WOMEN’S & CHILDREN’S HEALTH, ROLE OF FBO’s IN MAKING IT A REALITY

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“Healthy mothers and healthy children make healthy societies. And giving them health is a job for all. […] No woman should lose life giving life. And no child should come into this world motherless. Every woman is our sister and mother. Every child is our daughter or son.” - Ban Ki Moon

To know that a baby will be born soon is such wonderful news for many women impatient to have their babies in their arms and give them the best care they can.

Although the maternal mortality rate has dropped by almost half in the last 20 years (from over 540,000 deaths in 1990 to less than 290,000 in 2010), many women still die every day during childbirth or several days later because they had not received proper care or owing to other delivery complications; many others will suffer injuries which, if untreated, will expose them to life-long disability and/or humiliation. These problems are more prevalent in sub-Saharan Africa and South Asia, which record the highest rates of maternal mortality worldwide (some countries exceed twice the global rate).

"He defended the cause of the poor and needy, and so all went well. Is that not what it means to know me?” - declares the Lord. Jeremiah 22:16

Every day, world inequities are taking the lives of many women due to the lack of adequate health care systems and education to make decisions in health.
Many causes are preventable through basic interventions involving fathers, the whole family, the community and government, enabling every mother and child the best opportunity to live. We must also seek ways to address the cultural causes, such as sexual violence, forced or early marriage, limited choices in reproductive health, coerced sexual encounters, and teenage pregnancy—all major challenges to maternal health. Key strategies to overcome these obstacles involve community-based activities such as sponsorship of focus groups, women’s forums, community leader workshops, and school and youth groups aimed at addressing the issue of gender bias and its negative impacts.

It is also important to remember that, traditionally and historically, the role of bringing up children has been assigned to mothers who, from the womb, have to ensure the baby’s growth. So if a mother is not in good health, owing to such factors as poverty, HIV and AIDS, pregnancy and delivery complications, not only is her child’s survival at risk but it’s future as well.

In the last decades, it has been worth recognizing the role played by FBOs in facilitating access to health services in areas where geographical, political and socio-economic obstacles has made it difficult for every woman, child and person to achieve their right to health. In some areas FBOs health services are the only ones available. In other zones, FBOs have joined with the government to develop health programs, which is an important and necessary step in contexts which allow such partnerships and where the government is committed to developing its role in promoting social welfare, investing in the most valuable resource a country can have, the human being, since its conception.

This current number of Contact magazine is dedicated to the role of faith-based organizations in their efforts to promote and provide child and maternal health. Efforts and willingness to change are necessary in order to give to all women and children a decent shot at life. Shalom.

*By this everyone will know that you are my disciples, if you love one another.*
*John 13:35*

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Introduction

Eight Millennium Development Goals (MDGs) were established at the 2000 Millennium Summit to accelerate global progress in development¹. More than 23 international organizations and 192 United Nations (UN) member states agreed to achieve these goals by 2015. Millennium Development Goals 4 and 5 focus on reducing child mortality and improving maternal health, respectively.

According to the WHO, maternal conditions are leading causes of death and disability in low-income countries². The latest estimates indicate that more than 300,000 women die from pregnancy-related conditions each year and 4 million newborns die within the first 4 weeks of life. Almost all of these deaths occur amongst the poorest and most disadvantaged population groups and are largely preventable through timely prenatal care, skilled delivery, postnatal care, and emergency care in the event of complications.

The improvement of women’s and children’s access to needed care and the achievement of MDGs 4 and 5 require innovative approaches to service delivery and the establishment of inclusive partnerships. The recently launched UN Global Strategy for Women’s and Children’s Health ⁴ provides a comprehensive list of clear actions to reverse decades of underinvestment and increase the efficient delivery of services. The list includes a recommendation for national governments and bilateral and multilateral donors to make a concerted effort to align their priorities, increase their commitment to women and children, and invest in the establishment of effective collaborations with existing and new partners. In particular, the Global Strategy calls for civil society to play a role at the community level by educating, engaging, mobilizing, and strengthening the capacities of the community, and advocates increased attention to and investment in women and children.

religious leaders. These findings indicate that leveraging the influence of religious leaders and promoting faith-based or faith-inspired health services could be an effective means of addressing the challenges in maternal and child health in Africa, where a growing proportion of maternal and child deaths occur. For centuries, FBOs have played a key role in the global effort to promote health and well-being, especially among the most disadvantaged populations. Owing to insufficient local resources, FBOs originally concentrated on building hospitals and clinics and training healthcare workers to improve access to affordable health and rehabilitation services. The scope of FBO-run activities has expanded over time and FBOs are now considered important providers of health care, particularly in low-resource settings. Fifteen years ago, the World Development Report called for the greater use of nongovernmental organizations (NGOs), particularly FBOs, to improve service quality and fill existing gaps in healthcare services.

This call was repeated in a 2006 assessment of the impact of religion and religious entities on achieving universal access to services in the context of the HIV epidemic in Zambia and Lesotho. This assessment—carried out by the African Religious Health Assets Programme at the Universities of Cape Town, Witwatersrand, and KwaZulu Natal—stressed the need for greater appreciation of the contribution FBOs can make in the fight against HIV/AIDS in high-prevalence countries, a sentiment that should be expanded to include maternal and child health services.

The WHO estimates that 30–70% of the sprawling health care infrastructure across the African continent is owned or run by FBOs, with percentages varying within this range in different countries. The first census in Africa on the not-for-profit healthcare sector conducted by Uganda in 2001 for example, showed that 70% of all private not-for-profit health facilities in Uganda are owned by autonomous diocese and parishes. A multicountry study carried out in 2003–2005 by the Ecumenical Pharmaceutical Network in collaboration with the WHO similarly found that approximately 40% of the healthcare infrastructure across sub-Saharan Africa is operated by FBOs, and that faith-based drug supply organizations are fundamental to the provision of essential medicines to rural and remote areas, particularly when bottlenecks occur in the management and procurement of government supplies.

These reports clearly indicate that there is an extensive network of FBOs in Africa. The present systematic review of the literature was performed to assess the work of FBOs in the area of maternal/newborn health care in Africa during the past 2 decades, with the aim of better understanding their contribution in this field and evaluating the extent to which FBOs are featured in the scientific literature.

The second article published in 1992 reported on a 2-stage study in Yoruba, Nigeria. Yoruba has a local government

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maternity center and 7 mission (FBO) clinics run by African churches. The first stage of the study involved interviews with mission-trained midwives, pastors, government nurses, the local government dispenser, store operators, private clinic owners, women and male farmers to compare delivery services provided in government and faith-based clinics. The main reasons given for using FBO clinics for labor and delivery included the cleanliness of the facilities and the expectation that the outcomes would be positive (a healthy mother and infant).

Hospital and clinic records were also examined to calculate the number of births that occurred during 1983–1990. The second stage consisted of a survey of 837 women from 427 randomly selected households to determine where births took place during the time period 1983–1990. The results showed that 40% of the women delivered in FBO clinics, 43% in the government maternity center, and 17% at home.

Gilson et al. assessed the quality of services provided by a random sample of government and church dispensaries and health centers in Tanzania. The church dispensaries provided higher-quality curative care and delivery services, whereas the government dispensaries offered higher-quality health education and immunization services to women and children.

Lindelöw et al. reported on a survey conducted in 2000 on 155 facilities (dispensaries with and without maternity units) in Uganda. District and facility records were also reviewed. The facilities included government-owned, private for-profit, and private not-for-profit facilities (90% of these were FBOs). There were no major differences in the types and quality of services provided at the facilities. However, laboratory services were reported to be better in the not-for-profit facilities. The FBO facilities also offered a better working environment and were more likely than private for-profit facilities to provide services accessible to the poor, for example by charging lower prices for services.

Levin et al. published a case study examining the costs and quality of key maternal health services in different types of health facilities (public and mission hospitals and health centers) in Ghana, Malawi, and Uganda. They found that the availability of drugs and equipment did not differ measurably between public and mission (FBO) hospitals. However, at the health center level, equipment availability and client satisfaction were higher at mission facilities than at public facilities in 2 of the countries. Mission facilities also provided maternal health services at the same or better level of quality than public facilities did.

Lastly, Chand and Patterson reported on faith-based program models that were effective in improving maternal/newborn health outcomes in Mozambique, Tanzania, Uganda, and the Congo. These programs included the delivery of services such as prenatal care, prevention of malaria and sexually transmitted infections, nutrition counseling during pregnancy, and newborn care by religious medical and specific religious hospitals. A before/after evaluation showed that effective implementation of these programs reduced maternal, newborn, and child mortality and increased the number of women attending prenatal care visits, using a skilled birth

attendant, and breastfeeding exclusively. The programs also increased the number of pregnant women taking preventative treatment for malaria, the number of people attending follow-up services for malaria and the immunization coverage.

Discussion
The present findings are consistent with recent UN and other reports\textsuperscript{16,17} that acknowledge the critical role faith-based or faith inspired institutions can play in the delivery of maternal and newborn services. The contribution of FBOs in addressing service needs for pregnant women and newborns could be particularly relevant in sub-Saharan Africa, where more than 70\% of the population self-identifies as religious\textsuperscript{18}, access to health care is often limited and inequitably distributed, and the frequency of negative maternal and newborn health outcomes tends to be the highest in the world. Hospitals and facilities run by FBOs have historically been established where service needs are greatest and often remain active regardless of political changes or humanitarian crises. They are usually well-perceived and trusted by community members even though services might not be sufficiently funded to offer state-of-the-art care.

More studies are needed to explore the reasons why maternal and newborn healthcare services provided by FBOs in Africa might be of higher quality than governmental services.

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Conclusion
The present review shows that maternal and newborn health services provided by FBOs in Africa tend to be similar to those offered by governmental providers. The review also indicates that the quality of care delivered may be better in FBO facilities. This finding could be explained by the fact that FBO facilities and providers


Introduction

Both Laos and Cambodia have had discouraging statistics for maternal mortality rates (MMR)\(^1\), 405 maternal deaths per 100,000 live births in 2005 for Laos (down from 650 in 1995) and 461 per 100,000 for Cambodia (slightly lower than the figure for 1997). Though sharing many cultural traits, different political administrations have led to different health priorities and consequently a different choice of means to reach the Millennium Development Goals (MDGs).

Can these countries reach the MDGs as regards reducing maternal and infant mortality? These goals are only expressed in proportions, but absolute baseline figures are not known. Accurate statistics are hard to come by in countries with poor infrastructure, nevertheless the ongoing reduction of maternal and infant mortality is now firmly ingrained as a key objective, which is the main purpose of the MDGs.

\(^2\)According to the MDG targets established in 1990, Laos would have to reach an MMR of around 335 by 2015, and Cambodia a rate of 230 per 100,000 live births. These statistics, however, hide huge differences according to socio-economic class, ethnic group placement and remoteness of residences.

Background: Childbirth in Laos and Cambodia

In Laos only a small portion of women give birth in a clinic, dispensary or other type of medical care unit with professional support. Upper class women in Laos will go to Thailand to private clinics where many will have caesarians, while thousands of less affluent women still have to give birth in the darkness of their rural homes in unsafe conditions, with no access to professional birth attendance. A positive factor though is that the father of the child usually assists his wife in child delivery and becomes quite knowledgeable after a few deliveries. In Cambodia a similar pattern exists with 485% of home births being ii. The Guardian weekly: maternal mortality: how many women die in childbirth in your country? News-guardian.co.uk, and Women Watching their Governments: MDG5

\(^i\). MDG 4, reduce infant mortality by half by 2015 and MDG 5, reduce maternal mortality by half by 2015.

\(^ii\). Source: UNICEF: Real Lives-Reducing the
recorded compared to 15% health centre based deliveries.

Any policy reforms regarding pregnancy, delivery and post-delivery practices should build on the encouraging fact that, on the whole, Lao and Cambodian men assist their wives at childbirth and do not seem to find it a women-only affair. This is a point worth emphasizing due to an initiative launched in Laos in 2000, which aimed at making childbirth safer for women in remote villages.

**WHO and safer childbirth**

Around 20 years ago, WHO introduced safe motherhood houses where expectant mothers from remote villages could go to deliver while receiving good food and care as well as instructions on hygiene, health, nutrition and baby care. This was a corollary of WHO’s decision that, worldwide, the policy would be to discourage home births and systematically promote births in hospitals and clinics, confirming the trend towards placing of childbirth under medical care. Every delivery, WHO declared, carries a potential risk for mother and child, which can occur at the last moment or during the delivery. Therefore all deliveries should take place under medically trained supervision, near or in a structure where high quality obstetric assistance and life saving equipment are within immediate reach.

**Impact on motherhood and childbirth in Laos**

This change of strategy had immediate consequences for pregnancy, delivery and postnatal care in Laos. Initiatives for enrolled nurses to get a degree in midwifery were abandoned, as was the training of traditional birth attendants. Support for initiatives to improve the safety of home births, including the introduction of home birth packages and midwifery kits in rural areas, was discontinued.

Fortunately this policy has been abandoned and, while maintaining the objective of discouraging home births and promoting deliveries at health centers, great strides were being made to close the 20 year gap that this policy had caused in the training of midwives and skilled birth attendants.

Clinic based deliveries in regional health care centres should become the norm. Nevertheless, working on safer home deliveries would make it easier to get women to the nearest health care centre later on, and would give Laos and Cambodia time to establish health centres that are safe and trustworthy, where women would want to go.

According to interviews and feedback that I obtained over a period of three years (2000-2002) in nearly 140 health facilities located in remote areas from mothers who had given birth, professionally trained health providers had been available to administer care to mothers and babies. After a two decade gap in the country the new Community Midwives were trained under the National Skilled Birth Attendance plan, which supports the delivery of a national Integrated Package of Maternal, Neonatal and Child Health Services.

This is truly good news. It means that the needs of mothers-to-be, now at risk in remote areas, are being taken seriously and not being sacrificed for the sake of some global long term improvement plan.

**Other obstacles to safer motherhood and healthier babies**

Apart from better obstetric care, a number of other factors related to poverty, isolation and ignorance endanger the health of mother and baby and must also be tackled. The remarkable overall improvement in living standard, nutritional status and infrastructure in Laos and Cambodia, hide huge disparities caused by the following factors:

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• Under-age and over-age motherhood, as well as insufficiently spaced pregnancies.
• Poor use or absence of family planning, leading to insufficiently spaced pregnancies and unsafe abortions.
• Poor health and nutritional status of the mother, due to poverty but also cultural beliefs and practices.
• Poor hygiene and incomplete vaccination of mothers and newborns in Laos.
• No antenatal consultations possible, because there is no accessible professional pregnancy surveillance and care available.
• Cultural factors preventing timely visits to hospital: The first baby is the highest risk. However, among many ethnic groups, the young wife has to leave her own family to live with her in-laws, who do not necessarily agree to cover the costs of her transport to a hospital. The decision, to be made collectively by the male elders of her new community, is thus often not taken with the same concern as her own parents would have done.
• The health providers in the nearest medical centre may be disdainful towards patients from ethnic minorities, who in addition often don’t speak the main language, Lao or Khmer, but their own tribal language.
• In post-war liberal Cambodia the risk of HIV infection is very high, as there is a lot more commercial sexual activity and organized prostitution than in Laos.

Catching up with reality
In the last ten years much progress seems to have been made. Nevertheless, Laos and Cambodia will most likely need at least another ten years before most women will prefer to go to a hospital or health centre for child birth because it is safer, better and just as emotionally rewarding as staying at home in the intimacy of the bond between husband and wife or between parturient mother and close female relatives.

The goal in Laos now is to work towards that transformation. Birth attendants and nurses are being trained to assist women giving birth at home while a nationwide network of medical centres, equipped for emergencies, is being established where women can give birth safely under well trained professional guidance. It is my conviction that with a higher margin of safety, preference for giving birth in a medical centre will grow.

What can Christian or other faith-based organizations do to improve the situation and accelerate this change, necessary to reach the MDGs? The answer differs significantly from one country to the other.

In Cambodia there are no restrictions on foreign support in the health sector. Many faith-based organizations are active in the health sector, where services are largely free of cost. In Laos, however, the economy and basic services are centrally planned and strictly controlled. Outside direct influence on Lao society is kept to a minimum.

Change, however, is possible. When I visited Laos in April in 2012 with the director of human resources of the Delégation Catholique pour la Coopération (DCC), we were asked if we could help the government meet MDG 5 by providing it with highly qualified midwives who could establish mother and child health care posts in remote areas and train and supervise Laotian assistant midwives. This invitation to DCC to take responsibility for the training of midwives and healthcare for pregnant mothers, infants and young children was a real sign of liberalisation. In general the Lao government has been quite resistant to the influence of non-Buddhist faith-based organizations on its development. The influence of Western countries is eschewed, while business partnerships of all sizes, including mega ones, are favoured. Thus far, Catholic nuns have been entrusted to care for the handicapped. World Vision is also active in the health sector. The Catholic Relief
Service works mainly in the education sector.

We are looking forward to developing a dialogue with the Lao government that may eventually lead to a steady flow of DCC midwives training Lao midwives and establishing quality reproductive health services throughout the country to ensure that women, wherever they live, are assured safe pregnancy, safe deliveries, access to advice and support pre- and post-natal, as well as care for their newborns so that all children survive their first year in good health.

Laos and Cambodia may not fully reach their targets for safer motherhood by 2015 but they are certainly moving forward on their different paths. I am looking forward to continuing my discussions with the Lao government through its Mother and Child Health intermediary and hope to tell you in a year’s time the progress that has been made in reducing maternal and infant mortality due to safer pregnancy and delivery and better post delivery surveillance of both mother and child.

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AN APPROACH TO REPRODUCTIVE
HEALTH FROM AN ISLAMIC
PERSPECTIVE

Each year, more than 500,000 women, predominantly in less developed countries, die of causes related to pregnancy and childbirth.

In the developing world, there are still many families that do not have access to suitable healthcare, including ante natal and post natal care; they do not have the information and means to protect themselves from harmful practices and sexually transmitted infections (STIs); and are unable to make an informed choice about the spacing of their children.

The effects of poor reproductive health lead to large numbers of unwanted pregnancies and abortions; high rates of maternal and infant mortality and millions of women who are forced to undergo harmful practices such as Female Genital Cutting.

Women and girls face the greatest burden related to lack of adequate reproductive healthcare.

Although reproductive health information and services are available, there are still many factors preventing men, women and girls accessing these services; this is partly due to the sensitivity that reproductive health entails.

This article will give an overview of the different facets of reproductive health from an Islamic perspective. This article will offer recommendations on how to tackle reproductive health within Muslim settings.

Reproductive health in the Muslim World

Many international consultations took place in many part of the world including Muslim countries to unearth the sensitive issues that encloses reproductive health. Many have seen some progress in maternal and child health. Iran for instance has seen an improvement in the welfare and well being of their citizens. This country established reproductive health programmes such as free family planning services; good health service delivery; with the goal to reduce infant mortality and to promote women’s education and employment.

Although countries like Iran have seen an improvement in mother and child’s health, other Muslim countries are still facing serious reproductive health challenges.

The death rate among babies during and immediately after birth was found to be much higher for infants born amongst circumcised mothers (with infibulations). Circumcised women are significantly more likely to have caesarean sections, risks of extensive bleeding; longer hospital stays after delivery, perennial tear, prolonged labour, the need for episiotomies, and death.

Reproductive health is an issue that intertwines with cultural and religious barriers and unless it is dealt with in a culturally sensitively manner, it will continue to be an area that is difficult to address. In many countries, religion shapes values, actions, choices and influences behaviour. The ensuing paragraphs will briefly present the Islamic perspective around reproductive health.

Birth spacing

Health is considered in Islam as a basic human right and a blessing given by God to human beings. The Prophet (PBUH) said, "There are two blessings which many people do not appreciate: health and leisure time." It is a human’s responsibility to preserve the blessing of health. In the context of reproductive health, this means that all should be done to prevent pregnancy and childbirth from jeopardizing a woman’s health.
Procreation and children in the Islamic faith are seen as a blessing and one of the purposes of marriage. The Quran also warns about killing one’s children out of fear of poverty. The Quran states: “Wealth and children are the adornment of the life of this world” (Q 18:46). “O mankind! Be careful of your duty to you God who created you from a single soul, and from it created its mate and from them twain, has spread a multitude of men and women” (Q 4:1).

From this, some conclude that family planning goes against the principle of procreation. Nonetheless, many religious scholars and Muslim authors acknowledge that fertility can be controlled for birth spacing purposes if lack of it compromises the quality of life of the mother or the child, or the ability of the parents to raise their children. The Quran states: “God charges no soul except to its capacity”. (Q 2:286)

Islam regards the issue of family planning through the issue of birth spacing as a priority. A distance between children should be observed, and mothers are advised to breastfeed their children for two years. The Quran states: “And we have enjoined on man (to be dutiful and good) to his parent. His mother bore him in weakness and hardship, and his weaning is in two years” (Q 31:14)

Azl (coitus interruptus) was a form of contraception practiced at the time of the Prophet Mohammed (PBUH) and is Islamically acceptable by many Muslims. “We (the companions of the Prophet-PBUH) used to practice coitus interruptus during the lifetime of the messenger of God. The messenger of God came to know it and he did not forbid us from practicing it” (Sahih Muslim: 1440)

Unwanted pregnancies
Globally, around 45 million unintended pregnancies are terminated each year.

There is no consensus amongst Muslim scholars on the legality of abortion. Positions range from the permissibility of abortion under 120 days to prohibition. The Qur’an clearly disapproves of killing other humans: “Take not life which God has made sacred” [Q 6.151].

All Muslim scholars agree that the soul enters the foetus at 120 days from the date of conception. This consensus is based upon the following hadith and Qur’anic verse:

The Prophet (PBH) said, “Each of you is constituted in your mother’s womb for forty days as a nutfah (a drop of sperm), then it becomes an ‘alaqah (a clot of thick blood) for an equal period, then a mudghah (a piece of flesh) for another equal period, then the angel is sent and he breathes the soul into it”. 34 (Bukhari, 3036)

Consequently, there is a consensus amongst the four principal Islamic schools of thoughts that aborting after 120 days of gestation is strictly forbidden and considered as infanticide or murder. Even then, some scholars believe that an abortion is permitted if the mother’s life is in serious danger.

Nonetheless, there is a consensus that prior to 120 days, abortion is permissible as a just cause when the life of the mother...
is in danger.

One way to overcome and tackle the issue of unwanted pregnancy is to provide comprehensive information and services related to reproductive health.

**Reproductive health information**

In Islam, seeking knowledge is a duty to all Muslims. Seeking knowledge about reproductive health is no exception.

Islam encourages discussion of issues related to reproductive health. Aisha, the wife of the Prophet (PBUH) said, "Blessed are the women of the Ansar (the citizens of Madina). Shyness did not stand in their way seeking knowledge about religious matters related to sexuality." (Sahih Muslim).

Both reproductive health information and services are Islamically acceptable and are very important to improve maternal and child health. However, in order to achieve positive impact on reproductive health, the two need to be addressed in a religiously sound manner in order to be culturally appropriate.

**Issues to consider while working on reproductive health**

Reproductive health projects implemented in a religiously conservative area, should whenever possible involve religious leaders on a local and global level since they have strong influence on individuals in terms of their beliefs and in turn in their behaviour. Religious and community leaders should be the first point of contact. The evaluations of Islamic Relief previous work on reproductive health programs in Bangladesh and Pakistan were unanimous that the most effective programmes are programmes that actively involve the local Muslim leaders.

In order to have sustainable impact, it is essential to adopt a long term approach to reproductive health and avoid doing ‘quick fix’. A long process of consultation with the local community is essential since they need to have ownership over the project. It is essential to respect peoples’ choice about child bearing and not draw any judgements on the family size. In many communities, there is a wide belief that large families are in line with religious teachings. During a visit in one of Islamic Relief mother and child health care in Pakistan, a focus group discussion with the local community showed that men viewed having large families as being in line with Islamic teachings. Organisations should respect the choice of childbearing and provide reproductive health information and services to those in need of accessing them.

Working in an integrated manner is the key success for positive impact. Reproductive health projects should be part of a wider programme. To address the well being and welfare of the family, health, education and livelihood project should be offered as part of an integrated programme.

**The way forward**

Although there was a 34% reduction in maternal mortality between 1990 and 2008, this decline is less than half of what is required to meet the goals set by 2015.

The most at risk are vulnerable populations in remote areas. Progress of antenatal and maternal care has also progressed slowly in these areas. Organisation should be work in a decentralised manner in order to reach those in remote areas with a special focus on men. Although women and children face the biggest burden of reproductive health problems, men have a strong influence on women’s reproductive health choice.

Culture and religion play an integral part in people’s life and whenever possible it is essential to involve the community and religious leaders, especially to change behaviour.

It is important to recognise the importance of reproductive health education and services to enable families to plan the timing and spacing of their pregnancies consistent with their faith for family well-being, for the achievement of country health targets and to support achievement of the Millennium Development Goals (MDGs) by 2015.

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Worldwide
AN INTEGRATED APPROACH TO ADDRESSING MATERNAL MORTALITY

The United Nations has challenged the international community to tackle the issues that impact global health by establishing the Millennium Development Goals (MDGs). All of the MDGs, but specifically 5 and 6, focus on the health of women and children. In areas of conflict, disaster or high poverty, women and children bear some of the heaviest health burdens due to lack of access and/or utilization of health services. Childbirth-related injuries and illnesses are particularly devastating; recent data from the World Health Organization shows that essentially all (99%) of maternal deaths, amounting to about 1,000 a day, occur among mothers in developing countries. Maternal health is further challenged by longstanding religious, social, and cultural belief systems that marginalize and discriminate against women—putting them at risk for additional hardship due to violence or inadequate access to care.

To address these challenges and advance the UN’s MDGs, IMA World Health has been working to create sustainable programs with a strong focus on maternal health. While basic, essential medical interventions are pillars of these programs, IMA believes that success also depends on combining medical care with solutions that educate, empower, and change the behaviors of families and communities. This article touches on both health facility-based interventions and community interventions, including mobilization of religious leaders through Maternal, Newborn and Child Health Sermon Guides. Specific interventions are as follows:

IMPROVED MATERNAL HEALTH AND NEWBORN SERVICES

Comprehensive and quality maternal and newborn care are the pillars of the maternal health strategy. Project outcomes showed that getting expectant mothers and their husbands to take advantage of basic prenatal and maternity services increased their chances of benefiting from the other related offerings and interventions as well.

Key interventions in the program include:

Antenatal Care (ANC) Clinics: An initial challenge was that prenatal clinics in DR Congo traditionally have a high attendance rate, but women typically start their visits late (in the third trimester) -limiting interventions to only weight and blood pressure checks. To encourage more women to take advantage of all available services, the project did not charge for prenatal visits individually but rather integrated their global costs into standard delivery fees.

Further, the project provided, without supplemental costs, important “add-ons” such as malaria prevention drugs and nets, tetanus vaccination and multivitamins with folic acid. For example, through Ante-natal Clinics (ANC) clinics over one million malaria nets were distributed to pregnant women and children under five, resulting in near 100% coverage rate. By year four, the project achieved a 71% coverage rate for intermittent preventive treatment in pregnancy (IPTP) to reduce adverse consequences of malaria—compared to a national average of 5% and the national objective of 50%. ANC clinics also provided the first setting for

family planning counseling, and many offered comprehensive PMTCT services to prevent HIV transmission at birth. The project provided HIV counseling and screening to nearly 90,000 women annually by year four, and HIV testing was also offered to expectant fathers—reaching thousands of men.

As a result of these offerings and encouragement within the community, ANC rates rapidly reached 100% and clients even came from outside the health zones to USAID-supported facilities.

Assisted Delivery: Unattended births contribute significantly to maternal and fetal mortality and morbidity. A significant project challenge was to encourage women to have assisted deliveries by trained personnel in equipped centers. At project inception the rate of assisted deliveries hovered below 60%; at project's end the rate was nearly 90%. Factors contributing to this success included capacity building of health care workers, rehabilitating maternity facilities, and procuring delivery tables, lighting and supplies.

Active Management of the Third Stage of Labor (AMTSL): AMTSL includes the use of oxytocin to stimulate uterine contractions and avoid postpartum hemorrhage—a leading cause of maternal death in developing nations. Due to its success, this intervention quickly became the standard of care for not only AXxes but other health zones as well, where the rate is notably lower. Contributing factors included capacity building and supervision of health care workers, successful adaption of national data recording and collection sheets, adequate supply of oxytocin, and posting of protocol and instructions in all birthing centers.

Post-Natal Consultations (CPON): In addition to monitoring the health of mother and child during the critical first 72 hours, postpartum care visits are wonderful opportunities for teaching and counseling on practices such as exclusive breastfeeding, nutrition, hygiene, and family planning.

FAMILY PLANNING
Enabling couples to decide whether, when, and how often to have children has many benefits—not only to maternal health but also for the health and socio-economic conditions of children and families. According to 2010 UN data, some 215 million women in sub-Saharan Africa who would prefer to delay or avoid childbearing lack access to safe and effective contraception. It is estimated that meeting the unmet needs for contraception alone could cut the number of maternal deaths by almost a third.

As a result, providing high quality, informative family planning services was a key project objective. These interventions were largely focused on promoting birth spacing and avoiding unwanted pregnancies. The guiding principle was to provide information and counseling on all methods, then provide the method of choice to each client.

FISTULA REPAIR
Fistula is a severe injury that has often traumatic physical, social, emotional, and economic outcomes for women. Fistula is often caused by complications during obstructed labor but may also result from a violent attack. Because of incontinence and humiliation, women with fistula are often unable to work or interact with friends or the community—deepening their poverty and social isolation. Many are abandoned by their husbands.

Project activities to raise awareness and prevent/treat fistula included increasing training in assisted births and established protocols, the creation and support of mobile and hospital-based fistula repair teams, research on co-morbid factors

associated with fistula development and obstacles to care, and partnership with EngenderHealth to co-sponsor two national conferences to raise awareness and develop solutions.

Between 2007 and 2010, 1,276 women were treated for fistula through Project AXxes—each one a life restored.

SEXUAL AND GENDER BASED VIOLENCE (SGBV) AWARENESS AND PREVENTION

In addition to rapes by rebel militias in DR Congo, there are many social and cultural norms among the general population that lead to incidents of gender-based violence and other acts of discrimination. These may include forced or early marriage, limited choices in reproductive health, coerced sexual encounters, and teenage pregnancy—all major challenges to maternal health. Key strategies to overcome these obstacles include activities such as sponsorship of focus groups, women’s forums, community leader workshops, and school and youth groups aimed at addressing the issue of gender bias and its negative impacts.

Project AXxes also supported local NGO’s to promote the active participation of women in health center management, train hundreds of community and institutional leaders, and work with law enforcement personnel in promoting gender rights. Radio messages and printed materials were also used to mitigate harmful attitudes.

COMMUNITY RELAYS

Most interventions through Project AXxes relied on community relays to achieve widespread community awareness and cooperation. Community relays are networks of trained volunteers that use a variety of tools – including pamphlets, flipcharts, counseling cards, posters and media to disseminate information and promotional messaging to encourage behavior change and/or awareness on health issues. From malaria messaging to family planning to Sexual and Gender Based Violence (SGBV), the community relays played a major role in influencing women and families to take advantage of available medical services and to change attitudes towards women’s health.

SERMON GUIDES

In addition to Project AXxes, IMA is involved in many other programs supporting maternal and child health. For example, under the ACCESS Program (led by Jhpiego) IMA developed the Christian and Muslim Sermon Guides to Save the Lives of Mothers and Newborns: A Toolkit for Religious Leaders. Developed for religious and lay leaders, the Sermon Guide provides the necessary tools to educate their communities on safe motherhood issues from the pulpit as well as during counseling sessions, group (youth, men, women) meetings, etc. These tools have been adapted and used in Rwanda, Tanzania and Liberia as a community-focused strategy to reduce maternal newborn and infant mortality.

FINAL THOUGHTS

When it comes to maternal health it is clear that there is no one magical solution that will decrease mortality and morbidity across the board. Project AXxes showed that due to a variety of biological and cultural factors and challenges, an approach that incorporates many different medical and social interventions into a larger plan that benefits individuals—while successfully engaging families and communities—has the potential to improve maternal health both for this and future generations.

Emily Esworthy is the marketing manager with IMA Worldhealth.


One year ago, Jacaranda Health opened its doors to the mothers of Nairobi. In the peri-urban neighborhood of Kariobangi, nurses, receptionists, marketing staff and clinical advisors all pitched in to set up the exam rooms, lab tests and welcome tent on the grounds of Full Gospel Church, the community partner who hosted the mobile clinic for the day.

Jacaranda Health is new chain of maternity clinics that aims to change the way maternity care is delivered in urban Africa. Its staff entered the field of maternal healthcare in east Africa with a challenge: provide affordable, high-quality care to all women while building an organization that is financially sustainable.

Peri-urban areas — sprawling, bustling areas on the outskirts of cities — are the fastest growing population centers in the world as people migrate from rural areas to seek better economic opportunities.

Peri-urban areas — sprawling, bustling areas on the outskirts of cities — are the fastest growing population centers in the world as people migrate from rural areas to seek better economic opportunities. In Nairobi alone over 2/3 of the city lives in these areas, where health conditions and availability of medical services is poor as the cities expand faster than the public health infrastructure can keep pace with. Research by the African Population and Health Research Council has suggested a maternal mortality ratio of over 700 per 100,000 births in some of Nairobi’s neighborhoods, significantly higher than the national average, and a hundred times higher than some European countries.

Urban areas represent a unique challenge for maternal health. On the one hand facilities and nurses are within reach for mothers. Yet 30% of mothers still deliver at home, and quality of care in public and private facilities is often quite low.

Jacaranda’s approach is to set up clinics in these areas that offer high-quality service based on the best available maternal health innovations at rates that are affordable for the women who live there. The model for Jacaranda is a chain of clinics: mobile units that provide friendly antenatal care and publicize the organization, and fixed clinics where mothers can go for respectful obstetrical care, delivery, and postnatal care. The mobile unit is a van staffed by nurses and a receptionist, who unpack the vehicle each day to set up a functioning outpatient clinic complete with exam rooms and reception, all within in the partners’ facilities.

The full Gospel Church is one of the seven community partners; each partner hosts the clinic once every two weeks and helps spread the word in their peri-urban neighborhoods. To keep costs down without sacrificing quality of care, they rely on clinical interventions that have been shown to work, along with business innovations that have been found to boost efficiency and cost-effectiveness.

These include evidence-based protocols, checklists, and low-cost technologies that have been shown to work, along with business innovations such as direct marketing with community mobilizers, savings plans through mobile phone cash transfer systems, and inventory tracking that have been found to boost efficiency and cost-effectiveness.

In this respect, Jacaranda aims to serve as a laboratory for innovations in maternal health, testing technologies and service that can be replicated by the public and provide sector.

1 Maternal mortality in the informal settlements of Nairobi city: what do we know? Ziraba et al. Reproductive Health. 20 April 2009
Jacaranda’s first antenatal patients walked in off the dirt road in Kariobangi as soon as the gates at Full Gospel Church were open, and the day brought more patients than they could see in a single day. In the weeks since the first opening, Jacaranda has rotated clinics among seven community partners, and have been fine-tuning clinical processes, testing different marketing approaches and doing focus groups with patients to improve services.

Samples of blood being readied for a HIV/AIDS test at Jacaranda hospital

Jacaranda Health is not an ecumenical organization, but they clearly value churches as community partners: currently Jacaranda’s mobile clinic works with five churches representing different denominations, and will likely expand to more partners. They expressed several benefits of working with churches in providing maternity care:

• Churches are trusted in the community and add credibility in the eyes of patients, which is important in areas where medical practitioners are not always viewed with trust.
• The pastors are enthusiastic about providing health services to their congregations, and provide outreach and mention maternal health services in their sermons.
• These churches have some of the nicest facilities in the peri-urban neighborhoods, where Jacaranda nurses can set up exam rooms, and patients can congregate in a pleasant environment.

Besides the link with churches, Jacaranda staff mentioned several highlights of their first month of service delivery:

They are reaching the women they intended to, from a single mother of 17 getting her first medical visit 36 weeks into her pregnancy, to a mother on her fourth pregnancy who had experienced preterm labor and didn’t know where she should plan to deliver. Systems and protocols are working. They have been testing applications to create medical records by mobile phones, inventory management system and clinical and emergency protocols. With good results: patient data is easily accessible, they can follow up via Short Message Services (SMS). Patients have successfully been referred to partner facilities for complications and delivery, and are already returning to Jacaranda for postnatal care. Meanwhile, their partners from Harvard’s School of Public Health are progressing quickly on their baseline evaluation that will enable Jacaranda to measure and report on their impact.

Patients are returning. One of the big tests came four weeks after the first clinic day, when Jacaranda’s nurses wondered if the patients they referred back for antenatal follow-up visits would return? Ten out of 11 of them returned and paid full price. Jacaranda’s feedback forms so far show 95% of customers in the first month giving 5-stars for patient satisfaction. This works because patients appreciate the time with clinicians, respectful care, accessibility, and value for money.

And there are challenges too: for example, they are finding it difficult to convince some patients that a mobile clinic visiting once every two weeks – even one in a church or a school – is a reliable way of getting ongoing maternity care. Many mothers want continuity of care, and they want to

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stay with the same provider from ANC through delivery. Jacaranda has a unique model of ANC where pregnant mother remains with the same nurse for exams, labs, and counseling, this model has received positive reviews from patients and nurses.

In August 2012, Jacaranda opened a 12-bed maternity hospital to serve the clients it had been seeing in mobile clinics. The hospital employs a staff of nurses and midwives and provides safe deliveries and basic emergency obstetric care. They have developed strict referral protocols to send women who need cesarean sections or other complicated deliveries to partner facilities.

They are working to demonstrate success of the model by measuring health outcomes, quality of care, and improved health-seeking behaviors such as continuity from antenatal care through delivery, and uptake of postnatal care. The measurement of health outcomes and impact is important enough that they have hired an impact evaluation manager to help track success, and are building electronic health systems to monitor their operations. They are currently seeking a site for their second maternity and once the model is proven, plan to expand their network of clinics through Nairobi and then into other cities in Kenya and the region.

Nick Pearson is the Managing Director of Jacaranda Health Centre
Indonesia is the forth-largest country in term of population, with the largest Muslim population in the world. Christians are a minority but play a significant role in healthcare, humanitarian aid and development. The Christian Foundation for Public Health (Yakkum) was founded by the Christian church of Indonesia and the Christian church of Java in 1950.

Yakkum is a public-health service provider with 12 hospitals, 3 nursing/midwife academies, 1 medical faculty in partnership with Duta Wacana Christian University. It operates the country's largest rehabilitation and emergency relief unit.

Almost every Yakkum hospital has a community development unit to improve public health and empower capacity building and advocacy work in the hospital catchment areas and national health-humanitarian and development policies.

The management of Yakkum hospitals is based on WCC’s "sustainable church hospitals" concept, meaning it aims to provide affordable best quality health service for all with professional management and highest possible accessibility to solve the root problems of health. Yakkum works in partnership with 350 CBO’s and Patients Clubs. Yakkum hospitals are self-sustaining institutions without external funding support for services.

Recently, two of Yakkum’s hospitals participated in a government MNCH program. The participating hospitals were Bethesda Hospital and Emmanuel Christian Hospital, as a referral hospital for "Ponek 24 hours" for District of Banjarnegara, Central Java.

The main task of Bethesda Hospital is to assist the Provincial Health Office to improve the capacity of the Bajawa Regional General Hospital in obstetric and neonatal emergency services in order to meet the institutional requirement so that the hospital that can operate as a 24 hour Comprehensive Obstetric and Neonatal Emergency Service (Pelayanan Obstetri dan Neonatal Emergensi Komprehensif or PONEK).

This would in-turn help in reducing the maternal and child mortality rates in the East Nusa Tenggara, which has been known as the province with the highest such rates in Indonesia.

As senior partner, Bethesda Hospital is required to provide training; improve management and SOPs; and technically advise doctors or nurses of Bajawa general hospital in handling emergency obstetric and neonatal procedures.

Within a very short time span—between August and November 2010—progress was apparent. The rate of patient visit increased to 45.05%, maternal mortality rate was zero and neonatal mortality decreased from 27 cases in January to 7 cases in July 2010.

**Effectiveness**

PONEK’s 24-hours’ was designed by the Indonesian Ministry of Health in 2008 under the Guidelines of Implementation
the Comprehensive Emergency Obstetric and Neonatal Care 24-Hours in Hospital. PONEK 24-hours was initiated as part of the Making Pregnancy Safer (MPS) program which has been initiated globally by WHO in order to meet the MDGs gap on maternal and child mortality rate.

The MPS has three main indicators:

• All pregnant women and their newborns should be able to access skilled care during pregnancy, childbirth, and post-partum period.

• All women and their newborns should be able to access referral care when complications arise.

• Every women of reproductive age should have access to prevention and management of unwanted pregnancy and complications of unsafe abortion.

According to the UN Millennium Development Goals, Indonesia needs to meet the target of reducing infant and under-five mortality by two-thirds, from a baseline of 35/1000 live births in 1990. Under goal 5, Indonesia must reduce its maternal mortality rate by three quarters, which in actual numbers means a decrease of 307/100,000 in 1990 to 125/100,000 by 2015.

Currently, the government says that it has reduced the maternal mortality rate to 228/100,000 live births and child mortality rate to 26/1000 live births. However, the government has also admitted that progress has been slow.

Given the global economic uncertainty and the impact of climate change on health, Indonesia needs to accelerate its progress as the 2015 deadline rapidly approaches.

In this context, PONEK 24-hours plays a crucial role in the achievement of MDG goals 4 and 5 in that a key aim of this program is to provide quality health services in order to reduce maternal and child mortality.

Weaknesses

Many cases of pregnancy or birth that result in death are because the patient was referred to the hospital in very serious condition. Indeed, almost 90% of referrals are emergency cases and were hardly related to the problem of early diagnosis.

Most cases of maternal mortality were due to hemorrhage. Despite this well-known fact, the availability of blood remains a serious problem. Moreover, it is common in regional hospitals for there to be ambulances without any drivers, as no civil service appointments have been appointed as drivers. This points to the underlying problem that policies relating to the staffing and equipping of hospitals have not been comprehensively designed.

A capacity building program for hospital staff launched to support the program was deemed ineffective as most of the regional government offices did not have sufficient funds to provide the budget necessary for sustaining the program. The lack of financial resources has furthermore led to many trained doctors and nurses leaving the program to work elsewhere in search of better remuneration.

In short, Indonesia is in need of more innovative policies if it hopes to overcome the multiple problems it faces and reach the MDG targets.

Syamsul Ardiansyah & Sigit Wijayanta work for the Christian Foundation for Public Health in Jakarta, Indonesia.
Introduction

This is one of the few Biblical passages that deals with rape/incest (sexual violence), an expression of violence that is one of the major impediments to the achievement of Sexual and Reproductive Health and Rights for girls and women. Inversely, it is also one of the major causes of girls and women’s violation of their dignity, a dehumanizing inversion into their self-worth and healthy self-esteem. (http://hiphopwired.com/2010/06/17/parents-arrested-after-raping-1-month-old-child-to-death/) who have not even started to develop any concept about what their sexuality entails are violated. The perpetrators are often those who are supposed to be protecting and nurturing them in an atmosphere where they can build a positive self image that enhances a healthy sexual self. In some cases, girls who are just beginning to discover themselves as a wonderful creation of God, created in God’s image, exploring what role their sexuality plays in this discovery end up violated and forced to early unprepared pregnancy. This early motherhood often risks their own lives as their bodies might not have developed enough to healthily carry the fetus to full healthy term. Often the Churches struggle to deal with such life-and-death realities and instead apart from their temptation to moralizing such and laying all the blame on these victimized and violated girls, they seem to ‘conspire’ to silence.

To create a space where the readers can interactively engage with 2 Samuel 13:1-22 and raise issues that speak to them regarding how sexual violence impinges on sexual and reproductive health for women, we will use Contextual Bible Study (CBS) methodology to deal with this text. CBS as a brain child of Liberation Theology is a community-based interactive way of studying the Bible that helps advocacy for issues of concern within a given community. It cannot be taught because it is the voices of the participants that matter. The facilitator asks the discussion questions using the two major principles of Biblical hermeneutics: exegetical: literary or critical consciousness questions that draw on tools from Biblical studies—finding meaning of the Biblical text within its historical and social contexts; and interpretative: community consciousness questions that draw on feelings, experiences and resources from the community (the socially locating the readers (facilitator and the community concerned).

2 Samuel 13: 6-14

So Amnon lay down, and pretended to be ill; and when the king came to see him, Amnon said to the king, ‘Please let my sister Tamar come and make a couple of cakes in my sight, so that I may eat from her hand.’ 7 Then David sent home to Tamar, saying, ‘Go to your brother Amnon’s house, and prepare food for him.’ 8 So Tamar went to her brother Amnon’s house, where he was lying down. She took dough, kneaded it, made cakes in his sight, and baked the cakes. 9 Then she took the pan and set them out before him, but he refused to eat. Amnon said, ‘Send out everyone from me.’ So everyone went out from him. 10 Then Amnon said to Tamar, ‘Bring the food into the chamber, so that I may eat from your hand.’ So Tamar took the cakes she had made, and brought them into the chamber to Amnon her brother. 11 But when she brought them near him to eat, he took hold of her, and said to her, ‘Come, lie with me, my sister.’ 12 She answered him, ‘No, my brother, do not force me; for such a thing is not done in Israel; do not do anything so vile! 13 As for me, where could I carry my shame? And as for you, you would be as one of the scoundrels in Israel. Now therefore, I beg you, speak to the king; for he will not withhold me from you.’ 14 But he would not listen to her; and being stronger than she was, he forced her and lay with her.

Conclusion

Have we violated people like Tamar in our own contexts? If yes, what form has our violation taken? If the violated ‘Tamaras’ in our community ended up being pregnant from incest, what risks would they encounter: psychologically, physically and medically as part of our community? What resources do our communities have to ensure that such girls and women have their sexual and reproductive health protected or the impact of their violation is mitigated? How does an abused woman reflect what God is? How do our theologies address the problems of sexual violence against women; sexual and reproductive health and rights? What would you do to maintain integrity in your community after such incidents? How can we best break the silence around sexual violence? What praxis would we need to embark on so as to establish justice and peace in our communities? OR: Now that you have reflected on this as a community, what are you going to do:

• To create a safe space that protects children and women from sexual violence—theologically, socially, economically, health wise, politically and policy-wise?
• Mitigate the impact of sexual abuse?
• Bring healing and wholeness to the violated as well as the community as a whole?
• How will you deal with the perpetrators?

Dr Fulata Moyo is the Programme Executive of the Women in Church and Society at the World Council of Churches in Geneva, Switzerland.
RESOURCES

Every Woman Every Child
A global movement, spearheaded by UN General Secretary to mobilize and intensify global action to improve the health of women and children around the world. www.everywomaneverychild.org

Committing to Child Survival: A Promise Renewed
On June 14-15, 2012, in Washington, DC, the Governments of Ethiopia, India and the United States together with UNICEF, are mobilized the world to achieve an ambitious, yet achievable goals – to end preventable child deaths. http://www.apromiserenewed.org/

The Partnership for Maternal, Newborn & Child Health (PMNCH)
The Partnership (PMNCH) joins the reproductive, maternal, newborn and child health (RMNCH) communities into an alliance of more than 450 members to ensure that all women, infants and children not only remain healthy, but thrive. It focuses on 68 priority countries which represent 97% of all global maternal and child deaths. http://www.who.int/pmnch/en/

The Countdown to 2015 in Maternal, Newborn & Child Survival
The Countdown to 2015 Initiative measures coverage of basic health services proven to reduce maternal and child mortality and assesses domestic and donor resources, and also works to create accountability amongst governments and development partners and identifies knowledge gaps and proposes new actions to reach Millennium Development Goals 4 and 5. http://www.who.int/pmnch/activities/advocacy/20110601_countdownsection/en/index.html

Meet Maya
Meet May, a healthy baby whose birth is the result of stronger health systems supporting women, family and communities. A good tool for better understanding that health must be looked as a whole - what is preventing people from being healthy, and how can we civil society, international agencies and governments can contribute to have strong and supportive health systems which will impact on development.
Meet Maya: http://www.youtube.com/watch?v=PFVCNUOM5Us&feature=relmfu
Maya’s 2nd. Birthday: http://www.youtube.com/watch?v=5Jb6Ju3KQPE&feature=relmfu

Investing in Health for Africa
This study argues that Africa’s current economic growth can be improved if concerted efforts are made to improve the continent’s health care systems. The Report says investing in the African health sector could help save millions of lives and prevent lifelong disabilities. At the same time, investments in health would accelerate the move towards attaining the U.N. Millennium Development Goals (MDGs). http://www.who.int/pmnch/media/membenernews/2011/investing_health_africa_eng.pdf

Opportunities for Africa’s newborns: Practical data, policy and programmatic support for newborn care in Africa
The book provides an overview of the continuum of care through the lifecycle and opportunities to address gaps at all levels - family and community care, outreach services and health care facilities. Case studies are analysed in order to learn the practical steps for phasing interventions, strengthening and integrating service provision, and providing every mother, newborn and child in Africa with essential care.
http://www.who.int/pmnch/media/publications/oanfullreport.pdf

Community Prevention of Mother-to-Child Transmission of HIV (c-PMTCT)

Caring for the newborn at home: A training course for community health workers
The WHO Department of Maternal, Newborn, Child and Adolescent Health (MCA) and UNICEF initiated the development of materials to increase access to postnatal care services and essential interventions for pregnant and lactating women and their newborn infants which provide guidance for community health workers to conduct home visits in the antenatal period and the first weeks after the baby is born. http://www.who.int/maternal_child_adolescent/documents/caring_for_newborn/en/index.html

Pathfinder International offers tools for capacity building in sexual and reproductive health
http://www.pathfinder.org/publications-tools/
RESOURCES

Supporting efforts to end obstetric fistula
This report is prepared in response to General Assembly resolution 65/188 and outlines efforts made at the international, regional and national levels, and by the United Nations system, to end obstetric fistula.


Maternal and Child Health Integrated Program
MCHIP is the USAID Bureau for Global Health’s flagship maternal, neonatal and child health (MNCH) program, which focuses on reducing maternal, neonatal and child mortality and accelerating progress toward achieving Millennium Development Goals (MDGs) 4 and 5.

http://www.mchip.net/about

2013 Global Newborn Health Conference
http://www.mchip.net/node/1403

CONTACT deals with various aspects of the churches’ and community’s involvement in health, and seeks to report topical innovative and courageous approaches to the promotion of health and healing.

CONTACT is available on the World Council of Churches’ Website: http://wcc-coe.org/wcc/news/contact.html

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