EDITORIAL

Advancing implementation in maternal and newborn health: Two decades of experience

In the past 15 years, Jhpiego has had the privilege of working with governments and other partners to implement interventions for maternal and newborn health (MNH) in nearly 40 countries. This Supplement to the International Journal of Gynecology and Obstetrics (IJGO) is our attempt to share our analysis and learning from those experiences as the global health community looks toward 2030 and beyond, and to ensure that implementation challenges, as well as the resources required to address them, are an important part of the post-Millennium Development Goals conversation.

The new paradigm for MNH envisioned by the UN Secretary General’s Sustainable Development Goals and the Global Strategy for Women’s, Children’s, and Adolescents’ Health aims to bring evidence-based MNH interventions to national scale, setting ambitious targets to reach the unreached in every country and end all preventable deaths among women and children. Scale is not only about what works; it is about how to make that which has been proven to work in small, controlled areas apply equally well across all contexts. So we must ask ourselves: What does it take for health systems to reach every woman, every child, everywhere, every time?

The answer to this classic implementation science question is difficult to quantify, but we do have some evidence, and as with any scientific inquiry, we should start with the evidence that we have. The papers in the Supplement have been written by and for implementers, describing in detail what has been accomplished and highlighting lessons about what did and did not work. The lessons themselves will not be new to anyone who has worked in MNH as long as we have, but we believe that their thoughtful analysis and collective and inductive presentation is a unique illustration of the complexity of achieving—and then reinforcing—implementation results. Implementation science for MNH has a long road ahead.

The papers in the first section directly confront the “how” of implementation. Even if we have all the right interventions, we need political commitment and partnerships to bring those interventions to populations in need. Sometimes these elements are beyond the control of implementers owing to contextual factors and prioritizations inherent in real-world public health environments, but there are common principles that can help navigate politics and partnerships more strategically and systematically to reach goals more rapidly and with longer-lasting efforts. We should not, however, sacrifice quality for speed; quality improvement, particularly the linkages between quality and health outcomes, remains a critical but under-funded area of our work.

The second section examines the “who” of implementation, documenting ways to empower all cadres of frontline health workers with appropriate competencies to deliver evidence-based interventions, wherever women and children need them. It is our belief that those who work in MNH must truly embrace task-shifting and community interventions, especially those delivered by community health workers, to reach the unreachable and end preventable deaths in the last mile. MNH champions, including the readers of IJGO, play an essential role not only in modeling and echoing technical excellence but also in promoting the responsible task-shifting and community-based delivery that is required to facilitate sustainable impact at scale.

The third and final section explores specific interventions that have been or should be considered for scale: core examples of the “what” of MNH implementation. Jhpiego’s experiences in setting up programs for emergency obstetric and newborn care, postpartum family planning, malaria in pregnancy, and prevention of maternal-to-child transmission of HIV show the wide range of implementation factors and the reality that there is no single successful implementation strategy for all interventions. MNH interventions will go farther with a focus on pre-service education, engaging learners as early as possible.

Going forward, we need to harness the power of unlike minds and those of our beneficiaries to approach implementation with the kind of design thinking and crowd-sourced inputs that has benefitted the fields of business and engineering. MNH is at a critical crossroads as the era of the Millennium Development Goals ends and new goals are set. It is time to set goals that are more precise than “skilled care at birth” so we can hold ourselves accountable to coverage at scale, such as use of uterotonics and immediate postpartum contraception. If we are committed to eliminating preventable deaths among women and children, we must convince nations to invest in strengthening systems and in improving quality of care for mothers and newborns, and achieve quality at scale. Just as we found the resources to reach high immunization rates, we must find the resources and political will to implement other MNH interventions and measure that implementation to achieve impact at scale. In doing so, we will not only achieve greater maternal and newborn survival but start to reduce the morbidities that will remain an obstacle far beyond 2030. If we learn to implement better, women and children will receive more effective care and be more likely to return to their families safe and healthy.

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**Conflict of interest**

The authors have no conflicts of interest.

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