When we published the first issue of Lives last July, we had no way of knowing how you would respond. Would it be useful? Would it spark new ideas? Would it further our strong sense of community? Well, judging by your letters, the answer is an enthusiastic "yes".

Lives travels to more than 180 countries, and is published in English, French, and Chinese, with a Spanish edition also planned. Now, under the newly formed Partnership for Maternal, Newborn & Child Health, we will focus on child survival issues, as well as on maternal and newborn health. We look forward to finding new ways to reflect on these issues, including the important topic of the "joining-up" of maternal, newborn, and child health. What have been your experiences in taking up a continuum of care approach? What have been the rewards and what have been the struggles? We look forward to publishing your thoughts in our July issue. Please write us at lives@pmnch.org.

EDITORS’ NOTE

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Maternal Depression & Newborn Health
Allow me to extend my warmest congratulations for the successful launch of The Partnership for Maternal, Newborn & Child Health, which I had the honour and privilege to attend on the sidelines of the recent UN General Assembly in New York.

The level of attendance and the theme of the September 12 launching ceremony clearly demonstrate our common desire to advocate for MDGs 4 & 5, and to raise awareness on the need to further reduce maternal and child mortality. I am fully aware that there is a hard road to travel and a long way to go, but I am also convinced that, together, hand-in-hand, we can make it.

Alpha Oumar Konaré
Chairperson
Commission of the African Union
Addis Ababa, Ethiopia

Thanks for your new newsletter, replacing the Safe Motherhood one. I really enjoyed and appreciated it. I felt part of a vibrant, energetic team of concerned persons who hold at heart the condition of mothers and newborns.

Sr. Raymonde Gratton
St. Mary’s Mkanda
Mkanda, Mchinji
Malawi

Your newsletter really educated me. I would be glad if you would consider me for a subscription so I can assist my fellow workers.

Agawaoma Ogbi
Ibadan, Oyo
Nigeria

Lives is very informative and useful – a potent tool for reproductive and child health and allied fields. Lives is indeed a “live” telecast of maternal and child health events.

D. Dharma Rao
Hindustan Latex Family Planning Promotion Trust
Hyderabad, India

I have been working as a trainer/researcher in safe motherhood and newborn health. This newsletter is really important and fruitful for me, so it would be great to get it regularly.

Shyam Shrestha
MIRA
Kathmandu, Nepal

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Prof. Miki Karplus
Ben Gurion University
Beer Sheva, Israel

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Please keep my name on file so that I continue to receive this important magazine.

Dr. Ricardo G. Torres
Lima, Peru

Lives is published twice a year by The Partnership for Maternal, Newborn & Child Health.

The Partnership Secretariat is hosted and administered by the World Health Organization.

20 avenue Appia, 1211 Geneva 27, Switzerland
Tel: +41 22 791 49 14; Fax: +41 22 791 41 71
http://www.pmnch.org; lives@pmnch.org

Cover Photo: Randai Purty (25) and Basu (3 months), Talakhal, Orissa, India. Ami Vitale/panos Pictures.

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Editorial Sounding Board
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Global Launch for The Partnership

The Partnership for Maternal, Newborn & Child Health

The Partnership for Maternal, Newborn & Child Health was launched in New York on September 12, marking a bold new push for the reduction of maternal and child mortality around the world.

The Partnership has been formed from three existing groups, the Partnership for Safe Motherhood and Newborn Health, the Healthy Newborn Partnership, and the Child Survival Partnership (see pg. 4).

Working together, the founding partners seek to harmonize and intensify efforts to achieve Millennium Development Goals (MDGs) 4 & 5, which call for the reduction of child mortality by two-thirds and maternal mortality by two-thirds by 2015.

For further information about The Partnership: http://www.pmnch.org

Former Health Minister Songane to Lead Partnership

Francisco Songane, a former Minister of Health of Mozambique, has been named Director of The Partnership for Maternal, Newborn & Child Health, to be based in The Partnership’s secretariat office at the WHO in Geneva. Dr Songane, 51, is an obstetrician/gynecologist who also holds an MPH from Boston University and an MSc in Financial Economics from the University of London.

Dr Songane’s distinguished public health career has involved extensive work at sub-national, national, and international levels.

In Mozambique, he was a district medical director and teacher-trainer, as well as the director and OB-GYN department head of the country’s second-largest hospital, in Beira (1988-1999).

As Mozambique’s Minister of Health (2000-2004), he is credited for using a partnership approach in averting the outbreak of disease during the floods of 2000 and 2001, as well as for his key role in finalizing and launching Mozambique’s health-sector strategy. He steered a number of interventions during this time, including the introduction of a hepatitis B vaccine, trials on a potential malaria vaccine and the use of a more effective cholera vaccine, as well as the use of antiretroviral therapy in the public system – an example that has been shared globally.

Dr Songane’s extensive involvement with the international community has included serving as executive committee member and board member of GAVI. He was also a member of Task Force 4 of the UN Millennium Project (2002-2004), which analysed the practicalities of achieving the Millennium Development Goals related to maternal and child health.

He has published extensively on maternal health issues, and is presently enrolled in a doctoral programme at the Karolinska Institutet in Stockholm.

Kul Gautam, chairperson of The Partnership’s interim steering committee, says Dr Songane blends technical expertise, vision, and commitment. “He has continued to speak and act for maternal, newborn, and child health throughout his career.”

For his part, Dr Songane says: “I have delivered babies in rural areas and worked to bring the crisis of the world’s dying mothers and children to discussions at the highest level. As director of the new global Partnership, I hope to mobilize support and coordinate action with a country focus so that together, we can prevent the needless deaths of 11 million women and children in the world every year.”
A roundtable discussion was held in Addis Ababa, Ethiopia, in October to share information about The Partnership for Maternal, Newborn & Child Health, and to highlight opportunities to accelerate maternal, newborn, and child survival in Africa.

"Achieving MDGs 4 & 5: Helping Women and Children Survive" was attended by more than 100 representatives of national governments, UN agencies, NGOs, bilateral agencies, professional associations, and academic institutions. Speakers included Tedros Adhanom, Minister of Health, Ethiopia; Doyin Oluwole of WHO AFRO; Petra ten Hoope-Bender of The Partnership; Anne Tinker of Save the Children USA; and Björn Ljungqvist of UNICEF Ethiopia.

Event moderator Khama Rogo of The World Bank set the tone for the discussion by highlighting the urgency of partnership efforts in Africa: “While some countries have made substantial progress, the majority of African nations are not currently on target to achieve the 2015 MDGs for maternal and child health. Of the 20 countries worldwide with the highest maternal mortality ratios, 19 are in sub-Saharan Africa.”

Tedros Adhanom, co-chair of The Partnership, underscored the importance of building links among all players – from families through healthcare professionals, to governments and the global level: “Despite affordable and available life-saving interventions, countless mothers, babies, and children continue to die each day. This represents an unacceptable disparity and the right to survive is the first human right.”

The WHO’s Doyin Oluwole emphasized opportunities to link to, and accelerate, existing initiatives, such as the African Union-endorsed Roadmap for the Attainment of the MDGs Related to Maternal and Newborn Health. The challenges to The Partnership should not be underestimated and the successes and failures of other global partnerships and funds should be important lessons, she said.

The Partnership in Africa

The Partnership for Maternal, Newborn & Child Health is made up of more than 80 members representing partner countries, UN and multilateral agencies, nongovernmental organizations, health professional associations, bilateral donors and foundations, and academic and research institutions. It was launched in New York in September following the merger of the Partnership for Safe Motherhood and Newborn Health, the Healthy Newborn Partnership, and the Child Survival Partnership (see pg. 3).

The Partnership supports country-led efforts towards universal coverage of essential interventions for maternal, newborn, and child health by focusing on the following:

- **Country Support:** Actively promoting improved partner coordination in countries and supporting the creation, implementation, and evaluation of a comprehensive national plan;
- **Advocacy:** Raising the profile of maternal, newborn, and child health on political agendas and advocating for increased resources – financial and other;
- **Effective Interventions:** Promoting the assessment, scaling-up, and delivery of evidence-based, cost-effective interventions, with a focus on reducing inequities in access to care;
- **Monitoring and Evaluation:** Assessing progress by holding stakeholders at all levels accountable in meeting their financial and policy commitments.

The first meeting of all partner members is scheduled for late 2006, at which time the election of steering committee members will be undertaken. Presently serving as chairperson of the interim steering committee of The Partnership is Kuldip Gautam, deputy executive director of UNICEF. Co-chairs are held by Ethiopia’s Minister of Health, Tedros Adhanom, and Ann Starrs, executive vice-president of Family Care International.
A birth registration campaign in Cambodia has achieved a dramatic victory for newborn and child health. After little more than a year of campaigning, birth registration figures have leapt from less than 5% to an anticipated 80%, giving new protections and rights to children across the country.

In December 2002, the Royal Government of Cambodia decided that all citizens must be registered within three years. At the time, less than 5% of Cambodia’s 12 million population were registered, due to disruption in government systems caused by the Khmer Rouge years.

Plan Cambodia, UN Volunteers, and the Asian Development Bank worked closely with Cambodia’s Ministry of the Interior to carry out a national mobile registration campaign from October 2004. The campaign included a large number of posters across the country; a children’s fair with the participation of 4,000 children and parents; and a poster exhibition entitled “Birth Registration: Enhancing Opportunities for Children.”

Plan International has been working closely on this issue elsewhere in the world, and organized a joint conference on birth registration with UNICEF and UNFPA in February 2004 – the first-ever in the world. There, delegates issued a statement calling for free and obligatory birth registration for all children, agreeing that raising awareness and establishing legal frameworks were top priorities (http://www.plan-international.org/identity).

Birth registration is also a concern of the International Confederation of Midwives and the International Council of Nurses, which together campaign to increase birth registration around the world. Their joint statement is located at http://www.icn.ch/PR16_03.htm#1. Meanwhile, the newly created Health Metrics Network, a global collaboration to strengthen country health information systems, will tie into such efforts (http://www.who.int/healthmetrics).

Cambodia’s mobile registration strategy was carried out with the help of 13,000 Cambodian officials and 27 UN Volunteers, one for each province in the country. The government of Cambodia waived the usual registration fee throughout the campaign, also removing all fines and court judgements for late registration.

Brigid McConville

**New Definition of the Midwife**

The International Confederation of Midwives (ICM) has revised and updated its core document, “Definition of the Midwife”. The new definition was agreed at the ICM’s triennial meeting in Brisbane in July 2005. It reflects a number of key updates, including wording that emphasizes the accountability and professional status of the midwife; a specific reference to the midwifery partnership with women; and the addition of the words “the promotion of normal birth” to the description of midwifery care, reflecting ICM’s belief in the importance of a low-technology approach to care.

The original definition was created in 1972 and updated in 1990. It is in wide use, including by the WHO and FIGO.

**Definition of the Midwife**

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care, and advice during pregnancy, labour, and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance, and the carrying out of emergency measures.

The midwife has an important task in health counseling and education, not only for the woman, but also within the family and the community. This work should include antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health, and child care.

A midwife may practise in any setting, including the home, community, hospitals, clinics, or health units.

This document can be downloaded at: http://www.medicalknowledgeinstitute.com/files/ICM%20Definition%20of%20the%20Midwife%202005.pdf
The Saving Newborn Lives initiative has had a huge impact on changing health practices,” says SNL Director Anne Tinker. “For example, over the past two years, the initiative has helped increase the percentage of newborns born at home who receive care within one week after birth from 30% to 57% in Bolivian programme sites, and from 18% to 55% in Bangladeshi programme sites. In addition, newborn deaths from tetanus infection in Pakistan have been cut in half – from 28,000 annually to 14,000 – due to a nationwide effort by the Government, UNICEF, and Save the Children to vaccinate women of childbearing age.”

Saving Newborn Lives is host and founding member of the Healthy Newborn Partnership, which recently joined the Child Survival Partnership and the Partnership for Safe Motherhood and Newborn Health to form The Partnership for Maternal, Newborn & Child Health (see pg. 3).

In areas of Bolivia, Saving Newborn Lives has helped increase the percentage of newborns born at home who receive care within one week of birth from 30% to 57%.

Four million babies die every year in their first month of life, although 75% of those deaths could be prevented by simple, low-cost tools and services, such as clean razor blades for cutting the umbilical cord, antibiotic treatment for pneumonia, and family education about skin-to-skin contact for low-birthweight babies.

Saving Newborn Lives will focus on ways to identify and promote the large-scale adoption of tools and approaches that address the three main killers of one-week-old babies – infections, lack of oxygen supply to a baby during delivery and at birth, and low birth weight. Key activities in the 18 countries will include:

- Developing and testing new tools to fight the three leading causes of newborn death: severe infections, breathing problems, and complications of prematurity;
- Demonstrating and evaluating packages of proven strategies for reducing newborn illness and death, to determine which tools and approaches work best in different settings;
- Integrating newborn care into existing maternal and child health programmes;
- Helping countries overcome barriers to scaling-up newborn care.

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Newborn Health Policy Briefs

A new policy brief on neonatal health and survival is available from the Population Reference Bureau in collaboration with Saving Newborn Lives. The Maternal-Newborn-Child Health Continuum of Care: Collective Voices, Collective Effort to Save Lives is the latest in a series of briefs aimed at supporting policymakers and healthcare professionals in incorporating newborn care into existing safe motherhood and child survival programs.

Five titles exist in this “Policy Perspectives on Newborn Health” series, including: The Healthy Newborn Partnership (July 2004); Integrating Essential Newborn Care Into Countries’ Policies and Programs (September 2003); Using Evidence to Save Newborn Lives (May 2003); Why Invest in Newborn Health? (April 2003); and Healthy Mothers and Healthy Newborns: The Vital Link (April 2002). The briefs are available online at http://www.prb.org.
Integration Achieves 20% Drop in Child Deaths

Ann Veneman was only a fortnight into her new job as head of UNICEF when she took the podium of the World Health Assembly last May, poised to deliver some remarkable news: In several West and Central African countries, child death rates have dropped by an estimated 20% over the past three years.

How? Increased coverage of integrated maternal, newborn, and child health interventions in some of Africa's most hard-to-reach areas. “The early results of this initiative are remarkable,” she said. “They have shown us just what can be achieved over a short period of time through sound science using an integrated approach.”

The approach Veneman was talking about is UNICEF’s Accelerated Child Survival and Development (ACSD) programme, an integrated package of maternal, newborn, and child health interventions. The programme began in 100 districts in 11 countries in West-Central Africa in 2002, covering 17 million women and children. It offers three different packages of high-impact, low-cost interventions. These range from prevention and treatment approaches covered under the Integrated Management of Childhood Illness (IMCI) strategy, to antenatal care for women, to an enhanced immunization package with DTP3 and measles, as well as distribution of Vitamin A.

These packages are delivered in high child mortality districts through government health-centers and community outreach services, while parenting education on health skills is offered at the household level.

“Over the past 15 years, Africa on average has lost ground in keeping children alive and healthy,” said Veneman. “While sub-Saharan Africa has only 12% of the world’s population, it accounts for 42% of all deaths under age five around the world.”

The UNICEF programme relies on a partnership approach, drawing in governments and health ministries, the WHO, the World Bank, community leaders, and a range of NGOs. “Performance contracts” are negotiated at the local level, with each partner responsible for delivering specific results.

At the meeting, Veneman credited the Canadian Government for throwing down the gauntlet to UNICEF, offering $30 million to develop a programme to reduce child mortality by at least 15% – but one that would cost less than $1,000 per life saved.

Veneman said that in areas where the programme was fully implemented, child mortality was estimated to have improved by 20% for an added cost of $500 per life saved. According to new data, under-five mortality in some of Senegal’s most remote districts has dropped by 25% since 2002. In Mali, rates have dropped by 21%; Ghana and Benin were not far behind at 17% and 16% respectively.

UNICEF now plans to reach 60% of children across sub-Saharan Africa with these integrated community-based interventions by 2009. Lori McDougall

Preventing Postpartum Haemorrhage

New attention is being focused on postpartum haemorrhage, the leading cause of maternal death worldwide. The Postpartum Haemorrhage Initiative (PoPPHI) is advocating the Active Management of the Third Stage of Labour (AMTSL), which can reduce postpartum haemorrhage by up to 60%. PPH is defined as bleeding of more than 500 ml after birth.

PoPPHI is a three-year project funded by USAID and was launched in 2004 by five partner agencies: PATH, RTI International, EnGender Health, the International Federation of Gynecology and Obstetrics, and the International Confederation of Midwives.

PoPPHI’s mandate is to improve health-provider practices by expanding AMTSL through non-training approaches, as well as to improve its quality and availability at both the facility and community level.

It also aims to make uterotonic drugs and devices available more widely at the country level at low cost. Presently, at least 25% of the 500,000 maternal deaths globally, and up to 60% in some countries, are due to postpartum haemorrhage.

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“Every attendant at birth needs the skills to carry out AMTSL, as well as supplies and equipment,” says PoPPHI Director Deborah Armbuster of PATH. Oxytocin is the drug of choice for use in AMTSL, but it may not be available everywhere, she says. PoPPHI is working to change that, while also gathering information on oxytocin use in East Africa and Central America. Meanwhile, Gynuity Health Projects, with funding from the Gates Foundation, is conducting large-scale clinical trials to assess the effectiveness and determine dosages of misoprostol for both prevention and treatment of PPH. Brigid McConville

Active Management of the Third Stage of Labour

Active Management of the Third Stage of Labour (AMTSL) has been found to significantly reduce postpartum haemorrhage, decrease blood loss, and decrease the need for blood transfusions. The three main elements of AMTSL are:

- Administration of uterotonic agents (oxytocin is the most effective for prevention of PPH);
- Controlled cord traction;
- Uterine massage after delivery of the placenta.

To download a PPH Toolkit: http://www.pphprevention.org

About misoprostol in prevention of PPH: http://www.gynuity.org
Countdown to 2015
Experts Meet in London to Track Progress in Child Survival

Was 2005 the turning point for child mortality in the world’s poorer countries? This was certainly the hope of global development experts who met for two days at the University of London, December 13-14.

The “Countdown to 2015” conference was the first in a series of two-yearly reviews of progress in child survival, as called for by the Bellagio/Lancet Child Survival series of 2003. Speakers included WHO Director-General Lee Jong-wook; UNICEF Executive Director Ann Veneman; and the Princess Royal, Princess Anne.

The purpose of the London conference was to review progress made towards the coverage of child survival interventions; to identify and discuss how barriers to progress can be scaled; to agree on indicators that will serve as the basis for monitoring progress; and to foster institutional commitments to child survival efforts. The principle of addressing maternal, newborn, and child health as an entity, and of working synergistically, was a recurring theme of the conference.

A landmark report, Tracking Intervention Coverage for Child Survival: The 2005 Report, was launched at the meeting. It argues that nearly 35 million children’s lives could be saved in the next decade through a number of simple, effective, and cheap approaches. These measures include

Countries Share Success Stories in Reducing Child Mortality

Senegal: Improving Nutrition

Good nutrition is the basis of child health, argues Mamadou Sidibe, Senegal’s Minister for Planning and Sustainable Development, who was present at the London conference.

“Malnutrition robs us of energy, health, and life. It contributes to more than half of all child deaths,” says the Minister. “It reduces school performance and work potential. It embezzles Senegal of $1.6 billion and causes 300,000 child deaths across 10 years. The Government of Senegal finds this unacceptable and commits to change.”

In 2002, Senegal’s Commission against Malnutrition was established, located in the Prime Minister’s office and dedicated to a multisectoral approach, starting at the household and community level. This was tested and then tailored to different areas. Innovative approaches included pregnant women’s support groups and grandmothers’ groups, enabling women to learn from each other and building on the respect for older women in the community.

These initiatives will build on Senegal’s achievements in reducing malnutrition rates from 23% in 1992 to 17% in 2004. Meanwhile, infant mortality fell from 86 to 61 per 1,000, and child mortality from 199 to 121 per 1,000, between 1986 and 2005.

Bolivia: Free Health Care

“Infant and child mortality have dropped drastically in Bolivia,” according to former Minister of Health (until Jan. 2006) Alvaro Rafael Muñoz-Reyes. The key to success has been universal health insurance for mothers and children, paid for by public funds. This has removed financial barriers to health and increased access to health care in Bolivia.

“A legal and policy framework can address the obstacles of poor access to health through [providing] a national insurance scheme,” says Muñoz-Reyes. However, “it is very important for communities to be involved for [improvements] to be sustainable.”

Integrated Management of Childhood Illness in the community has brought marked improvements in health care for newborns between 2003 and 2004. Furthermore, national and local alliances have been instrumental in mobilizing resources, harmonizing efforts, and sustaining interventions.

In seven years spent working as a doctor in rural areas, Muñoz-Reyes saw how – with community support – women won their battle to “give birth in the position they want, despite the strong opposition of doctors. Now that women feel their wishes and beliefs will be respected, many more now access health services, and many lives are saved.”
vaccination, exclusive breastfeeding, access to safe drinking water and sanitation, the use of bednets for malaria, preventing transmission of HIV from mother to child, oral rehydration therapy, and the management of pneumonia.

Data from the report shows that of the 60 countries with the world's highest child mortality rates, no country is reaching children with all the affordable life-saving interventions that are available. Says Jennifer Bryce, co-author of the report, "Most of these 60 countries are reaching many of their children with at least some interventions, so we can see exactly what needs to be done, and where." The report establishes a baseline that future change can be measured against on a regular basis.

Some countries have rapidly increased the proportion of mothers and children with access to life-saving interventions. In Ghana, for instance, exclusive breastfeeding rates have quadrupled in recent years.

Similarly, the number of parents seeking health care for pneumonia, the world's biggest killer of children, has shot up in Liberia, Papua New Guinea, and South Africa. Meanwhile, bednet distribution is speeding up in Togo and Malawi.

Speed and simplicity are essential to meeting Millennium Development Goals 4 and 5, to reduce child mortality and improve maternal health.

Says Zulfiqar Bhutta of Aga Khan University in Pakistan, "We can work in communities with simple interventions... We also have to address social empowerment, the way that societies see maternal and newborn health. The equity gap is greatest when it comes to mothers and newborns."

“This report is a first scorecard on how we are doing,” says UNICEF Deputy Executive Director Kul Gautam, who is also chair of the interim steering committee of The Partnership for Maternal, Newborn & Child Health. The best way forward, he says, "is a continuum of care for healthy mothers, newborns, and children."

Organizers of the London conference were the Bellagio Child Survival Study Group, the London School of Hygiene and Tropical Medicine, WHO, UNICEF, The Lancet, The Partnership for Maternal, Newborn & Child Health, Save the Children, USAID, BASIS, the UK's Department for International Development, The World Bank, and the International Paediatric Association.

Brigid McConville

http://www.childsurvivalcountdown.com

Ethiopia: Focus on Health Systems

Child deaths are all too common (140 per 1,000) among Ethiopia's predominantly rural people. A third of these are in the neonatal period. Maternal deaths are 871 per 100,000.

The first Global Child Survival Partnership mission to Ethiopia took place in December 2003, and with strong government commitment, this led to a child survival strategy in November 2004. Harmonization is the key, explains the country's Minister of Health, Tedros Adhanom, who notes that Ethiopia now has "one plan, one budget, and one monitoring system. We call it tough love."

National health priorities are now maternal and child health, together with HIV/AIDS and malaria prevention and control. To deliver these, Ethiopia has put in place a "Health Extension Programme" and is expanding its provision of health centres. Says the Minister, "our aim is universal primary health care by 2008, with a health post in every village, and one health centre for every 25,000 people. We are one-third of the way to our target."

As part of the Health Extension Programme, volunteers from selected households will be given 96 hours of training in key health skills. A "social court" will enforce health by-laws. "We will train 3,000 Health Officers in three years," said the Minister. "Meanwhile, 2,167 clinics will be upgraded to health centres while 563 new health centres will be built." He says Ethiopia will need $3.1 billion to meet Millennium Development Goal 4, calling for a reduction in child mortality by two-thirds by 2015.

“Our philosophy is that households are the primary producers of health; just as they produce agricultural products, so they can produce health outcomes as well.” At the same time, “institutionalization is the centre piece in translating vision into action,” he says.

Nepal: Engaging the Community

Nepal has made rapid progress in reducing child mortality. In the past 20 years the under-five mortality rate has fallen from 201 to 70 per 1,000 live births.

Nepal’s Director of Child Health, YV Pradhan, puts this down to a series of public health interventions across the country. For instance, children with pneumonia have been treated by Female Community Health Volunteers (FCHVs), saving 8,500 children a year.

Similarly, says Dr Pradhan, “Vitamin A supplementation has been fantastic, with 90% of children included,” averting 12,000 child deaths a year. Meanwhile, working with women’s groups and training FCHVs to manage infections in newborns has also saved many lives.

“We now have 48,000 FCHVs, one for every 80 households,” says Dr Pradhan. “Half of them are not literate, but they have shown they can reduce deaths from pneumonia by 28% through community-based treatment. At first, our medical doctors worried about putting antibiotics into their hands, but we have been willing to delegate – and it works.”

Brigid McConville
Almost half the people alive today have been through one natural disaster or another in the past decade. That's some two and a half billion people.

Of those, mothers, babies, and children are especially affected by disasters and their aftermath. Not only are they generally less able to escape – by running, climbing, or swimming, for instance – but they suffer most when health services collapse. Pregnant women and newborns are left without skilled care. Children are threatened by unsafe water and lack of food, and by disease.

During the Pakistan earthquake, half of the 80,000 people killed were children. Many more women and children than men died during the tsunami in 2004. In four villages in Aceh, for instance, male survivors outnumbered female survivors by three to one.

Guatemala: Hurricane Stan

On October 3, 2005, Hurricane Stan hit Guatemala, causing devastating floods and mudslides. Ten days later, Sameer Sah from Plan International went to the badly affected south coast, where many families had been evacuated to shelters set up in schools.

“The most vulnerable people in any crisis are pregnant women and children. Their biggest problem in Guatemala is drinking water, as the wells have been polluted by the flooding. Children can die of diarrhoea while women can become sick or lose their babies. People were drinking bottled water, but that is limited. So we started rainwater-harvesting from structures on roof tops.

“Plan had trained young people that the top priority in an emergency is pregnant women and children. So the youth found out where the pregnant women were, when their babies were due, and found vehicles to take women to health centres for birth.

“Water-logging increases malaria and dengue fever, so communities are being provided with bednets. Pregnant women and small children will get them first, together with the sick.

Pakistan: The Earthquake

On October 8, 2005, a massive earthquake hit Kashmir, resulting in more than 70,000 deaths on the Pakistan side and almost 1,500 on the Indian side. According to initial UN estimates, 40,000 pregnant women were caught up in the quake, while one in five of those affected were children under five. Azra Ahsan, a gynaecologist in Karachi, Pakistan, volunteered her services.

“I went to a field hospital set up by the Citizen’s Foundation NGO in Muzaffarabad. I was with my husband, a surgeon, and three other female volunteers. Some friends warned us not to go because it was “not a place for a woman”. But on TV, I saw many foreign women there and I thought, If it is safe for them, it is safe for me.

“We were there for 10 days. What I saw is indescribable. At first, all I did was to catheterize so many young paraplegic women. Such is the custom here that it is unthinkable that a man could do this. I shudder to think of the outcome for these women, living in a mountainous terrain, their houses in ruins, and having lost scores of loved ones.

During our stay we performed more than 300 operations, largely on women and children who had been brought down the mountains by the helicopters. They had fractures, lacerated wounds, dislocated joints and spinal injuries. All were in a state of shock. I seldom saw anyone, even the children, cry in pain. All of them had lost several family members. They not only had physical wounds, but deep
emotional wounds that they could only experience in silence.

“There were landslides going around us all the time, and stench of death was hanging in the air with thousands still buried in the collapsed buildings around us. I saw many pregnant women who were booked to deliver in local hospitals that had perished with patients and staff still in the rubble.

“I also delivered the first baby in the camp. The mother had been flown down on a relief flight from the mountains, and she was in labour. She said that all of the houses in her village had been destroyed, many people there were killed or injured, and everyone was sleeping in the open.

“Fortunately, she had a natural birth, and cheers went round the hospital as well as the Army Stadium when people heard the news. This baby symbolized a new beginning.”

USA: Hurricane Katrina

Last August, Hurricane Katrina hit the coast of Louisiana, causing massive flooding to the city of New Orleans. Midwife and nurse Robbie Prepas joined a disaster medical assistance team at the city’s airport.

“About 2,000 evacuees were there without food or water, without working toilets or electricity. The people were very poor, even compared with many I have worked with in developing countries.

“We treated everything from heart attacks and gunshot wounds to strokes, high blood pressure, diabetes, and asthma. People were dehydrated and hadn’t eaten for days. Many were HIV-positive and without medication.

“Yet the evacuees kept coming in, some having walked for days. Every space was covered with people, and still there was virtually no food or water.

“I delivered one baby at the airport and twins in an ambulance. One of the twins was breech, so their mother had been on the way to hospital [for a caesarean]. The moms and babies were all fine and healthy, but sadly there was no way we could let their families know that.

– I was still not able to walk – but some were even worse off. So I was not alone with this tragedy.

“During my stay in this house, I became the nurse to our group and took care of those who were wounded and sick. I had no choice. People desperately needed me, and I needed them. Without this work I would not have been able to continue living.

“I went home on the seventh day to check the condition of my house and I found it destroyed. The whole area had been hit badly and two-thirds of the people in my area were gone. Then my brother took me back to Bukittinggi, the town where I was born. There I spent two weeks with my mother and relatives.

“My old friends from nursing school had heard about what happened to me. They all came to greet me at the airport. I felt so sad, but also happy because they had not forgotten me. Every morning, three or four of them came to comfort me, changing my bandages each day until I got better. The affection from my relatives and friends made me feel stronger and more able to cope with my loss.

“When I came back to Banda Aceh, I knew had to continue with my life. In February I started again with a new clinic in Lueng Bata in Banda Aceh. I was able to give free care to mothers and babies for the first two months.”
Around the world, every day, fathers have a significant impact on mothers’ and children’s health and life chances. Yet fathers are often left out of the picture when it comes to maternal, newborn, and child health programming.

“Fathers often have decision-making power and control over resources,” says Patrice Engle, a senior advisor on early childhood to UNICEF. Yet many health interventions “continue to target solely women, who may not have the authority to put them into practice.” Says Dr Engle: “Fathers’ involvement is one of the greatest, yet underutilized, sources of support available to children.”

Things are changing, however. Between 2002 and 2003, the number of UNICEF country offices using father-specific strategies in their parenting interventions nearly trebled, from 10 to 28 countries. Since then, in 2004, the United Nations Commission on the Status of Women has called for fathers as well as mothers to be included in programmes for babies and children.

Writing in *FatherWorld* magazine, published by UK charity Fathers Direct (http://www.fathersdirect.com), Engle noted that significant changes in fathers’ behaviour were reported in several of the countries UNICEF has been working in. Although these changes are a result of a wide range of factors, they include:

- less expenditure by fathers on themselves and more on their families;
- improved infant and young-child feeding practices;
- increased school participation and success for girls;
- improved maternal access to antenatal care;
- increased birth weight;
- improved breastfeeding rates.

An international conference on fatherhood organized by Fathers Direct in 2003 focused on making the most of fathers for children’s welfare and development, to enhance gender equality, to better access health care, and to tackle child poverty, poor nutrition, and HIV/AIDS. Fifty experts from five continents attended the conference, together with senior UN officials.

The conference highlighted the urgent need for research in order to influence public policies – ranging from health to education and social services – in light of their effect on fathers and families.

“The attitudes and actions of the male partners of pregnant women can – and do – impact on maternal and infant health outcomes,” says Tom Beardshaw of Fathers Direct. Beardshaw advocates “policy and practice frameworks that motivate men [to care for] the health and well-being of their partners and children, and which tackle harmful attitudes and behaviours.”

**Papa Power**

Fathers’ Role in Family Health Overlooked

Aka Pygmy men do more infant caregiving than fathers in any other known society, according to the report. On average, they hold, or are within reach, of their babies 47% of the time, beating dads from Sweden (number one in the western world), who average 45% of parental child care.

Worldwide, among fathers who do contribute to care, they now contribute between a quarter and a third as much time as women do, with contributions of fathers on the rise. The study also found that:

- Fathers do one-third of parental childcare in the UK;
- US fathers’ contribution has gone up from one-half to two-thirds that of mothers in the past decade;
- Caring for children boosts men’s psychological well-being;
- New fathers’ hormones change when their babies are born, resembling the hormonal changes of their partners.

However, in many cultures around the world, men are not seen as caregivers. Of 156 cultures surveyed, only 20% promote men’s close relationships with infants, and only 5% with young children.

**Pygmy Dads the Best**

Papa power is on the rise, according to a recent global survey. *FatherWorld* magazine looked at fathers on five continents to find the world’s best dads. The winner? The Aka Pygmies of northern Congo. When the mother is not available, the father calms his baby by giving him a nipple to suck.
Health in Africa

Health in Africa is the theme of a special issue of the British Medical Journal (BMJ). This issue of the BMJ (Vol. 331, 1 October 2005; http://www bmj com) offers a mix of new research and opinion on major killers such as HIV/AIDS and malaria, as well as on “underappreciated conditions”, such as postpartum haemorrhage and gender inequity.

Most of the authors are researchers in South Africa and Nigeria, and individuals working in Africa and connected to British or American schools of public health. Their work includes papers on drugs for postpartum haemorrhage and malaria in babies and children.

For instance, one paper looks at how intermittent preventive treatment for malaria can work for infants in Ghana (Daniel Chandramohan et al.), and how anti-malarial drugs such as artemether-lumefantrine might help children in Zambia (Dejan Zurovac et al.). Another paper shows how misoprostol can reduce death and illness in childbirth by reducing the incidence of severe haemorrhage (Lars Heij et al.).

The wider issues are here too. One paper looks at how removing user fees for health care could save some 233,000 children’s lives a year in 20 African countries (Chris James et al.).

This issue of the BMJ illustrates both the scale of the challenge and the breadth of the task. Managing human resources; meeting the Millennium Development Goals; combating corruption – all are highlighted as integral to improving health across Africa. Brigid McConville

Maternal Depression and Newborn Health

It was once presumed that postpartum care in developing countries was protective of mental health, as new mothers are provided with an honoured status, mandated rest, increased practical assistance, and the opportunity to follow culturally prescribed rituals. However, researchers are now finding rates of postnatal depression to be two to three times higher than those in rich countries, where 10-15% of women experience depression in the first year after giving birth. This suggests that initiatives to improve newborn and child health would benefit from efforts to improve maternal mental health.

Recent research in Vietnam, Pakistan, India, Turkey, and South Africa has revealed depression rates ranging from 23-40%. For instance, a study of 506 women in Ho Chi Minh City, Vietnam, revealed depression rates of 32.7% (Fisher et al., BJOG: An International Journal of Obstetrics and Gynaecology, 2004); a study of 632 women in Southern Kahuta, Pakistan, suggested rates of 28% at 12 weeks postpartum (Rahman et al., Psychological Medicine, 2003); and a study of 2,514 women who had given birth the previous year in eastern and central Turkey found rates of 27.2% (Inandi et al., International Journal of Epidemiology, 2002).

Investigators are also noting striking similarities between the risk factors for depression in mothers of newborns in poor countries and those in the industrialized world. These include:

• Unwanted pregnancy (Fisher et al., 2004);
• Poor relationship with a partner, including his being unavailable at the time of the baby’s birth; providing insufficient practical or emotional support; having little involvement in infant care; holding rigid sex role expectations or being critical, coercive, or violent (Fisher et al., 2004; Patel et al., American Journal of Psychiatry, 2002; Rahman et al., Child: Care, Health and Development, 2003);
• Lack of practical and emotional support, or criticism from family members (Inandi, 2002).

Postpartum depression can have significant consequences for newborns. Affected mothers tend to cease breastfeeding earlier (Cooper et al., Journal of Psychosomatic Research, 1993) and respond less sensitively to their infants. Independent of other risks, the infants of mothers who are depressed, especially those experiencing social disadvantage, are more than twice as likely to be underweight and three times more likely to be short for age at six months of age (Patel et al., 2002).

Women who are depressed are less able to comprehend and utilize health education – yet health promotion programs to improve child health very often depend on mothers.

Review prepared by Jane Fisher (University of Melbourne), Meena Cabral de Mello (WHO), Vikram Patel (London School of Hygiene and Tropical Medicine), and Atif Rahman (Royal Manchester Children’s Hospital, UK).

Higher Risk of HIV in Pregnancy

The risk of becoming infected with HIV is higher when women are pregnant, according to a study published recently by The Lancet (Vol. 366, 1182-1188, 1 October 2005; http://www.thelancet.com).

The study found that pregnant women in the Rakai district of Uganda were twice as likely to become infected with HIV/AIDS as women who were not pregnant.

RH Gray and colleagues monitored more than 10,000 women; about a fifth were pregnant or breastfeeding. They found that the higher risk in pregnancy is unlikely to be due to sexually risky behaviour. Instead, “hormonal changes affecting the genital tract mucosa, or immune responses” may be responsible.

It follows that women should be warned of this potential risk, and that condom use or sexual abstinence should also be promoted. This would additionally protect women from other sexually transmitted infections that could harm both mother and newborn.

In the authors’ view, this adds to “the compelling rationale for provision of family-planning services, especially where the risk of HIV exposure is high”. Brigid McConville
Rose Mlay: Making Mothers Count in Tanzania

Rose Mlay is coordinator of the White Ribbon Alliance of Tanzania. She spoke to Brigid McConville.

Q: What are the priorities for safe motherhood in Tanzania?
A: We need more nurse-midwives and doctors. Yet since 1994, the number of nurse-midwives employed has decreased tremendously. Those who are now willing to go to remote areas should receive extra incentives, such as housing and salary increases. Meanwhile, traditional birth attendants (TBAs) should take the role of enticing women to seek skilled care.

Tanzanian policy makers, men, and the community at large need to understand that maternal mortality is increasing here, mainly due to lack of skilled birth attendants. The complications that cause a woman to lose her precious life – haemorrhage, hypertension, obstruction, sepsis, anaemia, HIV – and that of the baby, cannot be tackled by a relative or TBA.

Some of our [older] policy makers adore TBAs because one assisted their mother during childbirth. But today, women in our villages are even more anaemic and malnourished than they used to be, plus they might be HIV-positive with malaria. For many women today, to lose a few milliitres of blood may lead to death.

Q: How do you feel about the progress of safe motherhood in Tanzania?
A: I often feel discouraged, but I am not giving up. Sixty per cent of our mothers give birth at home without skilled care, yet TBAs are not able to manage the complications that threaten mothers and newborns. Our grandmothers were suffering from fistula and still today’s mothers are experiencing the same terrible problem. This is unacceptable.

Q: What are the major challenges you face?
A: A serious challenge is the impact of HIV/AIDS and the involvement of men in prevention. I believe men must accompany women to antenatal clinics and go through couple voluntary counselling and testing for HIV (CVCT), receiving the results together. [We have found] men in such situations are very compassionate, ensuring that the newborn is protected and the wife is well cared for. Tackling HIV should never be separated from the work of safe motherhood and vice versa."

White Ribbon Alliance of Tanzania (WRATZ) was launched in March 2004; it is working with Tanzania’s Ministry of Health to increase the numbers of skilled attendants, their skills, and employment. WRATZ now has 241 member organizations and individuals. Contact: wra_tz@yahoo.com

Julian Lob-Levyt: Saving Lives Through Long-Term Financing

Julian Lob-Levyt is executive secretary of the Global Alliance for Vaccines and Immunization (GAVI), which recently initiated the International Finance Facility for Immunization (IFFIm) to increase and regularize aid flows for immunization and health systems. He spoke with Jacqueline Toupin.

On saving lives: “The IFFIm could prevent 5 million child deaths by 2015, in addition to the 1.5 million prevented if investments in the GAVI Alliance continue at their current level. We anticipate raising US$ 4 billion of new funds that will create more stable aid for immunization for the world’s poorest countries and provide certainty for manufacturers to invest in new and under-used vaccines.”

On improving sexual and reproductive health: “We are also excited about the potential for vaccines for sexual and reproductive health, such as an HPV vaccine to prevent cervical cancer.”

On GAVI and The Partnership for Maternal, Newborn & Child Health: “One of the reasons we are excited about our link to The Partnership is because of The Partnership’s focus on basic health services. With the IFFIm, we are opening a new ‘health systems window’, which is more flexible and targeted to fund cross-cutting problems like the development of human resources.”

On the development of health systems: “The bigger prize of the IFFIm is the ability to rehabilitate basic health services. Countries have given us a clear message that they need long-term, secure financing for health systems. Within the context of the global efforts of the World Health Organization, the World Bank, and UNICEF, who are leading this vision, the IFFIm can help do that.”

About the IFFIm

The International Finance Facility for Immunization (IFFIm) was launched in September 2005 by GAVI to increase aid and to ensure reliable and predictable funding flows for immunization and health systems in the run-up to 2015 – the target date of the Millennium Development Goals.

The IFFIm raises funds by borrowing against long-term, legally binding commitments from a wide range of donors. This enables these pledges to be converted to cash that can be disbursed immediately in the form of grants to fund immunization programmes in recipient countries. With bonds issued against these donor pledges in the international capital markets, the IFFIm will then pay bondholders an agreed rate of interest and will repay the capital value of the bonds on maturity as donor pledges are realized over the duration of the programme.

An anticipated IFFIm investment of US$ 4 billion is expected to prevent 5 million child deaths between 2005-2015 and more than 5 million future adult deaths (http://www.iffim.com).
Dear Midwives: We Need Each Other – and the MDGs Need Us

By Khama Rogo

The reduction of maternal mortality by 2015 is one of the key MDGs, and it is now self-evident that skilled care is at the core of this quest. Midwifery is the core currency of measurement of the level of skilled care. This should not be a surprise given that these are the skills that sustain obstetric practice. In this context, midwifery and obstetrics are really one and the same practice; at most, different faces of the same coin.

As will be known to many of you, this common sense is not always apparent to members of our two professions. The relationship between midwives and obstetricians leaves a lot to be desired, often due to pettiness and petulance, largely on the part of our colleagues, the obstetricians.

In my many years of practice, I have failed to understand the root cause of the problem and why two people who are so beholden to each other, so miserably often fail to appreciate one another. One usually relates such senseless conflicts to religious fanatics or racial bigots.

Do we have their equivalents – professional bigots – in our midst? And could that be the reason behind the misunderstandings? Who benefits from the conflicts and how can we address the problem?

As a trained obstetrician, I can openly confess one thing that you already know. I learnt my obstetrics at the feet of midwives. Most of us do. All good obstetricians must. I owe it to each and every midwife who held my hands (and scalpel) in the labour room and in theatre over a quarter of a century ago for what I am today. This acceptance has always provided me with a strong sense of identity with each and every midwife, and a serene humility in their presence.

The world needs midwives, now more than ever. The world recognizes that without midwives, there can be no safe motherhood. And every obstetrician will accept that without the midwife, obstetric practice is dead.

We therefore need to build bridges. But this requires leadership. My passionate appeal to you is to help construct a roadmap that will open up dialogue between these two professions all levels. We must call a truce that will give birth to a new relationship of love and respect for each other, to the great benefit of millions of women and mothers who depend so much on the combination of our skills.

This is what the world needs if we are to attain the MDGs: coherence, tolerance, and harmony between the professions, putting the interest of the patient first.

After all, we need each other – and the women whose health we are trained to preserve need us.

Khama Rogo is lead health specialist at The World Bank. This is adapted from a speech to the 27th Congress of the International Confederation of Midwives in Brisbane in July 2005.
Sections include background information on STI/RTI and their complications; how to approach STI/RTI as an integral part of reproductive health services; and how to diagnose and treat STI/RTI-related problems.

State of the World Population 2005
The Promise of Equality: Gender Equality, Reproductive Health and the Millennium Development Goals
UNFPA
2005, 128 pgs. (English, French, Spanish)
ISBN: 92-91477-02
This year's report explores the degree to which the global community has fulfilled its pledges. It tracks progress, exposes shortfalls, and examines the links between poverty, gender equality, human rights, reproductive health, conflict and violence against women and girls.

Maternal Health
Achieving Skilled Attendance for All
A Synthesis of Current Knowledge and Recommend-ed Actions for Scaling Up
Sandra MacDonagh
DFID Health Resource Centre
2005, 37 pgs. (English)
This report provides a synthesis of the evidence for the drive towards ‘skilled attendance for all’ and suggests steps that need to be taken to achieve this vision. This report reviews interventions in countries that have reduced maternal mortality, and includes epidemiological studies, evaluations of intervention programmes, and data modelling.

Evidence-Led Obstetric Care
Strategies to Change Practice and Policy
WHO
2005, 50 pgs. (English)
This report is based on a meeting held in Geneva in January 2004 under the auspices of the Department of Reproductive Health and Research of the WHO. The meeting focused on ways of promoting evidence-based care in the areas of pregnancy and childbirth, using the WHO Reproductive Health Library (RHL) as a source of review evidence.

Fight for Life
Series of 8 videos (English)
The BBC and the WHO’s Making Pregnancy Safer has collaborated in the production of a series of films exploring the issues surrounding conception, pregnancy, birth, and early childhood around the world. Countries covered in the series to date include Afghanistan, Bangladesh, Bolivia, India, Malawi, Moldova, Mongolia, and Uganda.

Formal and Informal Fees for Maternal Health Care Services in Five Countries
Policies, Practices, and Perspectives
S. Sharma et al.
USAID/POLICY Working Paper Series
2005, 54 pgs (English)
This study, conducted in Egypt, India, Kenya, Peru, and Vietnam, examines the degree to which exemptions to user fees for maternal health services actually protect access for the poor, and the extent to which such exemptions may need to be supplemented with other strategies.

Newborn Health
HIV and Infant Feeding
Counselling Tools
UNICEF/WHO
PDFs: http://www.who.int/child-adolescent-health/publications/NUTRITION/HIV_IF_CT.htm
This set of tools includes a flipchart for use during counselling sessions with HIV-positive pregnant women and/or mothers; take-home flyers that explain how to practise safer infant feeding, according to the mother’s decision; and a reference guide that acts as a handbook, providing more technical and practical details than the counselling cards.

Household-to-Hospital Continuum of Maternal and Newborn Care
ACCESS
2005, 16 pgs. (English)
PDF: http://www.accessstohospital.org/tool/series/HHCCreport_ACCESS.pdf
This policy brief explores issues related to the integration of community- and facility-based maternal and newborn programming and implementation. “Household-to-Hospital Continuum of Care” (HHCC) addresses social and health system issues in the community, bringing together community members and health-care providers.

The “Rights” Start to Life
A Statistical Analysis of Birth Registration
UNICEF
2005, 35 pgs. (English)
ISBN: 92-808-3858-0
Birth registration is often considered to be a legal formal-ity, unrelated to child health, education, development, or protection. This publication analyses the reasons for non-registration and the differentials of registration, concluding with recommendations for new programmatic approaches that can improve rates of birth registration.

Continued on pg. 15