseling at the community and health service level can help women understand and adhere to IFA supplementation, family planning and other interventions.

- Use supportive supervision systems to reinforce adequate counseling of pregnant women and ensure that local realities are addressed in the counseling provided.
- Empower health workers and volunteers for quality counseling to improve adherence.

Strengthen monitoring and evaluation.



Monitoring program implementation indicators can facilitate quality service delivery of interventions addressing the root causes of maternal anemia.

- Integrate into routine health information systems indicators on quality and coverage of ANC, family planning and reproductive health, malaria prevention and other health services.
- Establish supportive supervision systems for both clinical staff and community-based volunteers to put the information to work in addressing gaps in implementation and reinforcing program progress.

Six priorities for policymakers can save lives, improve health, increase productivity and make maternal anemia control a reality.

Resources

The following resources provide more information about the causes and consequences of maternal anemia and promising practices in its prevention and control.

A2Z /ACCESS/FANTA. *Maternal Anemia: A Preventable Killer* (2006).

Agarwal, KN., Agarwal, DK., Mishra, KP. *Impact of anemia prophylaxis in pregnancy on maternal hemoglobin, serum ferritin and birth weight.* Indian J Med Res (1991); 94:277–80.

FIGO/ICM. *Prevention and Treatment of Post-partum Haemorrhage: New Advances for Low Resource Settings* (2006).

Galloway, R. *Anemia Prevention and Control: What Works Part 1 | Part 2.* Population, Health, and Nutrition Information Project (2003).

Hemminki, E., Rimpela, U. *Iron supplementation, maternal packed cell volume, and fetal growth.* Arch Dis Child (1991); 66:422–5.

McLean, E., Cogswell, M., Egli, E., Wojdyla, D., de Benoist, B. *Worldwide prevalence of anemia.* WHO Vitamin and Mineral Nutrition Information System, 1993–2005, 2008 Public Health Nutrition: 2(4), 444–454.

Kraemer, K. and Zimmerman, M. (Editors). *Nutritional Anemia.* Sight and Life Press, Basel, Switzerland (2007).

Prendiville, WJ., Elbourne, D., McDonald, S. *Active versus expectant management in the third stage of labour (Review).* The Cochrane Library (2008), Issue 1.

Singla, PN., Tyagi, M., Kumar, A., Dash, D., Shankar, R. *Fetal growth in maternal anemia,* J Trop Pediatr (1997); 43:89–92.

Stoltzfus, RJ., Mullany & Black. *Comparative quantification of health risks: Global and regional burden of disease attributable to selected major risk factors.* WHO, Geneva (2004).

Thomas, D., Frankenberg, E., Friedman, J., Habicht, JP. et al. *Causal effect of health on labor market outcomes: Evidence from a random assignment iron supplementation intervention* (2004).

Zeng, L., Dibley, MJ., Cheng, Y., Dang, S., Chang, S., Kong, L., Yan, H. *Impact of micronutrient supplementation during pregnancy on birth weight, duration of gestation, and perinatal mortality in rural western China: double blind cluster randomized controlled trial.* BMJ (2008); 337:a2001

Zhang, Q., Ananth, CV., Li, Z., and Smulian, JC. *Maternal anemia and preterm birth: a prospective cohort study.* International Journal of Epidemiology (2009);1–10.

References

1. McLean, E., Cogswell, M., Egli, E., Wojdyla, D., de Benoist, B. *Worldwide prevalence of anaemia,* WHO Vitamin and Mineral Nutrition Information System, 1993–2005, 2008, Public Health Nutrition: 12, 444–454.
2. Stoltzfus, RJ., Mullany & Black. *Iron Deficiency Anemia, Comparative quantification of health risks: Global and regional burden of disease attributable to selected major risk factors,* WHO, Geneva, (2004).
3. Allen, L. *Anemia and Iron Deficiency: effects on pregnancy outcome.* AJCN (2000); 71 (suppl) 1280S-84S.
4. Horton, S. and Ross, J. *The Economics of Iron Deficiency.* Food Policy (2003); 28: 51–75.



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