What you are holding in your hands is a new generation of the Safe Motherhood newsletter, formerly published by the World Health Organization. Lives will be published every six months by the Partnership for Safe Motherhood and Newborn Health, an independent global health partnership based at the WHO in Geneva.

Lives will report on the latest news and trends in maternal and child health, highlighting best-practice case studies and keeping you up to date on global advocacy efforts. Like Safe Motherhood, Lives will feature country-level innovations, personalities, and news, while an expanded “New Resources” section will offer links to the latest materials, including those with immediate online access. Ideas or comments? A submission to our new “Opinion” column? We look forward to hearing from you at lives@safemotherhood.org
The need for urgent, large-scale action to achieve UN Millennium Development Goals 4 & 5 has sparked a new global health partnership.

The Partnership for Maternal, Newborn, and Child Health will be created from three existing alliances: the Partnership for Safe Motherhood and Newborn Health, headquartered at the World Health Organization in Geneva and the publisher of this newsletter; the Healthy Newborn Partnership, based at Save the Children USA; and the Child Survival Partnership, based at UNICEF in New York. The new partnership will be launched in September in New York at the UN’s 2005 World Summit, which will examine progress towards the Millennium Development Goals.

“The scale of the problem demands urgent, co-ordinated action,” says Petra ten Hoope-Bender, executive officer of the Partnership for Safe Motherhood and Newborn Health and interim director of the new partnership. “More than a half-a-million women die each year of childbirth-related problems and 11 million children do not see their fifth birthday. Yet maternal, newborn, and child health needs have lost out in past decades to other global priorities. This new partnership recognizes that you need to address maternal, newborn, and child health as an integrated issue and to push for greater political and financial commitment on that basis.”

The new alliance, to be based at the WHO in Geneva, will support country-level efforts to expand the reach of essential interventions for reducing maternal, newborn, and child mortality; promote the adoption and development of evidence-based, cost-effective approaches to reduce such mortality; and promote greater co-ordination and co-operation among all stakeholders.

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Delhi Declaration Calls for Action on Maternal, Newborn, and Child Health

Increasing public expenditures, however, is only one part of the strategy. It has to be accompanied by innovations in the management of delivery systems.

– Sonia Gandhi

A three-day meeting of health ministers, experts, and advocates has resulted in an unprecedented global consensus that outlines the way forward for reducing maternal, newborn, and child mortality. The Delhi Declaration is a call to action for achieving UN Millennium Development Goals 4 & 5. It underlines the importance of greater financial and political commitment to increase coverage of cost-effective and proven interventions that can save up to 7 million lives per year.

The document was agreed in New Delhi during “Lives in the Balance: The Partnership Meeting for Maternal, Newborn, and Child Health”, 7-9 April. The high-level meeting sought to address key constraints and gather support for scaling-up interventions to improve maternal, newborn, and child health in the world’s most affected countries. Ministers and delegations attending the meeting came from Ethiopia, Tanzania, Uganda, Mali, Mozambique, India, Nepal, Pakistan, Bangladesh, Cambodia, Bolivia, and Canada. The meeting was inaugurated by WHO Director-General Dr Lee Jong-wook and UNICEF’s outgoing executive director, Carol Bellamy, among other dignitaries.

The Declaration, which highlights the need to strengthen health systems and expand the supply of skilled health personnel and commodities, was launched at the end of the three-day meeting by India’s Sonia Gandhi, chairperson of the National Advisory Council. “The Delhi Declaration is an important step in the right direction,” said Gandhi. “It sets the stage for decisive action by governments, international institutions, and civil society organizations. Through this Declaration, we affirm our commitment and renew our resolve to work together.”

“Lives in the Balance” was hosted by the Government of India and organized by the Partnership for Safe Motherhood and Newborn Health, together with the Healthy Newborn Partnership and the Child Survival Partnership.

The three partnerships used the occasion of the meeting to announce their intention to merge into a single global partnership to boost advocacy efforts, as well as to support national governments in strengthening health systems (see left).

Said Shahida Azfar of the Child Survival Partnership: “Through concerted action and increased financial and political commitment, we can achieve a major reduction in mortality all over the world.”


Make Every Mother and Child Count calls for a new approach to save the lives of mothers and children. The report says the number of women and children who die each year could be sharply reduced through wider use of key interventions and a “continuum of care” approach for mother and child that begins before pregnancy and extends through childbirth and into childhood.

The report adds that putting in place the health workforce needed for scaling up maternal, newborn, and child-health services towards universal access is the first and most pressing task.

“More than 6 million children could be saved if they had simple healthcare, and thousands of women could be saved if they had access to skilled care,” said Dr Lee. Emphasizing the fact that healthy mothers are the foundation of every society, he added that WHO and its partners were not attempting the impossible: “The Millennium Development Goals for health are attainable. Our message today is one of hope.”

Rebecca Harding
Supermodel Named WHO Ambassador

Ethiopian supermodel and mother Liya Kebede is making news away from the runway these days: She is WHO’s newly appointed Goodwill Ambassador for Maternal, Newborn, and Child Health. Kebede will be responsible for raising global awareness of these issues and supporting WHO in its campaign to improve the health of mothers and children. Kebede’s appointment was announced in early March, in the run-up to World Health Day 2005: “Make Every Mother and Child Count.”

Kebede’s immediate duties have included an appearance on the popular Oprah Winfrey Show in the US. The segment, “Oprah goes to Ethiopia”, will air in September. It profiles Kebede in her new role with WHO and features the Addis Ababa fistula hospital that Kebede visited earlier this year.

Kebede also appeared on the cover of American Vogue magazine in May, highlighting her new role as campaigner for the health of women, newborns, and children around the world. Rebecca Harding

2005 World Summit to Review Progress on MDGs

Five years after the Millennium Declaration was signed in September 2000, the UN will convene a high-level meeting of world leaders, 14-16 September, at its New York headquarters for a comprehensive review of the progress made towards the Millennium Development Goals (MDGs).

The 2005 World Summit, to be held at the beginning of the UN’s 60th General Assembly, will also tackle issues such as human rights, peace and security, and how to strengthen the United Nations. The outcome of the Summit will be a political declaration focusing on four major issues: freedom from want, freedom from fear, freedom to live in dignity, and the imperative for collective action.

The meeting “will give us a unique opportunity to inject new energy into the pursuit of the vision that is embodied in the Millennium Declaration,” said UN Secretary-General Kofi Annan in setting out the plans for the three-day plenary.

Development will be high on the agenda for the World Summit, as governments are expected to renew their commitment to achieving the MDGs by 2015. Of the eight MDGs, two are directly related to maternal and newborn health. Goal 4 on child mortality sets a target of reducing the under-five mortality rate by two-thirds from 1990 levels. Goal 5 on maternal health calls for reducing the maternal mortality ratio by three-quarters from 1990 levels.

In the lead-up to the Summit, civil society organizations and the private sector were invited for informal interactive hearings of the General Assembly in late June. Also, a number of international meetings are helping to set priorities as the declaration is being negotiated. For example, the resolution “Working Towards Universal Coverage of Maternal, Newborn, and Child Health”, recently adopted by the World Health Assembly’s 192 member states, is expected to frame discussion of these issues. The resolution calls for governments to “commit resources and accelerate national action towards universal access and coverage with maternal, newborn, and child health interventions, through reproductive health care.”

Shannon Kowalski-Morton

Fistula Fortnight

It is surely one of pregnancy’s cruellest outcomes, turning mothers into social outcasts. The UNFPA and its partners set out to draw global attention to the issue by holding a “Fistula Fortnight” in northern Nigeria during February 2005.

For two weeks, Nigerian surgeons joined forces with volunteer doctors from the United States and United Kingdom to treat 545 women. Dozens of Nigerian doctors, nurses, and social workers were also given training in surgery and post-operative care.

About 800,000 Nigerian women live with this preventable injury, which results from prolonged obstructed labour. Often the baby dies and the woman is left with chronic incontinence. “When the women arrive, they feel like outcasts [with] no hope,” says Mustafa Lawal, one of the trainee surgeons from Kebbi state. “When their fistulas are repaired, they are very happy.”

“For 20 years, I was leaking,” says Aminatu Liman, 60. She suffered fistula after three days in labour with her third child, who was stillborn. She was treated at the Maryam Abacha Hospital in Sokoto. “I’m very happy and grateful,” she says.

Women like Aminatu show us “the necessity of good maternal health care,” says UNFPA Executive Director Thoraya Ahmed Obeid. “The ‘Fistula Fortnight’ has helped us address the tremendous backlog of patients. Together we can end fistula by strengthening maternal health systems.”

The Nigerian event is part of a global campaign by UNFPA and its partners to end fistula, which affects more than 2 million women around the world. The campaign was launched in 2003 and now covers more than 30 countries in sub-Saharan Africa, South Asia, and some Arab States. The campaign works in prevention, treatment, and support, to help women return to their communities after repair (http://www.endfistula.org).

Smaller-scale versions of the Nigerian Fistula Fortnight may be held as early as March 2006, says UNFPA Media Officer Micol Zarb. Candidate countries include Mauritania, Mali, and Djibouti, where there will be strong emphasis on the training of local providers. Brigid McConville
The Lancet Draws Global Attention to Newborn Health

“Eight million children are either stillborn or die each year within the first month of life. This figure never makes news. The aim of the present Lancet series is to erase the excuse of ignorance for public and political inaction once and for all.”

– Richard Horton, Editor, The Lancet

Leading international medical journal The Lancet has published a landmark series of papers on newborn health, drawing global attention to important new research about the issue.

According to the March 2005 publication, 4 million newborn babies worldwide die each year, and nearly 3 million of them could be saved if they and their mothers had access to low-cost care such as tetanus immunizations during pregnancy, exclusive breastfeeding, clean delivery, and antibiotics to treat illness.

The UN Millennium Development Goal 4 for child survival cannot be met without substantial progress in reducing neonatal deaths, yet most safe motherhood and child survival programmes have not previously included systematic attention to newborn health.

“The global commitment to achieving the Millennium Development Goal 4 for child survival cannot be met without substantial progress in reducing neonatal deaths, yet most safe motherhood and child survival programmes have not previously included systematic attention to newborn health.”

Neonatal mortality can be reduced to less than 15 per 1000 births (less than one-third of current rates in Africa) without highly technical care. Analysis conducted for The Lancet series found that 16 low-tech and cost-effective interventions could be provided to 90% of women and babies in the 75 highest mortality countries for only US$ 1 extra per capita per year. (These interventions are featured in the pull-out poster on pgs. 8-9.) Since these 16 interventions belong within packages of care addressing maternal and child health, 70% of the extra running costs required would also benefit mothers and children.

The newborn series follows the highly successful Bellagio Child Survival series, published in July 2003 in The Lancet, which focused on affordable, effective measures to prevent deaths of millions of children under the age of five, and highlighted newborn deaths as a neglected area. A Lancet series on maternal health is being planned. These publications are in tune with the messages of the World Health Report 2005: Make Every Mother and Child Count and Who’s Got the Power?: Transforming Health Systems for Women and Children, the report of the UN Millennium Project’s Task Force on Child Health and Maternal Health (see pg. 7).

The Lancet newborn series was launched in London and Washington, DC, in early March and drew strong media attention. “It is important to note that we do not need to discover a cure or pay for high-tech equipment to reduce newborn deaths, and the Lancet research underscores that,” said Anne Tinker, director of the Saving Newborn Lives initiative at Save the Children USA, in her comments at the crowded US press launch.

Subsequent launches followed in Pakistan, Egypt, and Nepal and are expected in other locations in Africa, Asia, and South America in the coming months. The series is being translated into both French and Spanish. Within a few weeks of publication, a number of African governments requested technical support for integrating newborn health interventions into existing programmes and a broad coalition of partners is working together to provide this support.

Many international health and development agencies contributed to the production of The Lancet newborn series, including the World Health Organization, UNICEF, The World Bank, and Saving Newborn Lives, as well as leading academic organizations. The Bill & Melinda Gates Foundation and USAID provided funding.

The series can be accessed at http://www.thelancet.com/collections/neonatal_survival. Kruti Kapadia

![Causes of Death in the First Month of Life](image_url)
Brisbane Hosts ICM Congress

More than 2,000 midwives from around the world are expected to attend “Midwifery: Pathways to Healthy Nations”, the 27th Triennial Congress of the International Confederation of Midwives, held in Brisbane, Australia, from July 24 to 28 (http://www.midwives.com).

The event is held every three years as a global forum for the exchange of knowledge and experience among those concerned with maternity, newborn, and women’s health care. This year’s programme will feature a different theme each day, including History (the achievements and legacy of the past), Professionalism (the convergence or contradictions of midwifery as a profession and the needs of women and families), Current Ways of Knowing (a critical look at how midwifery works for and with childbearing women), and Future Pathways (how midwifery can become more responsive, responsible, and adaptable towards women’s needs).

The event is expected to attract many first-time Congress attendees, including representatives of the Afghan Midwives Association, inaugurated this year on May 5, the International Day of the Midwife. This Triennial is hosted by the Australian Congress of Midwives Inc., a long-time member of the ICM, which consists of 84 member associations worldwide.

“Bringing midwives together is at the heart of all ICM’s many activities,” says Kathy Herschderfer, secretary-general of the ICM. “Each midwife on her own is a powerful person, but when midwives come together from across the world, they become an unstoppable force.”

Brigid McConville

Events

This section provides information on events of international interest. Submissions: lives@safemotherhood.org

1-4 Sept.
4th Congress of the World Society for Pediatric Infectious Diseases
Warsaw, Poland
http://www.kenes.com/wspid2005

11-14 Sept.
2nd International Conference on Birth Defects and Disabilities in the Developing World
Beijing, China
http://www.chinamed.com.cn/birthdefects

15-18 Sept.
International Stillbirth Alliance 2005 Conference
Arlington, VA, USA
http://www.stillbirthalliance.org

23-24 Sept.
8th Seminar, European Society of Contraception
Warsaw, Poland
http://www.contraception-esc.com

1-5 Oct.
XIX Asian and Oceanic Congress of Obstetrics and Gynecology
Seoul, Republic of Korea
http://www.aocog2005.org

12-15 Oct.
“The Fetus as a Patient”: 20th Anniversary Jubilee Conference
Sveti Stefan, Montenegro
http://www.fetus2005.org

8-11 Nov.
5th International Pelvic Floor Dysfunction Society Congress
Buenos Aires, Argentina
http://www.iuga2006.com

13-14 Dec.
Conference on Child Survival
London, UK
http://www.childsurvivalpartnership.org/london-conf.asp

India’s Renu Sharma and her baby, Monica, here aged one week, are featured in WHO’s Great Expectations online series (http://www.who.int/features/great_expectations). The series tracked six women from around the world throughout pregnancy, delivery, and the postpartum period. The series will now go on to follow the lives of their children, starting in September.
Who’s Got The Power?: Health Systems, Equity Are Key

In 2000, the world’s leaders committed themselves to eight Millennium Development Goals (MDGs) as a blueprint for reducing poverty, disease, and hunger through progress in primary education, female empowerment, and maternal and child health among others. To provide governments and civil society with a practical plan for achieving these goals by 2015, an independent advisory body to the UN, the Millennium Project, commissioned 10 thematic Task Forces to propose concrete strategies and develop a framework of action.

Over a span of two years and as a result of extensive consultation, the Task Force on Child Health and Maternal Health (MDGs 4 & 5) analysed what it will take to meet the goals of reducing child mortality and improving maternal health. In its final report, published earlier this year, the Task Force issued a set of nine recommendations for realizing improvements in child mortality and maternal health (see below).

Lynn Freedman, Associate Professor of Clinical Public Health at the Mailman School of Public Health at Columbia University in New York, was a senior advisor to the Task Force and lead author of its report, Who’s Got the Power: Transforming Health Systems for Women and Children (http://www.unmillenniumproject.org/documents/maternalchild-complete.pdf). She anticipates the findings will generate momentum for reframing maternal, newborn, and child health, moving from a focus on disease-specific interventions to a focus on health systems, equity, and human rights. “The report calls on health policymakers to address broad systemic issues that affect the delivery of maternal, newborn, and child health services, such as health-sector financing, human-resource systems, and poverty-reduction strategies,” she says.

Freedman noted that the report can serve as an important tool for civil society groups to hold their governments accountable for progress on the MDGs. In addition, she hopes the report will influence deliberations and outcomes at the upcoming 2005 World Summit (see pg. 4), specifically in terms of revising the targets and indicators, and influencing national-level policies for improving maternal and child health. Shafia Rashid

Recommendations of the MDG Task Force on Child Health and Maternal Health

1. Health Systems: Health Systems, particularly at the district level, must be strengthened, with priority given to strategies for reaching the child health and maternal health goals.
   - Health systems are key to the sustainable and equitable delivery of technical interventions.
   - Health systems should be understood as core social institutions that are indispensable for reducing poverty and advancing democratic development and human rights.
   - To increase equity, policies should strengthen legitimacy of well-governed states, prevent excess segmentation of the health system, and enhance the power of the poor and marginalised to make claims for care.

2. Financing: Strengthening health systems will require considerable additional funding.
   - Bilateral donors and international financial institutions should substantially increase aid.
   - Countries should increase allocations to their health systems.
   - User fees for basic health services should be abolished.

3. Human Resources: The health workforce must be developed according to the goals of the health system, with the rights and livelihoods of the workers addressed.
   - Any health workforce strategy should include plans for building a cadre of skilled birth attendants.
   - Regulations and practices, including those related to “scope of profession,” should be changed to empower a wider range of health workers to perform life-saving procedures safely and effectively.

4. Sexual and Reproductive Health and Rights: Sexual and reproductive health and rights are essential to meeting all the MDGs, including those on child health and maternal health.
   - Universal access to reproductive health services should be ensured.
   - HIV/AIDS initiatives should be integrated with programmes on sexual and reproductive health and rights.
   - Adolescents should receive explicit attention with services that are sensitive to their increased vulnerabilities and designed to meet their needs.
   - In circumstances where abortion is not against the law, abortion services should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion.
   - Governments and other relevant actors should review and revise laws, regulations, and practices — including those on abortion — that jeopardize women’s health.

5. Child Mortality: Child-health interventions should be scaled up to 100% coverage.
   - Child-health interventions should be increasingly offered within the community, backed-up by the facility-based health system.
   - Child nutrition should receive additional attention.
   - Interventions to prevent neonatal deaths should receive increased investment.

6. Maternal Mortality: Maternal mortality strategies should focus on building a functioning primary health-care system, from first referral-level facilities to the community level.
   - Emergency obstetric care must be accessible for all women who experience complications in pregnancy and childbirth.
   - Skilled birth attendants, whether based in facilities or communities, should be the backbone of the system.
   - Skilled attendants for all deliveries must be integrated with a functioning district health system that supplies, supports, and supervises them adequately.

7. Global Mechanisms: Poverty-reduction strategies and funding mechanisms should support and promote actions that strengthen equitable access to quality healthcare and do not undermine it.
   - Global institutions should commit to long-term investments.
   - Restrictions to funding of salaries and recurrent costs should be removed.
   - Donor funding should be aligned with national health programmes.
   - Health stakeholders should participate fully in policy development and funding plans.

8. Information Systems: Information systems are an essential element in building equitable health systems.
   - Indicators of health-system functioning must be developed and integrated into policy and budget cycles.
   - Health information systems should provide appropriate, accurate, and timely information to inform management and policy decisions.
   - Countries must take steps to strengthen vital registration systems.

9. Targets and Indicators: The MDG targets and indicators should be modified as follows:
   - All targets should be framed in equity-sensitive terms.
   - Universal access to reproductive health systems should be added as a target to MDG 5.
   - All targets should have an appropriate set of indicators.

### High-Impact, Simple Interventions to Save Newborn Lives

#### Within the Continuum of Maternal and Child Health Care

<table>
<thead>
<tr>
<th>Pre-pregnancy</th>
<th>Pregnancy</th>
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<tbody>
<tr>
<td><strong>Clinical Care</strong></td>
<td>Skilled obstetric and immediate newborn care, including resuscitation</td>
</tr>
<tr>
<td></td>
<td>Emergency obstetric care to manage complications such as obstructed labour, breech, haemorrhage, pre-eclampsia and preterm labour</td>
</tr>
<tr>
<td></td>
<td>Antibiotics for preterm rupture of membranes#</td>
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<td></td>
<td>Corticosteroids for preterm labour#</td>
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<tr>
<td><strong>Outreach Services</strong></td>
<td>Four-visit antenatal package, including tetanus immunisation, detection and management of syphilis, other infections, pre-eclampsia, and pregnancy complications</td>
</tr>
<tr>
<td></td>
<td>Malaria intermittent presumptive therapy*</td>
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<tr>
<td></td>
<td>Detection and treatment of bacteriuria#</td>
</tr>
<tr>
<td><strong>Family Community</strong></td>
<td>Birth preparedness and promotion of demand for care and readiness for emergencies</td>
</tr>
<tr>
<td></td>
<td>Counselling and preparation for newborn care</td>
</tr>
<tr>
<td><strong>Clean Delivery</strong></td>
<td>Hygienic care of early and breastfeeding</td>
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</tbody>
</table>

* Situational interventions necessary in certain settings, such as high malaria prevalence.
# Additional interventions for settings with stronger health systems and lower mortality.

### Executive Summary:


<table>
<thead>
<tr>
<th>Neonatal period</th>
<th>Infancy</th>
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<tbody>
<tr>
<td>Emergency newborn care for illness, especially sepsis management, and care of very low birth-weight babies, including kangaroo mother care</td>
<td></td>
</tr>
<tr>
<td>Postnatal care to support healthy practices</td>
<td>Healthy home care, including breastfeeding promotion, hygienic cord/skin care, thermal care, promoting demand for care</td>
</tr>
<tr>
<td>Early detection and referral of complications</td>
<td>Extra care of low birth-weight babies</td>
</tr>
<tr>
<td></td>
<td>Community case management for pneumonia</td>
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Fifty Years in Safe Motherhood

Imtiaz Kamal is a nurse-midwife, public health scientist, and author who has worked in 51 countries with WHO and many other agencies. She is now the Secretary General of Pakistan’s National Committee for Maternal Health, and is a founding member of the newly formed Midwifery Association of Pakistan. At 78, she still works full-time for safe motherhood.

Q. What has your life been like as a pioneer for safe motherhood?

My struggle to promote midwifery in Pakistan has been going on for half a century. I have been jeered at, taunted, and shunned – as well as honoured and decorated. I am one of the lucky fighters because I have started to see the results of this uphill journey while I am still alive.

Q. What are the most encouraging changes you have seen?

Midwifery is being talked about at the highest policy levels now, and at last it is on the donor agenda. Our obstetricians are starting to accept that without competent midwives there is no hope of lowering the unacceptably high maternal and neonatal mortality in Pakistan. Midwives are waking up to their identity. Earlier this year, the Midwifery Association of Pakistan was established.

Q. What is the most urgent priority in safe motherhood?

In Pakistan, midwifery is a neglected profession with very little or no practical training. There are only two qualified teachers in the country. I am one of them.

Every female nurse is required to do midwifery, but it is just seen as a requirement to climb the career ladder. Those (non-Registered Nurses) who are only trained in midwifery are at the bottom of that ladder. Yet they are the ones who practise midwifery.

So the top priority is to produce competent midwifery teachers who can produce competent community midwives. Simultaneously, we must improve health-care facilities so that these can provide emergency obstetric and neonatal care.

Q. What is the biggest hurdle to overcome?

The biggest hurdle is the poor status of midwifery. Midwives here are seen as glorified traditional birth attendants. Their education is poor, their salaries are low, and so the profession has no prestige. When midwives start commanding respect, many problems will be solved.

But it is a long road. In 2000, I did an analysis of midwifery education in Pakistan. I made many enemies but it gave midwifery a quantum leap.

Q. What motivates you? What is your reward?

My reward is that midwifery is gradually emerging as an essential element of safe motherhood. Obstetricians are now coming to us for help. Recently, the Federation of International Gynaecologists and Obstetricians (FIGO) and PATH both planned projects that are the first-ever collaborative activities of midwives and obstetricians here.

Q. Are you optimistic about the future?

A. Our rate of success is painfully slow, but no crusade is ever easy or painless. There is light at the end of the tunnel.

Brigid McConville

Magnesium Sulfate: A Life-Saving Drug

Josephine is cradling her baby daughter Faith outside her house in Western Kenya. “I am very happy,” she smiles, “happy to be alive!”

On a postnatal visit to Josephine, her midwife Alice explains that she recently became the first client at the local hospital to be treated with magnesium sulfate. “Josephine had no antenatal care,” says Alice, “and she was admitted to our hospital with eclamptic fits. We treated her with this very good drug and now she and her baby are fine.”

Dr Msimbi Soita of Kakamega General Hospital in Western Kenya explains that, “Until recently, four out of 10 mothers admitted with eclampsia were dying and seven out of their 10 babies were also dying”. That is until the hospital began following the WHO recommendations to use magnesium sulfate (as opposed to diazepam) to treat high blood pressure.

Since then, he says, only one mother has died, “and she came in very late”.

At national level, the Kenyan government has acted to ensure that supplies of magnesium sulfate will soon be available in hospitals across the country. According to Dr James Nyikal, Kenya’s director of Medical Services, “We have now made a policy decision that we are going to have magnesium sulfate, and we’ve communicated that to our Chief Pharmacist and our Procurement Officer. We are now working out the quantities we need.”

Brigid McConville

It Works: Magnesium Sulfate Saves Lives

• Magnesium sulfate can halve the risk of life-threatening convulsions and the risk of death in pregnant women with problems of high blood pressure, according to the findings of a major international clinical trial published in The Lancet (2002).

• Worldwide, pre-eclampsia and eclampsia occur in about 3% of pregnant women and account for about 12% of deaths (up to 60,000 deaths) related to pregnancy.

• According to WHO, almost half of these deaths can be prevented by inexpensive treatment with magnesium sulfate.
Features

FCI Initiative Boosts Skilled Birthing Care

Childbirth is a time fraught with emotion: anticipation, nervousness, fear, joy. Anger is not what most people think about or feel. But Family Care International knew that they were touching the hearts and minds of its community when its Skilled Care Initiative team in Burkina Faso presented a play about the dangers of giving birth at home. From the audience, one of the men leapt up, grabbed a stick, and started yelling, enraged at the actor who had forced his “wife” to deliver with a traditional birth attendant instead of going to the health clinic.

As the Skilled Care Initiative wraps up its fifth and final year, there is every indication that it will meet its goal of increasing skilled attendance rates in the project areas by at least 10%. The Initiative, which is being implemented by Family Care International with funding from the Bill & Melinda Gates Foundation, has proven to be a truly effective weapon in the battle to save women’s lives. It reaches into four rural districts in Africa (in Kenya, Tanzania, and Burkina Faso). It emphasizes skilled care before, during, and after childbirth. It focuses on better training, support, and facilities for skilled attendants, along with a multifaceted “package” of activities, including ground-breaking research and evaluation tools, and a community-centred strategy to ensure that women want to, and are able to, deliver with a skilled attendant by their side.

The data confirms a strong link between knowledge, planning, and the use of skilled care.

skilled attendants, along with a multifaceted “package” of activities, including ground-breaking research and evaluation tools, and a community-centred strategy to ensure that women want to, and are able to, deliver with a skilled attendant by their side.

In this way, the Skilled Care Initiative is exploring what it takes to make skilled care available to women, based on a real understanding of the constraints women and health providers face. Only five years ago in Burkina Faso, rates of skilled attendance were among the lowest in Africa. Since the Skilled Care Initiative was introduced in 2000, the proportion of women in the project district who deliver with skilled care has risen from about one-fifth to about one-third, according to health facility records. In Tanzania, clinics in the Skilled Care Initiative project district are reporting that the number of women who deliver with skilled assistance each month has risen by an impressive 20-50%.

The first years of the Skilled Care Initiative were dedicated to research and a range of activities to strengthen local capacity and improve care in health facilities training, providing supplies and equipment, upgrading communication and transport mechanisms, and strengthening supervision and monitoring. The next stage was a focused Behaviour Change Communication strategy to give people the specific information and support they need to help them move from their previous practices to new and healthier behaviours.

While health talks, counselling, and printed materials are used in clinics and villages in each project area, some of the most exciting elements of the strategy take full advantage of popular culture. Participatory theatre, songs, and dance are effective ways to encourage discussion and to inspire deeply personal commitments to saving lives.

Local leaders have also given the Initiative tremendous personal support. In Ratanga, Kenya, one local chief has asked his wife, a trained traditional birth attendant, to stop conducting deliveries in the home because “I do not want to write statements on deaths of mothers.” Another head chief, who oversees 18 villages, has made it a weekly ritual to visit the health centres on antenatal care days to encourage the women to return to the facility for delivery.

Although the final project data will not be collected and analysed until 2006, the Skilled Care team has noted an interesting trend: Use of skilled care increased steadily in the beginning of the project (as health services were being improved), and then began to jump more sharply once the Behaviour Change Communication strategy was launched. The data has also confirmed a strong link between knowledge and planning and the use of skilled care. In fact, women who can recognize the danger signs and are aware of the importance of delivery in a health facility, and women who discuss plans for delivery with their families and put aside money to pay for costs, etc., are between two and four times more likely to seek skilled care than others (http://familycareintl.org/pubs/PDF/SCI/TechnicalBrief_HHS_Eng.pdf).

In the discussion following the play in Burkina Faso, the stick-wielding audience member admitted that his own wife had given birth at home without any preparation and without his involvement. Watching an actor behave the same way, and seeing how that behavior could end in a woman’s death, brought the man to the swift conclusion that, “I must turn the stick against myself; we are often blind to our own actions, and deaf to our own words.”
This section highlights recently published books, manuals, guides, and monographs on reproductive, maternal, and newborn health of global interest. Submissions for future issues may be made to: lives@safemotherhood.org

**Reproductive Health**

**The Effects of Contraception on Obstetric Outcomes**
Cicely Marston and John Ciecan
WHO
2004, 49 pgs. (English)
ISBN 92-4-159225-7

This report examines the evidence for the assertion that contraceptive use benefits maternal health by reducing the number of high-risk births. In addition, the authors present new evidence that unwanted births represent a greater threat to the mother’s health than wanted births because less time and money are invested in antenatal care.

**Improving the Performance of Primary Providers in Family Planning and Reproductive Health Results and Lessons Learned from the PRIME II Project 1999–2004**
IntraHealth International, Chapel Hill, North Carolina, USA
2005, 57 pgs. (English)
PDF: http://www.prime2.org/prime2/section/60.html

A report on accomplishments and findings from the USAID-funded global initiative, which worked in 25 countries. The final report provides an overview of PRIME II’s technical leadership areas and activities in reproductive-health focus areas (postpartum haemorrhage, safe motherhood, advocacy against female genital cutting, adolescents).

**Millennium Development Goals & Sexual & Reproductive Health**
Briefing Cards
Family Care International, New York, NY, USA
2005, 20 pgs. (English, French, Spanish)
English PDF: http://www.familycareint.org/pubs/PDF/SRH13E.pdf

Set of eight reference cards providing clear, concise information on the links between sexual and reproductive health and the first seven Millennium Development Goals. Each card also includes commitments made by governments at prior international conferences, as well as statistics, quotes, and key actions.

**Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets**
WHO
2004, 36 pgs. (English, French, Chinese)
English PDF: http://www.who.int/reproductive-health/publications/strategy.pdf

The text of the first global strategy on reproductive health adopted by the World Health Assembly in May 2004. Part I gets right major discrepancies between global goals and global realities, describing the principal barriers to progress. Part II sets out the strategy for change, highlighting core aspects of sexual and reproductive health services.

**Unsafe Abortion**
WHO
2004, 35 pgs. (English)
ISBN 92-4-159180-3
PDF: www.who.int/reproductive-health/publications/unsafe_abortion_estimates_4estimates.pdf

This edition of Unsafe Abortion is based on figures for the year 2000. It indicates that both incidence of unsafe abortion and resulting mortality are rising among unmarried adolescent women in urban areas, particularly where abortion is illegal and fertility regulation services are inadequate or inappropriate.

**WHO Reproductive Health Library 2005**
Informing Best Practice in Reproductive Health 2005, CD and online access (http://www.wholibrary.com) ISSN: 1745-9931
The latest edition of WHO’s Reproductive Health Library features papers on interventionist vs. expectant care for severe pre-eclampsia before term, as well as treatments for primary postpartum haemorrhage and medical methods for first-trimester abortion.

**Maternal Health**

**Accelerating Progress Towards Achieving the MDG to Improve Maternal Health**
A Collection of Promising Approaches
G. Nanda, K. Swiftick, E. Lule
The Wecare Bank, HTML Discussion Paper 2005, 174 pgs. (English)
PDF: http://sites/researcher.org/HEALTHNUTRITIONANDPOPULATION/Resources/28167-1056688101677/NandaAcceleratingProgresswithCover.pdf

Based on field research and practice, this paper brings together a wide range of approaches that aim to improve maternal-health outcomes, providing evidence on how to prioritize and implement maternal-health programmes, and how to scale-up efforts.

**Behavioural Change Interventions for Safe Motherhood**
Common Problems, Unique Solutions
JHPIEGO
2004, 78 pgs. (English)
PDF: http://www.jhpiego.org/resources/BCLforSM.pdf

This paper is based on the evaluation of behavioural change interventions undertaken in Nepal, Indonesia, Burkina Faso, and Guatemala by the Maternal and Neonatal Health programme implemented jointly by JH/CCP, CEDPA, and PATH.

**A Book for Midwives (Revised)**
Care for Pregnancy, Birth and Women’s Health
S. Klein, S. Miller, F. Thomson (eds)
The Wecare Bank, $25 paperback
ISBN: 924296-23-6 (English ed.).
ISBN: 0-942366-28-7 (Spanish ed.)
Table of contents and sample chapters available online: http://www.wecarebank.org/midwives_chapters.htm

This updated and revised edition of A Book for Midwives includes advice on preventing and managing obstetric complications, the health needs of new babies, and HIV/AIDS in pregnancy and birth. New chapters on reproductive health include pelvic exams, family planning counseling, IUD insertion and removal, and manual vacuum aspiration.

**HIV Prevention in Maternal Health Services Management Guide**
UNFPA & EngenderHealth
2004, 149 pgs. (English)
ISBN 0-96714-694-8

This guide aims to address programming gaps in the prevention of HIV and other sexually transmitted infections in maternal-health services. It also aims to increase the capacity of maternal-health providers and community-based providers to offer pregnant and postpartum women HIV and STI prevention services and referrals.

**“How To Note”: Reducing Maternal Deaths**
Rights and Responsibilities
Department for International Development (UK)
2005, 12 pgs. (English)

This policy note outlines ways to strengthen policy and political support for maternal health; to apply a rights perspective to strengthening health systems; to increase state accountability for maternal health; and to integrate a rights perspective into aid instruments.

**Igniting Change**
Capacity-Building Tools for Safe Motherhood Alliances
Nancy Russell et al.
JHPIEGO
2004, 102 pgs. (English)
PDF: http://www.mnh.jhpiego.org/Resources/CTools.pdf

This is a collection of tools intended to focus and strengthen collective efforts to improve maternal and neonatal health. The tools emphasize strengthening group processes, building capacity for linkages between diverse stakeholders, and helping stakeholders work as a team to advocate for safe motherhood.

**Maternal Mortality Update 2004**
Delivering into Good Hands
UNFPA
2005, 21 pgs. (English, French, Spanish)
English PDF: http://www.unfpa.org/publications/detail.cfm?id=2228&literType=PDF

Every two years, UNFPA’s Maternal Mortality Update documents strategies for reducing maternal mortality and morbidity in the developing world. The 2004 update, published in collaboration with the Dugald Dalrymple Centre for Research on Women’s Health at the University of Aberdeen, focuses on the role of skilled attendance.

**Into Good Hands**
Progress Reports from the Field
UNFPA
2005, 57 pgs. (English, French, Spanish)
English PDF: http://www.unfpa.org/publications/detail.cfm?id=2238&literType=PDF

This companion book explores the Maternal Mortality Update 2004 (see above) provides examples of policies, research, and activities aimed at improving skilled attendance in four regions by UNFPA and the SAFE (Skilled Attendance For Everyone) research study.

**Monitoring Birth Preparedness and Complication Readiness**
Tools and Indicators for Maternal and Newborn Health
Rosana C. Del Barco (ed.)
JHPIEGO
2004, 338 pgs. (English)

This DFID policy paper explores how to increase the pace of change in improving maternal health. It describes effective interventions that have led to falls in mortality and recommends a number of priority actions.

**Reducing Maternal Deaths**
Evidence and Action
Department for International Development (UK)
2004, 35 pgs. (English)

This DFID policy paper explores how to increase the pace of change in improving maternal health. It describes effective interventions that have led to falls in mortality and recommends a number of priority actions.

**Saving Women’s Lives**
The Health Impact of Unsafe Abortion
Elizabeth Westley
FCI/Partnership for Safe Motherhood and Newborn Health
2005, 46 pgs. (English)

This is the report of a conference held in Kuala Lumpur, Malaysia, from 29 September to 3 October 2003. The aims of the conference were to highlight unsafe abortion as a major public health problem, to illustrate the context in which unsafe abortions occur, and to foster the development of strategies to address the problem.
Newborn Health

Building Trust in Immunization
Partnering with Religious Leaders and Groups
UNICEF
2004, 36 pgs. (English)

This workshop provides guidelines for communication and programme officers and their immunization partners on forging alliances with religious leaders and other groups on immunization.

Care of the Newborn
Reference Manual
Save the Children
2004, 237 pgs. (English)
PDF: http://www.savethechildren.org/publications/snl/00%20-%20Care%20of%20the%20Newborn%20Reference%20Manual%20(3.6MB).pdf

This manual is designed to train all health-care workers in essential care for newborns in their first 28 days of life. This manual defines and illustrates the skills needed to keep newborns healthy, including routine and preventive care, as well as early detection and management of life-threatening problems.

Family Planning and the Prevention of Mother-to-Child Transmission
A Review of the Literature
Kim Best
Family Health International
2004, 58 pgs. (English)
PDF: http://www.fhi.org/NR/rdonlyres/ehm4ci7qpkw42QPw9bjt24j3q/30/612d5/yewukbacc4xvlnhopassfzbfz/FFPMTCT.pdf

Many HIV-positive births could be prevented by simply preventing unintended pregnancies among infected women. This review summarizes the literature on integrating family-planning services with other services to prevent HIV-positive births.

Immunization Summary 2005
A Statistical Reference
UNICEF & WHO
2005, 203 pgs. (English)

This reference book presents detailed statistics on the performance of local and national immunization systems for 193 countries and territories. It includes trends in coverage rates for six antigens; the proportion of districts achieving targets for DTP3 and measles-containing vaccine; and current immunization schedules on a country-by-country basis.

Low Birthweight
Country, Regional and Global Estimates
UNICEF and WHO
2004, 27 pgs. (English)
ISBN 92-806-3832-7

This report presents country, regional, and global estimates of low birthweight for 2000, together with a detailed description of the methodology used.

Neonatal Survival
The Lancet
March 2005, 51 pgs. (English)
http://www.thelancet.com/collections/neonatal_survival

This reference guide, produced under the Saving Newborn Lives initiative, provides support for programme managers and researchers in conducting qualitative research for the purpose of planning a behavioural change communications strategy to improve newborn-care practices.

Maternal & Newborn Health
Basic Maternal and Newborn Care
Barbara Kinzie and Patricia Gomez
JHPIEGO
2004, 426 pgs. (English, French)
PDF: http://www.dec.org/pdf_docs/PNADA598.pdf

A set of global guidelines for the care of women experiencing normal pregnancies, childbirths, and postpartum periods, as well as for the care of normal newborns. Brings together global lessons learned.

Entry into this World: Who Should Assist?
Birth Attendants and Newborn Health
Indira Narayanam et al.
JHPIEGO
2004, 12 pgs. (English)
PDF: http://www.basics.org/pdf/EntryIntoThisWorld.pdf

This publication presents a process and tools that can be used to conduct facility-level assessment and strengthening, with the goal of improving essential maternal- and newborn-care services.

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Who’s Got The Power?
Transforming Health Systems for Women and Children
John A. Ross and Jane E. Begala
POLICY Project, Working Paper Series No. 15
2004, 24 pgs. (English)

This publication reports on the results of the Maternal and Neonatal Programme Effort Index, designed to measure the strength and character of government programmes to improve maternal and newborn health.

Site Assessment and Strengthening for Maternal and Newborn Health Programmes
Ann Blouze et al. (eds.)
JHPIEGO
2004, 156 pgs. (English)

This publication presents a process and tools that can be used to conduct facility-level assessment and strengthening, with the goal of improving essential maternal- and newborn-care services.

The World Health Report 2005
Make Every Mother and Child Count
WHO
2005, 260 pgs. (English, French, Spanish)
ISBN 9241562900
§36 (Developing Countries: Swiss Francs 15)

To order: bookorders@who.int

This report analyses the obstacles to progress in maternal, newborn, and child health and provides a series of recommendations to overcoming them. It is contested that mortality rates could be sharply reduced through wider use of key interventions and a “continuum of care” approach for mother and child.
Holding Governments to Account

By Lori McDougall

FUNDAR Raises the Profile of Maternal Health in Mexico

Budget analysis isn’t usually a gripping subject for most people. Not so in Mexico, where a network of civil organizations have carried out a highly effective campaign to raise the profile of maternal mortality and hold the government to account for its spending decisions. The result? New money for maternal health and closer ties between civil society and government.

FUNDAR is an independent centre for research and analysis in Mexico City (http://www.fundar.org.mx). It employs an unusual mix of budget analysis and interdisciplinary research to hold governments to account for their pledges and policies. By monitoring civil society and government.

In 2002, FUNDAR embarked on a project aimed at reducing maternal mortality in Mexico. Rates had stagnated in the 1990s, holding steady at 6.2 maternal deaths per 10,000 live births registered. Yet Mexico had pledged to the world to reduce maternal mortality, and indeed there had been three different programmes over the past decade to achieve just that — all with little effect.

FUNDAR employs an unusual mix of budget analysis and interdisciplinary research to hold governments to account.

“Maternal mortality is such a clear example of how exclusion, poverty, and gender discrimination affect women’s lives,” says FUNDAR’s executive director, Helena Hofbauer. “Since we had worked on health issues and gender budgeting, it seemed like the perfect starting point to deal with the many different aspects we are interested in.”

FUNDAR was experienced in analysing budgets from a gender perspective, but it began to form alliances with maternal- and reproductive-health experts and advocates to broaden its approach beyond federal budget analysis. It wanted to gain a ground-level perspective, sharpen its political strategy, and create a highly effective advocacy tool that could be used by a wide range of groups, including politicians and senior health officials themselves.

This alliance had remarkable impact. It was able to demonstrate the shortcomings of the health budget and contrast infrastructure expenditure on maternal and reproductive health to other areas of government spending — notably Mexico’s Navy and Defence departments. In taking this approach, FUNDAR and its partners built a convincing case for greater health investment, which they deployed to great strategic effect with legislators, the public, and the media.

The campaign worked: In 2003, Mexico’s federal budget showed a massive increase in resources earmarked for maternal health (from 62 million at the national level to 602 million pesos through decentralized funds). It was a clear victory for good research, clever marketing of results, and effective partnership-building.

Even so, that victory needs to be seen in a wider context, says FUNDAR. Funding is unevenly spread among and within states and populations, making it difficult to achieve substantial reductions in maternal mortality. This is what led FUNDAR and its partners in Chiapas, Oaxaca, and Guerrero to conduct a fresh round of budget analysis in 2003 regarding actions aimed at reducing maternal mortality. That exercise threw new light on the reasons underlying the sustained maternal mortality rates. The results were published via briefing documents distributed among politicians, as well as at a press conference involving both political and civil society representatives, and at a meeting with legislators about the 2004 budget proposal.

Mexico’s 2004 budget proved a bit of a shock for FUNDAR. Dedicated funds for maternal health had now been both reduced and swallowed up into bigger programmes, making future monitoring and analysis very difficult for organizations that seek to promote public accountability.

Four years into its work on maternal health, FUNDAR takes a balanced view of its progress, citing both successes and challenges. The Mexican health system remains hobbled by the unequal distribution of infrastructure and resources, both human and financial. Access to emergency care during delivery remains a major issue. Given these conditions, the bid to reduce maternal mortality is bound to meet with limited success.

However, the alliances forged between the groups working on this issue remain strong, and ground has been established for collaboration with the Ministry of Health. By costing-out emergency obstetric care, for instance, it has been possible to argue that the Ministry of Health can actually advance towards its implementation.

FUNDAR plans to continue to work on maternal mortality for at least the next few years, says Hofbauer. The efforts are yielding rewards, since the profile of maternal mortality has clearly been heightened in Mexico — a testament to the power of innovative research, sharp political strategies, and effective private-public alliances.

This article is based on a presentation by Helena Hofbauer, executive director of FUNDAR, at Lives in the Balance: The Partnership Meeting for Maternal, Newborn, and Child Health in New Delhi in April (see pg. 3), as well as on “The Public Budget and Maternal Mortality in Mexico: An Overview of the Experience” by Daniela Diaz and Helena Hofbauer, Nov. 2004.
It is often challenging to work as a male midwife in a Muslim community. In this part of Kenya, many people have deep-rooted cultural and religious beliefs that shun men attending to women. Equally frustrating is that my work environment is deficient in many essential basics [such as water and blood for transfusion], and that families here only bring their women to hospital as a last resort.

I developed an interest in midwifery when I volunteered to interpret for a German nurse working in our village. I realized that midwifery can give satisfaction and spiritual resources, especially for renewal of faith and courage when weary and discouraged.

Many more people now appreciate the good work done by male midwives. In some quarters, they are preferred to their female counterparts. Families have confidence and trust in male midwives when discussing issues and making crucial decisions.

For instance, a young woman, aged 16, recently came into our hospital. She had been in labour for several days at home and was forced to sneak out because her mother-in-law was against hospital delivery. But although she had cephalo-pelvic disproportion, her husband’s family refused to give their [required] consent for her to have a Caesarean section. I intervened and convinced them to let her sign her own consent form and so this mother’s life, and that of her baby, was saved.

Kenya needs more male midwives. Currently in my district, 30 out of 98 midwives are male. But midwifery is a low-status occupation here. The salary is not commensurate with our workload and responsibilities. However my family is happy that I work as a midwife and appreciates my dedication.

The role of men in safe motherhood here generally leaves a lot to be desired. Men should take more active role. Each man should monitor the health and progress of his pregnant partner by accompanying her to the clinic, empowering her economically and giving her freedom to make independent choices about birth planning, nutrition, and contraception. However, things are gradually improving.

The birth of my first child earlier this year was a very joyous moment for me as a father and a midwife. I assisted in the delivery. My son’s name is Muhsin, and he and his mother are both doing well.

Whenever I attend to a woman in labour I feel am attending to a mother and child just like my own. This gives me the energy to do all I can to care for them. This is what gives me courage, commitment, and pleasure in my job as a midwife.

Ahmed Boray Arale is a midwife and the senior nursing officer at Garissa Provincial General Hospital in Northeast Kenya. He is featured in the Beyond the Numbers film mentioned below.

**Beyond the Numbers**

The team that produced the popular 2004 advocacy film My Sister, My Self (featured in Safe Motherhood issue 31) has created a follow-up film.

Beyond the Numbers shows how health workers are reducing maternal deaths by looking into what went wrong and then making changes based on that knowledge.

Shot in South Africa and Kenya, the 20-minute film traces the stories of three mothers who died, and one who just survived.

It shows how their midwives, nurses, and doctors had the courage to investigate each case, and to take action so that other mothers and newborns will be safer.


For free copies of Beyond the Numbers: broomfield.hall@virgin.net
THE DELHI DECLARATION ON MATERNAL, NEWBORN AND CHILD HEALTH

9 April, 2005

We, the Ministers and delegations from Bangladesh, Bolivia, Cambodia, Ethiopia, India, Mali, Mozambique, Nepal, Pakistan, Tanzania and Uganda, as well as the representatives of other governments, the United Nations, the World Bank, foundations, national and international NGOs, professional bodies, academia, and civil society from all continents, assembled in New Delhi, India, to participate in "Lives in the Balance: The Partnership Meeting on Maternal, Newborn and Child Health" from 7-9 April 2005, recognize that:

Lives in the Balance

- The lives of millions of women and children are in the balance today. Each year, pregnancy and childbirth claim the lives of more than a half million women, while more than 10 million children, including 4 million newborns, die each year. In addition, more than 3 million babies are stillborn. This tragedy must end.
- As many as 99% of the maternal, newborn and child deaths occur in developing countries. The highest burden is faced by lesser-developed countries of Africa and Asia, particularly within poor families.
- Cost-effective, evidence-based interventions, if taken to scale worldwide, can prevent close to three-fourths of maternal deaths, and more than two-thirds of child deaths. Thus, we have - almost within reach - the means to save nearly 7 million lives each year.

With a Global Commitment to the 2015 Vision, an Opportunity Beckons

- The Millennium Development Goals (MDGs) signify the world’s commitment to achieving time-bound and quantifiable improvements in development and poverty reduction by 2015, including MDGs 4 and 5 defining global targets in maternal and child health.
- With health clearly recognized as essential to poverty reduction, the global health community has a rare opportunity to surmount obstacles - political, financial, technical and programmatic - that have hampered progress to date.
- Despite avowed consensus, however, the current rate of progress is not sufficient to attain the child survival and maternal health MDGs in many countries. Only through coordinated and concerted action and unprecedented resource mobilization at the national and international levels can we hope to meet our commitments by 2015. This will also require strong collaborations with other sectors, including education, nutrition, water and sanitation among others.

The Way Forward

This high-level meeting on maternal, newborn and child health (MNCH) asserts that the way forward is to:

- Take an integrated approach to reproductive, maternal, newborn and child health, ensuring a continuum of care from pregnancy through childhood, recognizing that maternal, newborn and child health are inseparable and interdependent, and that the achievement of their MDGs must be based on a strong commitment to the rights of women, children and adolescents;
- Recognize that there is no single model of care to prevent maternal, newborn and child morbidity and mortality, and therefore countries are required to design and implement programmes that are tailored to the needs and realities of the national and sub-national settings, employing a rational mix of quality family/community outreach and clinical services, in public and private sectors, to scale-up known cost-effective interventions;
- Affirm that universal access to sexual and reproductive health is essential to meeting MDG 5 and will make significant contributions toward MDG 4;
- Build systems for the collection and use of high-quality data, disaggregated by equity parameters to inform policy and programmes;
- Invest in strengthening health systems, from community to the referral levels, to ensure sustained and long-term improvements in reproductive, maternal, newborn and child health;
- Incorporate specific strategies to address inequities in reproductive, maternal, newborn and child health programmes to ensure that interventions reach and benefit the poor, the marginalized and the underserved; and
- Build effective partnerships comprising governments, development partners, donors, civil society, the private sector, professional associations and academia in a strong and unprecedented common mission to achieve MDGs 4 and 5.

A Call to Action

Recognizing that the responsibility of saving maternal, newborn and child lives and promoting their health lies not only with the countries, but also with the international community working together as committed partners, we:

- Reaffirm the aforementioned stakeholders.
- Appeal for the highest national and international political commitment to maternal, newborn and child health;
- Request governments, private sector, civil society and international partners to leverage and commit the required resources (currently estimated in the World Health Report 2005 as an additional US$9 billion on the average per year) to achieve MDGs 4 and 5; and
- Recommend the adoption of a target for MDG 5 relating to universal access to sexual and reproductive health with appropriate indicators, as well as recommend the addition of the neonatal mortality indicator to MDG 4.

We issue the following call to action:

Countries should orient their national and sub-national development plans and budgets to fully achieve the maternal and child health MDGs by 2015.

For that, they need to:

- Develop urgently, integrated national plans with national targets for coverage, outcomes and resource allocations, with active participation of all stakeholders;
- By the middle of 2006 at the latest, develop plans of action to achieve such coverage, meet shortages of skilled health personnel and commodities, and devise mechanisms to involve all partners;
- Mobilize resources to finance the plans of action, in traditional and innovative ways, and identify needs for external support, where necessary;
- By the end of 2006 at the latest, launch the plan of action and accelerate the delivery of high-impact strategic interventions; and
- By 2007 at the latest, have in place a system to monitor and report coverage, resources and outcomes directed toward achieving mortality reduction and promotion of health.

The partnership of multinational organizations, bilateral partners, international foundations, and NGOs working with countries should:

- Agree to support fully, at all levels of their organizations, the implementation of these comprehensive national plans;
- From this day onward, find and commit additional resources required to close the projected resource gap in support of country programmes aimed at achieving MDGs 4 and 5;
- Provide the necessary support to countries to deliver interventions at all levels for high and equitable coverage, for reproductive, maternal, newborn and child health programming, and for health-system strengthening;
- Develop and implement strategies to address the critical shortages in skilled health-care providers, thus accelerating progress in reproductive, maternal, newborn and child health programmes in many developing countries;
- Develop, support and maintain an agreed system to promote greater accountability of, and co-ordination among, partners at global and national levels to provide the fullest impetus to global action for attaining MDGs 4 and 5; and
- Designate an annual “World Maternal, Newborn and Child Health Day” to encourage greater global visibility of this agenda and to provide an opportunity for countries and the international community to re-assert their commitment to this cause.

Now is the time to translate statements of intent into action
Now is the time to save 7 million lives in the balance