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From the Literature

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From the Literature

The Forgotten Newborn*

In recent years child survival activities (such as childhood immunization and diarrhea control programs) have led to a dramatic decrease in mortality among children under five. Despite this success, however, the newborn mortality rate in developing nations is still alarming—over 40 percent of all deaths of children under five occur in the first month—even though there are proven, cost-effective ways to prevent newborn mortality.

It is estimated that 34 out of every 1,000 babies born in developing countries die before they reach the age of one month, most of them at home. For the most part, the child survival revolution has bypassed the newborn.

One reason for the continued high newborn death rates is the gap between safe motherhood and child survival efforts. Safe motherhood programs typically focus on the survival of the mother, and child survival strategies usually address the problems of children over one month. There has been little international effort to develop a maternal-child health approach that includes care during the first month of life. Ideally, maternal-child programs would target the care of mothers, newborns, and children up to the age of five.

Saving Newborn Lives Initiative

As a newborn care provider, you may be involved in helping others learn why it is important to focus on newborn health. In addition to understanding the global problem, you may also want to get information on the newborn situation in your own country or region. When providers, tutors, programmers, and policymakers understand the situation and have the correct information, they can advocate for improved newborn care and survival.

Newborn Mortality

Health statistics show that worldwide:

About 4 million babies die each year.

Another 4 million babies each year are stillborn; most die in late pregnancy or labor.

Most newborn deaths occur in developing countries.

The Two-Thirds Rule

Health statistics also show that:

About two-thirds of infant deaths* occur in the first month of life.**

Of those who die in the first month, about two-thirds die in the first week of life.

Of those who die in the first week, two-thirds die in the first 24 hours of life.

*Deaths in the first year of life

**In the newborn period

About two-thirds of infant deaths occur in the first month of life.

Of those, about two-thirds die in the first week of life.

Of those, two-thirds die in the first 24 hours of life.

Main Causes of Newborn Deaths

Research from around the world has identified the main causes of newborn deaths. About 85 percent of newborn deaths are from three main causes: infections, birth asphyxia, and complications of prematurity. Low birth weight (LBW) is an important contributing factor in many neonatal deaths.

In addition to the direct causes of death, many newborns die because of their mother's poor health or because of lack of access to essential care. Sometimes the family may live hours away from a referral facility or there may not be a skilled provider in their community.
The newborn child is extremely vulnerable unless she receives appropriate basic care, also called essential newborn care. When normal babies do not receive this essential care, they quickly fall sick—and too often they die. For premature or low birth weight babies, the danger is even greater.

Newborn Survival

Most newborn deaths are entirely preventable, thanks to a number of simple, low-cost actions that can be taken by health care workers, mothers, and families. But many health care providers have not been trained in essential newborn care, and many mothers do not know how to protect their newborns.
This manual explains the fundamentals of essential newborn care for all babies and what to do in the event of a problem or complication. Armed with this knowledge, health care providers can play a crucial role in helping mothers, family members, and the community takes better care of newborns and put them on the road to a healthy life.

***Reference: Care of the Newborn Reference Manual, Save the Children Federation.**

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WOMEN, AGEING AND HEALTH

Three basic considerations impel the greater recognition of health of ageing women as a major health and development issue for the future:

- The numbers of ageing women are increasing worldwide;
- Women's life course beyond age 50 extends for a significant period and is increasing everywhere in the world; and
- There is a very significant scope for improving the health of ageing women and thus ensuring that they remain a resource for their families and communities.

Most ageing women are living in the developing regions of the world. Currently, more than half of the world's women aged 60 years and over are living in developing regions, 198 million compared with 135 million in the developed regions. And the percentage of older women living in developing regions will grow dramatically in the future, since two-thirds of the women in the age group 45-59 currently live in developing countries as compared with only one third in the developed countries.

There are significant differences in life expectancy of women and men. In the developed nations of the world, women live on average six to eight years longer than men. Life expectancy for women now exceeds 80 years in at least 35 countries and is approaching this threshold in several other countries. However, the life expectancy of women in countries at different levels of development is markedly different, ranging from just over 50 years in the least developed countries through the 60s and 70s in those undergoing rapid economic development.

But life expectancy at birth alone can be misleading, disguising the duration of women's lives in developing countries. For women in developing countries who survive the early lifespan stages to reach middle age, life expectancy approaches that of women in developed countries. At age 65, women in developing countries now have about three quarters of the remaining life expectancy of their counterparts in developed countries, and the gap will narrow in the future as mortality steadily declines at younger ages.

Longer lives are not necessarily healthier lives. Since the likelihood of disability increases with age, it is hardly surprising that national surveys reveal increasing numbers of disabled women among the older populations. In a few developed countries, however, recent data reveals that the rates of disability among the older population are steadily declining. The available data, on the other hand, is still insufficient to assess the real extent of disability among the world's older women.

The term "healthy life expectancy" has been developed to describe the number of years one can expect to live in relatively good health. Healthy life expectancy is not necessarily life expectancy free of disease. Rather, the concept of healthy life expectancy as normally used refers to life expectancy without limitation of functions that may be the consequence of one or more chronic conditions.

More than forty-five countries now have estimates of healthy life expectancy. One general conclusion is warranted based on these studies: women can generally expect to spend more years of their lives with some functional limitations than men. This is valid for developed as well as developing countries.

Among the types of disability, mobility disability, in particular walking disability, is currently acknowledged as one of the most important quality of life and public health concerns of older women. Slow walking speed is a risk factor for falls and other accidents, resulting in fractures, further disability and loss of independence. In developing countries, loosing the ability to walk may be associated with even greater risks of adverse outcomes as walking is often the most common means of transportation.

While older women may suffer more functional limitations than men, it is inaccurate to say that older women are generally frail. It must be emphasised that the vast majority of older women and men are in generally good health, especially during the "young-old" ages. Recent studies in developed countries have shown that the prevalence of disability for both women and men to be less than 5 per cent for persons aged 60 to 64, less than 10 per cent for persons aged 70 to 74, and then rising to slightly more than 20 per cent among those aged 85 and over. And in developed countries, the rates of nursing home use are generally very low for persons under the age of 80. But with more and more women reaching 80 plus there is concern about the quality of their extended lives.

There are powerful economic, social, political and cultural determinants which influence how women age, with far-reaching consequences for health and quality of life, as well as costs to the health care systems. For example, poverty at older ages often reflects poor economic status earlier in life and is a determinant of health at all stages of life. Countries that have data on poverty by age and sex (mostly the developed countries) show that older

women are more likely to be poor than older men. But in many developing countries there are often simply no reliable data on poverty tabulated by sex and age.

Poverty is also linked to inadequate access to food and nutrition and the health of older women often reflects the cumulative impact of poor diets. For example, years of child bearing and sacrificing her own nutrition to that of the family can leave the older woman with chronic anaemia.

Another determinant of health is education; levels of education and literacy among current cohorts of older women in developing countries are low. Increased literacy for older women will bring health benefits for them and their families.

Lack of safe drinking water, a gender-based division of domestic chores (including the carrying of water), environmental hazards, such as contact with polluted water, agricultural pesticides and indoor air pollution, all have a cumulative negative impact on the health of women as they age in many developing countries.

Older women everywhere are far more likely to be widowed than older men and most women can expect widowhood to be a normal part of their adult daily lives. While most women adjust both emotionally and financially to their changed situation, traditional widowhood practices in some countries result in situations of violence and abuse and pose a serious threat to older women's health and well-being.

Widowhood is often being preceded by a period of caregiving to the deceased spouse combined in many cases with care giving to dependent parents, grandchildren and other dependent family members. Older women are an important source of caregiving and such activities are most often unremunerated.

In many countries, access to health care is tied to coverage by national social security and health insurance systems which in turn are linked to employment in the formal sector of the economy. As many older women in developing countries have worked all of their lives in the informal sector or in unpaid activities, access to health care often remains unaffordable and difficult at best.

What is a gender-sensitive life course approach to older women's health? Because the major preventable causes of morbidity and mortality all take effect over the life course, prevention strategies will be most effective when initiated as early in the life course as possible. For example, the health benefits of exercise and physical activities are well known and exercise should be promoted in all age groups from children to centenarians. Barriers for girls and women to exercise should be removed and culturally appropriate strategies for exercise should be put into place. This would help prevent functional dependence in old age and maintain mobility of older women at an adequate level for management of daily life.

Other modifiable risk factors associated with poor mobility in old age include smoking and deviance from normal weight. Cessation of smoking, promotion of exercise and improved diet are in fact primary prevention strategies for many causes of death and disability. In addition, it is of paramount importance that younger women have the opportunity to build

and maintain strong bones in order to maintain bone density and prevent osteoporosis at later ages.

Another example of preventable diseases is heart disease and stroke which are the major causes of death and disability in ageing women, accounting for close to 60% of all adult female deaths. The common view of heart disease and stroke as men's health problems has tended to overshadow the recognition of their significance for ageing women's health. Half of all deaths of women over 50 in developing countries are due to these conditions. Although communicable diseases are not yet fully controlled in these countries, they are no longer important causes of sickness and death in old age.

For many types of cancer, particularly breast cancer and cervical cancer, early detection is the main strategy for prevention. For breast cancer early detection include physical examination of the breasts by trained health workers, breast self examination and mammography. As general screening programmes by mammography are still far beyond the resources of developing countries, there is an urgent need to improve the effectiveness of breast self examinations strategies.

WHO's response to maintain the health of older women

WHO's Ageing and Health Programme (AHE) recognises that gender is one of the major determinants of health. In addition to biological differences, a gender approach to health includes an analysis of how different social and economic roles, decision-making power and access to resources affect the health status of men and women at older ages.

The AHE Programme is committed to apply the gender perspective in all of its activities, notably in the areas of research, information dissemination, training, advocacy and policy development. Moreover, the Programme promotes the concept of Active Ageing which stresses that older people are a resource for their families and communities and that policies should be developed which enable older people to remain active for as long as possible in their later years. To facilitate the implementation of Active Ageing policies and strategies at all levels -- national and community -- gender sensitive guidelines and strategies are being developed. The AHE Programme works in close partnership with Governments, academic institutions and civil society organisations.

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*Violence against women (VAW) ***

Violence affects at least one in three women and girls in the world. Violence against women (VAW) is rooted in unequal power relations between men and women, so efforts to end VAW must promote women's empowerment and gender equality. National governments are increasingly instituting legal reforms to put violence against women, once regarded as a private issue, firmly on the public agenda.

Ending VAW is also at the top of the international peace, security, human rights and development agendas. In 2008, the United Nations

Secretary-General launched the Unite to End Violence Against Women Campaign, which calls on governments, civil society, the private sector and the entire United Nations system to meet the challenge by 2015, the deadline for achieving the Millennium Development Goals (MDGs). The Security Council, whose resolutions impose mandatory obligations on States with penalties for non-compliance, recently passed Resolution 1820 which recognizes that, when used as a tactic of war, sexual violence against civilians "may impede the restoration of international peace and security.

States are obligated, under the due diligence standard, to respond as effectively as their capacity and resources allow to investigate, prosecute, provide remedies for and, importantly, prevent violence against women. Building national accountability to address VAW requires simultaneous efforts at the levels of mandates, procedures, and deep culture in all of the institutions that prevent and prosecute violence and address the needs of survivors.

1. MANDATE REFORM

National legislation that prevents and penalizes all forms of violence against women and girls must be enacted. According to the *Secretary-General's In-Depth Study on All Forms of Violence Against Women*, 89 countries had instituted by 2006 some form of legislative prohibition on domestic violence. In Liberia, one of the first laws passed following the election of President Johnson Sirleaf was a strong law criminalizing rape and making it a non-parole offence so suspects cannot return to communities to intimidate victims and witnesses.

National law must be harmonized with **international and regional human-rights instruments** and standards. General Recommendation

19 of the CEDAW Committee addresses violence against women and has been referred to by national courts, including the Indian Supreme Court, to secure women's rights. It is critical to monitor implementation of international and regional commitments and use

relevant complaints mechanisms, such as the Inter-American Convention *Belém do Pará* or the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.

Reliable data on VAW must be collected and made public. Information is central to informed policy and program development and monitoring. This includes population-based surveys on the multiple manifestations of violence against women and girls, their prevalence, causes, consequences, and the impact of interventions over the medium to longer-term; service-level data to assess sector performance (health, judicial and security); and surveys on attitudes and behaviors. The task of building data on VAW is made more

challenging by the fact that VAW is one of the least reported crimes and, charges are pressed in only a fraction of cases.

2. PROCEDURAL CHANGES

National policy and funding frameworks must be developed. National Action Plans exclusively devoted to addressing violence against women serve as a valuable instrument for establishing the institutional, technical and financial resources required for a holistic, coordinated, multi-sectoral approach. These plans must aim to provide for a 'frontline' response from the police, medical and livelihood support services,

in addition to legal services and long-term prevention. Cambodia was the first country to include targets on domestic violence and trafficking in its National MDG Plan 2005.v Mozambique incorporated elements of the National Plan of Action to End Violence Against Women into the Poverty Reduction Strategy, and South Africa addressed violence against women throughout its national HIV/AIDS strategy.

Standard operating procedures and performance measures must be changed to translate laws and action plans into new practices.

Presidential or ministerial decrees and protocols that assign roles and responsibilities to the ministries involved, and set minimal operating and performance standards, can support the implementation of laws and policies.

Resources must be earmarked to finance the wide range of actions to address VAW. Costs range from financing law enforcement reform

and paying for health care, to ensuring free access (fee waivers, transportation) for poor women and girls. In August 2007, the President of Brazil announced US$590 million to implement the new *Maria da Penha* Law on violence against women. The budgetary pledge is a leading example of a substantial allocation for implementation of legislation. The United Nations Trust Fund to End Violence Against Women, the principal fund dedicated for this issue, received total contributions of $10 million from its founding in 1996 to 2004, with that total climbing to a committed $40 million for the period 2005-08. By comparison, the Global Fund on HIV and AIDS, Malaria and Tuberculosis has reached over $10 billion since its establishment in 2002. A telling measure of accountability will be whether the Secretary-General's campaign target for the Trust Fund of reaching a minimum of US$100 million per year by 2015 will be met.

Monitoring mechanisms must be inclusive at both national and local levels, to bring together the government, women's and other civil-society organizations, experts and researchers. For example, Afghanistan established an inter-ministerial commission on violence against women via Presidential decree, with UNIFEM support.

3. CULTURAL CHANGE

Empower women and girls, mobilize men and boys. Real and lasting change to end violence against women and girls needs to be grounded at the community level, where acts of abuse occur and where women should be able to demand their rights to justice, protection and support. Involving men and boys in actions to prevent and respond to violence against women is critical to finding a meaningful solution. A vibrant, well-informed civil society, armed with hard data, empowered with knowledge of their rights and governments' obligations, and equipped to demand accountability is a hallmark of sustained progress.

Launch and sustain campaigns. Spearheaded by women's movements, campaigns such as 16 Days of Activism have been instrumental in breaking the silence and raising awareness. UNIFEM crafted and forged the first United Nations Campaign on the issue in Latin America

and the Caribbean in the late 1990s, and has continued such efforts, including its most recent global campaign, "Say No", which has garnered hundreds of thousands of signatures from individuals, partner organisations and governments.

As United Nations Secretary-General Ban Ki-Moon summed up at the launch of the UNITE campaign, "Violence against women and girls makes its hideous imprint on every continent, country and culture. It is time to focus on the concrete actions that all of us can and must take to prevent and eliminate this scourge... It is time to break through the walls of silence, and make legal norms a reality in women's lives."

***** Source: PROGRESS OF THE WORLD'S WOMEN 2008/2009, UNIFEM, Who Answers to Women?*** http://www.unifem.org/progress/2008

HISTORICAL ACHIEVEMENTS IN WORLD HEALTH***

Any checkup should include a case history.1 A review of the unprecedented improvements in human health in the last century provides important perspectives on the current situation.

Until the 19th century, deaths of infants and children were commonplace worldwide. Poor nourishment left most people stunted by today's standards. Infectious diseases such as smallpox, measles, and tuberculosis decimated entire communities and left many people scarred and crippled. Life expectancy was low throughout the world.

Even for women in England, who had the world's highest average lifespan between 1600 and 1840, life expectancy fluctuated between 35 and 45 years, half what it is today This overall picture has changed rapidly and dramatically since the mid-19th century. The medical community brought many infectious diseases under control, and even eradicated smallpox; better nutrition and overall health conditions lowered mortality rates for everyone, especially children; and life spans increased dramatically. After 1840,

the upward trend in life spans proceeded at a surprisingly sustained and uniform rate of increase of 2.5 years per decade for the next 160 years. By 1900, the highest average life expectancy just surpassed 60 years; by 2000, it exceeded 80 years.

However, even though the gains in health and life expectancy have not been uniform around the globe and have not occurred at the same time or to the same extent, they have been widespread:

• Smallpox was eradicated worldwide by 1977.

• Polio remains in only a handful of countries.

• Diphtheria, whooping cough, measles, and tetanus are rare or absent in many parts of the world.

• Child mortality, while still high in many places, has declined almost everywhere.

• Average life expectancy has increased—albeit with setbacks—around the world. Between 1960 and 2002, average life expectancy rose from 36 to 71 years in China, from 56 to 71 years in Latin America and the Caribbean, from 47 to 69 years in the Middle East and North Africa, and from 44 to 63 years in South Asia. Even in Sub-Saharan Africa, average life expectancy rose from 40 to 50 years in 1990 before falling back to 46 years in 2002, largely because of the spreading HIV/AIDS epidemic. Even though life expectancy in high-income countries exceeds that in developing regions, convergence is notable. In 1910, for example, a male born in the United States could expect to live 49 years, but had he been born in Chile, his life expectancy would have been only 29 years.

By the late 1990s, in contrast, U.S. life expectancy had reached 73 years and that of Chile had reached 72 years.
*****Source: Priorities in Health. The World Bank 2006.**

Recommendations of the Commission on Social Determinants of Health****

The Commission on Social Determinants of Health (CSDH) was a three-year effort begun in 2005 to provide evidence base recommendations for action on social determinants to reduce health inequities. The Commission accumulated an unprecedented collection of material to guide this process, drawing from theme-based knowledge networks, civil society experiences, country partners and departments within WHO.
The final report of the CSDH contains a detailed series of recommendations for action, organized around the following three overarching recommendations. **http://www.who.int/social_determinants/thecommission/finalreport/closethegap_how/en/index3.html**

1. Improve daily living conditions
Key improvements required in the well-being of girls and women; the circumstances in which their children are born, early child development and education for girls and boys; living and working conditions; social protection policy; and conditions for a flourishing older life.

2. Tackle the inequitable distribution of power, money and resources
To address health inequities it is necessary to address inequities in the way society is organized. This requires a strong public sector that is committed, capable and adequately financed. This in turn requires strengthened governance including stronger civil society and an accountable private sector. Governance dedicated to pursuing equity is required at all levels.

3. Measure and understand the problem and assess the impact of action
It is essential to acknowledge the problem of health inequity and ensure that it is measured – both within countries and globally. National and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health are required that also evaluate the health equity impact of policy and action. Other requirements are the training of policy-makers and health practitioners, increased public understanding of social determinants of health, and a stronger social determinants focus in research.
**** ***Source WHO. World Health Report 2008.***

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Challenges in measuring maternal deaths*****

Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy, from any cause related to or aggravated by the pregnancy or its management. Causes of deaths can be divided into direct causes that are related to obstetric complications during pregnancy,

labour or the post-partum period, and indirect causes. There are five direct causes: haemorrhage (usually occurring postpartum), sepsis, eclampsia, obstructed labour and complications of abortion. Indirect obstetric deaths occur from either previously existing conditions or from conditions arising in pregnancy which are not related to direct obstetric causes but may be aggravated by the physiological effects of pregnancy. These include such conditions as HIV and AIDS, malaria, anaemia and cardiovascular diseases. Simply because a woman develops a complication does not mean that death is inevitable; inappropriate or incorrect treatment or lack of appropriate, timely interventions underlie most maternal deaths.

Accurate classification of the causes of maternal death, whether direct or indirect, accidental or incidental, is challenging To accurately categorize a death as maternal, information is needed on the cause of death as well as pregnancy status, or the time of death in relation to the pregnancy. This information may be missing, misclassified or under-reported even in industrialized countries with fully functioning vital registration systems, as well as in developing countries facing high burdens of maternal mortality. There are several reasons for this: First, many deliveries take place at home, particularly in the least developed countries and in rural areas, complicating efforts to establish cause of death. Second, civil registration systems may be incomplete or, even if deemed complete, attribution of causes of death may be inadequate. Third, modern medicine may delay a women's death beyond the 42-day post-partum period. For these reasons, in some cases alternative definitions of maternal mortality are used. One concept refers to any cause of death during pregnancy or the post-partum period. Another concept takes into account deaths from direct or indirect causes that occur after the post-partum period up to one year following pregnancy.

The main measure of mortality risk is the maternal mortality ratio, which is identified as the number of maternal deaths during a given period of time per 100,000 live births during the same period, which is generally a year. Another key measure is the lifetime risk of maternal death, which reflects the probability of becoming pregnant and the probability of dying from a maternal cause during a women's reproductive lifespan.

In other words, the risk of maternal death is related to two main factors: mortality risk associated with a single pregnancy or live birth; and the number of pregnancies that women have during their reproductive years.

Working together to improve estimations of maternal deaths

Several agencies are collaborating to establish more accurate measurements of maternal mortality rates and levels worldwide, and assess progress towards Target A of Millennium Development Goal 5, which seeks to reduce the maternal mortality rate by three quarters between 1990 and 2015. The Maternal Mortality Working Group, which originally comprised the World Health Organization, UNICEF and the United Nations

Population Fund, developed internationally comparable global estimates of maternal mortality for 1990, 1995 and 2000.

In 2006, the World Bank, United Nations Population Division and several outside technical experts joined the group, which subsequently developed a new set of globally comparable maternal mortality estimates for 2005, building on previous methodology and new data. The process generated estimates for countries with no national data, and adjusted available country data to correct for under-reporting and misclassification.

Of the 171 countries reviewed by the Maternal Mortality Working Group for the 2005 estimations, appropriate national level data were unavailable for 61 countries, representing

one quarter of global births. For these countries, models were used to estimate maternal mortality.

For the 2005 estimates, data were drawn from eight categories of sources: complete civil registration systems with good attribution of data, complete civil registration systems with uncertain or poor attribution of data, direct sisterhood methods, reproductive-age mortality studies, disease surveillance or sample registration, census, special studies and no national data. Estimates for each source were calculated according to a different formula, taking into account factors such as correcting for known bias and determining realistic uncertainty bounds.

Measures of maternal mortality are prepared with a margin of uncertainty, highlighting the fact that while they are the best estimates available, the actual rate may be higher or lower than the average. Although this is true of any statistic, the high degree of uncertainty for maternal mortality ratios indicates that all data points should be interpreted cautiously.

Notwithstanding the challenges of data collection and measurement, the 2005 inter-agency estimates for maternal mortality were sufficiently rigorous to produce trend analysis, assessing progress from the 1990 baseline date of MDG 5 to 2005. The lack of improvement in reducing maternal mortality identified in many developing countries has helped bring greater attention to achieving MDG 5.

The 2005 maternal mortality estimates are far from perfect, and much work is still required to refine the processes of data collection and estimation. But they reflect a strong commitment on the part of the international community to continually strive for greater accuracy and precision. These ongoing efforts will support and guide actions to improve maternal health and ensure that women count.

Source: UNICEF. State of World Children Report 2009.