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Frau  
Sonja Goldfinger  
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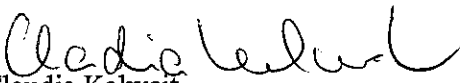
91522 Ansbach

29. Dezember 2009

Sehr geehrte Frau Goldfinger,

vielen Dank für Ihr Schreiben zu unserer Aktion 1 Packung Pampers = 1 Impfdosis, welches wir an Unicef zur Beantwortung weitergeleitet haben. Unten stehend finden Sie die Antwort von Unicef, die hoffentlich zur Klärung der Sachlage beitragen wird.

Mit freundlichen Grüßen

  
Claudia Kalweit  
Verbraucher-Beratung

Sehr geehrte Frau Goldfinger,

**vielen Dank für Ihr Schreiben. Sie fragen darin nach weiteren Informationen über den Nutzen und die Wirksamkeit von Tetanus-Impfungen. Die Wirksamkeit von Impfstoffen gegen unterschiedliche Infektionskrankheiten wird seit Jahrzehnten von staatlichen Stellen und der Weltgesundheitsorganisation WHO dokumentiert.**

**In Industrieländern ist ein Impfstoff ein Mittel unter vielen anderen, um Krankheiten vorzubeugen. Auch bei akuten Erkrankungen kann beispielsweise zwischen einer schulmedizinischen Behandlung und einer alternativen Heilmethode gewählt werden. Diese Wahlmöglichkeit ist ein Luxus, den wir uns leisten können. In Entwicklungsländern ist hingegen selbst eine medizinische Basisversorgung oft nicht gewährleistet. Deshalb muss UNICEF bei den Gesundheitsprogrammen vor allem auf Prävention setzen. Dazu gehören nicht nur die Schutzimpfungen, sondern beispielsweise auch die Verbesserung der Qualität des Trinkwassers, die Förderung des Stillens oder die Ernährungsberatung.**

- 2 -

**Erst mit groß angelegten Impfkampagnen seit den achtziger Jahren ist es gelungen, jährlich drei Millionen Kinder vor dem Tod oder Behinderungen zu bewahren. Millionen Kinder müssten nicht sterben, wenn sie geimpft würden. Deshalb halten wir Schutzimpfungen in den Entwicklungsländern für ein geeignetes Mittel zur Bekämpfung von Kindersterblichkeit. In anliegendem Dokument finden Sie weitere Informationen über die weltweite Kampagne gegen Tetanus und ihre bisherigen, klar nachweisbaren Erfolge.**

**Für weitere Fragen, Berichte und Quellennachweise können Sie sich an die WHO oder auch an das Robert-Koch-Institut wenden. Die Adressen lauten:**

**· WHO-ECEH Bonn, Görresstraße 15, 53113 Bonn, Tel.: (0228) 2094-0,  
[www.euro.who.int/cehbonn](http://www.euro.who.int/cehbonn)**

**· Robert-Koch-Institut, Postfach 65 02 61, 13302 Berlin, Tel.: 030/18 754-0,  
[www.rki.de](http://www.rki.de)**

**Mit freundlichen Grüßen**



**Maternal and Neonatal Tetanus  
Elimination Initiative**  
Pampers UNICEF 2009 campaign launch

A health worker vaccinates Fenitra, who is pregnant, against tetanus in a health centre in the village of Ambohijafy.

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# MATERNAL AND NEONATAL TETANUS (MNT) ELIMINATION INITIATIVE

Pampers UNICEF 2009 campaign launch

## ISSUE

### Why eliminate MNT? *Make an invisible killer visible!*

For many people Maternal and Neonatal Tetanus (MNT) is abstract. Most people have never seen the disease and many have not even heard of it. Mothers in the industrialized world no longer think of tetanus as a potential threat to their newborns. Yet according to World Health Organization (WHO) estimates from 2004, an estimated 128,000 newborns die of the disease each year<sup>1</sup>; this translates into around 350 deaths in children under one month of age EVERY DAY or one death every 4 minutes! Several thousand mothers are also estimated to die of maternal tetanus.

How does a disease that kills so many newborns remain invisible? Perhaps the most significant reason is that most cases occur in areas and among populations that are hard to reach, marginalized, with no political clout, with a compromised socio-economic situation or limited to no access to health services. In addition, as the disease and death occur in very young infants usually within the first 7 to 14 days of life, most infants suffer and die at home, most without ever coming in contact with a health provider. Sadly, both their birth and death go unnoticed and unrecorded by health workers.

So why are so many women and their newborns still at risk of contracting tetanus? The cases of Maternal and Neonatal Tetanus continue to occur in mothers (and their newborns) who have to deliver at home without a trained midwife, mostly alone or in presence of an untrained traditional birth attendant (TBA) or a family member. Delivery on an unclean surface, with unclean hands and instruments increases the chances of the spread of infection to both mother and baby during the birthing process. In addition, the TBA or family may recommend application of harmful traditional substances (ghee, ashes, earth, and animal dung) to stop the bleeding of the umbilical cord and to promote quick drying which further increases the risk of contracting tetanus. Immunization services are also not regularly available or not available at all in these areas. Unfortunately, most of these women have no access to health services where they could benefit from Tetanus Toxoid (TT) vaccination during antenatal care or be guided on how to deliver safely and how to protect the umbilical cord stump.

Yet all that is required to prevent the unnecessary and painful deaths of newborns and their mothers is commitment and funding. While a mix of strategies is recommended to prevent Maternal and Neonatal Tetanus (refer to text box 1), the easiest, quickest and most cost-effective preventive measure is vaccination of the expectant mother with the TT vaccine. Delivery of three doses of the TT vaccine to an expectant mother to protect her and any children she may have in the next 5 years, costs - on an average - US\$1.80.

#### TEXT BOX 1

#### WHO / UNICEF recommended strategies to achieve the elimination of MNT

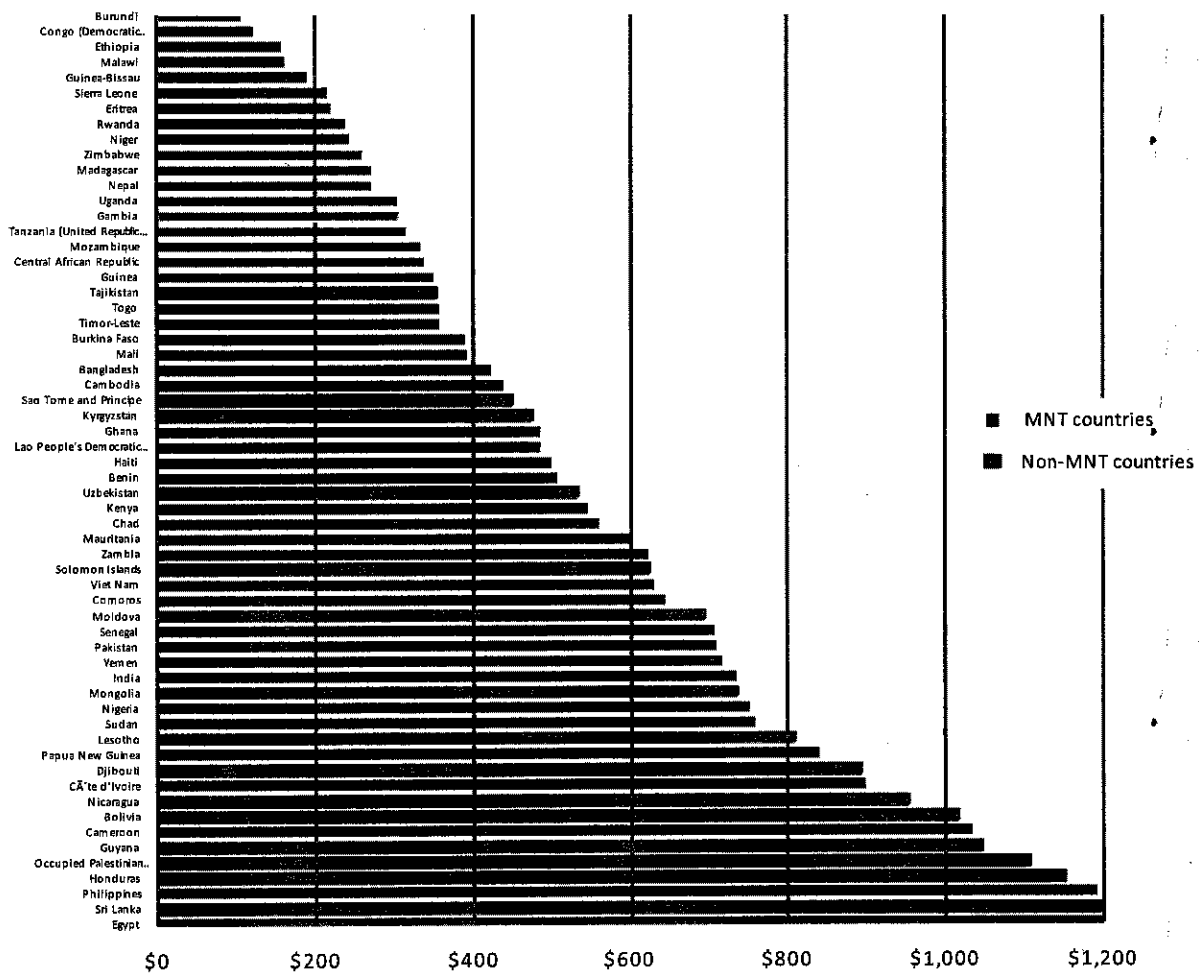
- Promote clean delivery and cord care practices to prevent infection during and after delivery
- Immunize women during pregnancy with Tetanus Toxoid (TT) or Tetanus Toxoid & Diphtheria (Td) vaccine
- Immunize women of reproductive age with TT or Td vaccine, through three properly spaced rounds of Supplemental Immunization Activities (TT-SIAs) in high-risk areas
- Surveillance for NT to detect and investigate cases and conduct appropriate case response

<sup>1</sup> The Global Burden of Disease, 2004 update. This publication is available on the Internet at: [http://www.who.int/healthinfo/global\\_burden\\_disease/2004\\_report\\_update/en/index.html](http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html)

## Top 60 poorest countries - by GDP per capita

Figure 1

44 of these are MNT countries\*



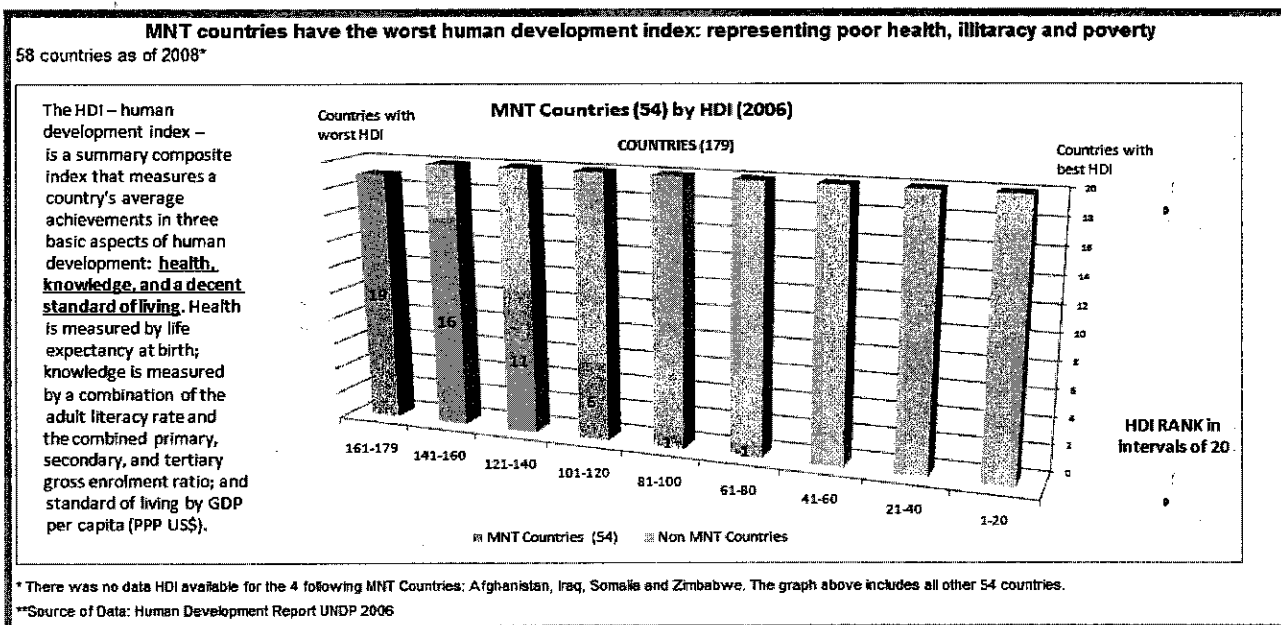
### MNT affects the poorest, most underprivileged and least educated population:

MNT is a disease - and an indicator - of lack of access and development. Figure 1 shows that 44 of the world's poorest 60 countries are from among the original list of 58 countries that had not eliminated MNT by 1999.

Figure 2 which looks at Human Development Index- a combined index of health, knowledge and standard of living - shows the same pattern, i.e. that MNT is a disease most prevalent in countries with the poorest and most uneducated populations that do not have access to quality health care.

These figures show that MNT is a disease of the underserved and disadvantaged. The less developed and the poorer a country is, the higher the likelihood that MNT remains a main killer in that country.

But these figures hide an even greater problem: one of vulnerability within populations. Indeed, within these countries, MNT disproportionately affects populations and districts that have lower coverage levels for immunization, antenatal care and a skilled attendant at birth. These districts often also have lower literacy rates and populations that live in or close to poverty. For people that do not have access to health care - either to get immunized, or to have deliveries conducted in hygienic conditions - MNT is a major problem. These are usually the same people who also lack schools, infrastructure, such as roads and communication, and employment opportunities. MNT truly is a disease of the poor.



## ACTION

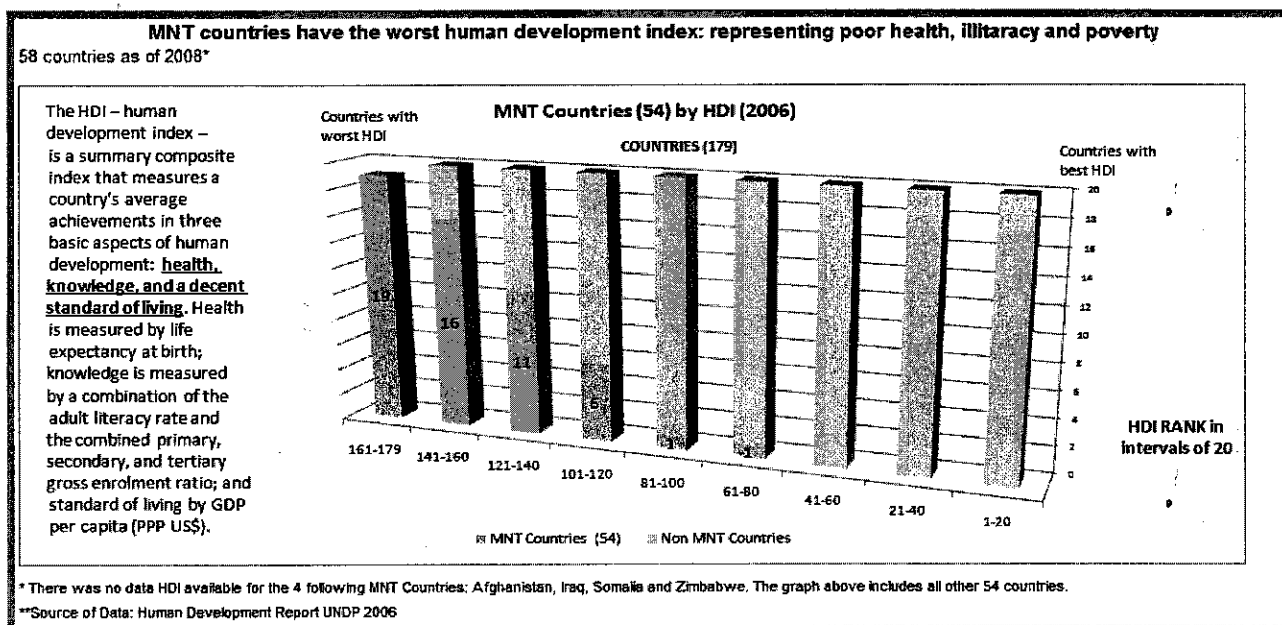
### Progress towards Maternal and Neonatal Tetanus (MNT) Elimination

Since the re-launch of the MNT elimination initiative (refer to text box 2) in 1999, 14 of the 58 countries where MNT was a public health problem in 1999 and 15 states in India, have achieved elimination (refer to the list in text box 3). This success was a result of a firm commitment from the national governments of these countries to the elimination goal. Technical partners like WHO, UNFPA, CDC and PATH provided clear and strategic guidance to national governments. Financial partners including Bill and Melinda Gates Foundation (BMGF), Ronald McDonald House Charities (RMHC) Global Alliance for Vaccines and Immunization (GAVI), Becton Dickinson and Company (BD), many other organizations and individuals and most recently Pampers have, together, helped raise more than US\$181 million for MNT elimination activities since 2000.

### TEXT BOX 2

#### Global Commitment: Maternal and Neonatal Tetanus Elimination Initiative

- Launched as 'Neonatal Tetanus Elimination Initiative' in 1989 through a World Health Assembly (WHA) resolution
- Re-launched as 'Maternal and Neonatal Tetanus Elimination Initiative' in 1999 by UNICEF, WHO and UNFPA
- Focus of re-launch was on 58 countries that had not eliminated MNT by 1999
- Country 'elimination' of neonatal Tetanus as a public health problem defined as <1 neonatal Tetanus death per 1000 live births in every district of a country. Elimination of Neonatal Tetanus is a proxy for maternal tetanus elimination



## ACTION

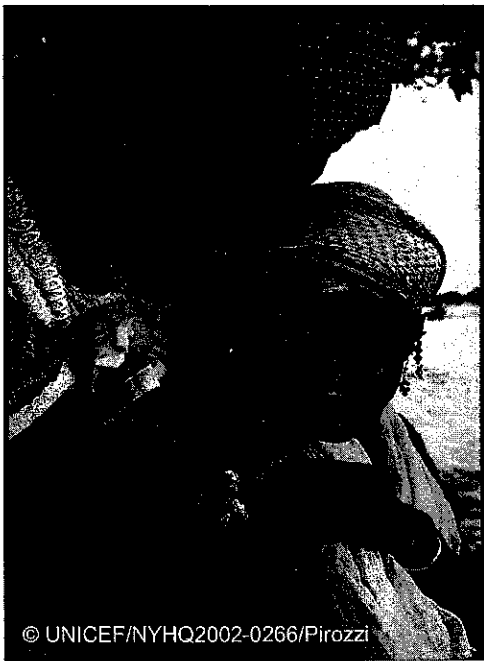
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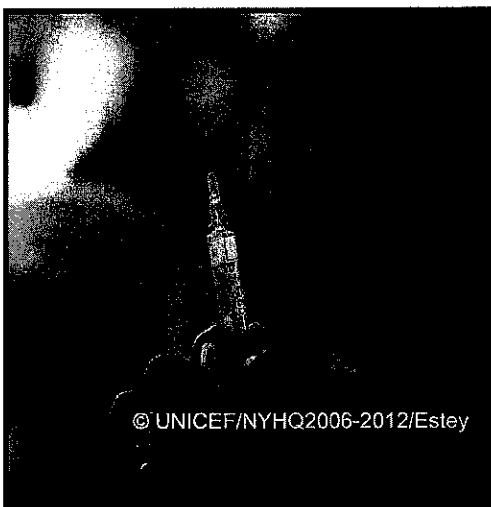


To date, 14 countries have completed all planned activities; 12 of these are waiting to be validated by WHO within the next 6 to 9 months, two others are still waiting for data reviews to assess if they are ready for validation. Four of these 14 countries namely, Central African Republic, Cote d'Ivoire, Myanmar and Timor Leste have benefitted from Pampers' support.

Between 2007 and June 2009, Pampers has raised funds for more than 200 million doses of TT vaccine. These funds have so far helped UNICEF and its partners target approx 45.5 million women for protection against tetanus.

Of the remaining countries where activities are underway or planned, at least 4 additional countries are expected to complete all needed activities by the end of 2009 thanks to Pampers' support. It is also expected that all but 19 countries will have reached the MNT Elimination goal by end 2010 and these 19 will reach the elimination goal by 2012, provided the funding needs are met.

As MNT cannot be eradicated, activities will need to continue even after MNT elimination has been achieved. The supplemental immunization activities that are being implemented in the high risk areas to achieve MNT elimination will have an impact of several years, and will provide a window of opportunity to improve access to 'routine' services. Indeed, many countries have started to improve routine immunization services through improved planning, monitoring and training (the so-called 'Reaching Every District' approach). Countries are implementing 'Child Health Days' as a way to increase access to immunization. Globally, there is a widespread recognition that Health Systems need to be strengthened, which when implemented will also improve access to clean deliveries and immunization. Meanwhile, many girls who are now reaching childbearing age received three doses of Diphtheria, Tetanus and Pertussis (DTP) vaccine in their own infancy, hence reducing the need for multiple doses in adulthood. With all these initiatives, there is a real chance that MNT will remain 'eliminated', but continued vigilance is required. And where elimination has been achieved through supplementary immunization activity (SIA), but improvements in access to health care remain absent, it is possible that some small-scale follow-up SIAs may be needed in selected high-risk areas, such need will need to be determined on a case-by-case basis.



#### TEXT BOX 3

### Tetanus Toxoid vaccine

- Available for over 80 years
- At 7 cents a dose, one of most inexpensive vaccines.
- One of the most safe vaccines
- An effective vaccine: after 3 doses almost 100% of the vaccinated individuals are protected
- A stable vaccine that can withstand exposure to around 20C for months and storage at 37C for a few weeks without loss of potency

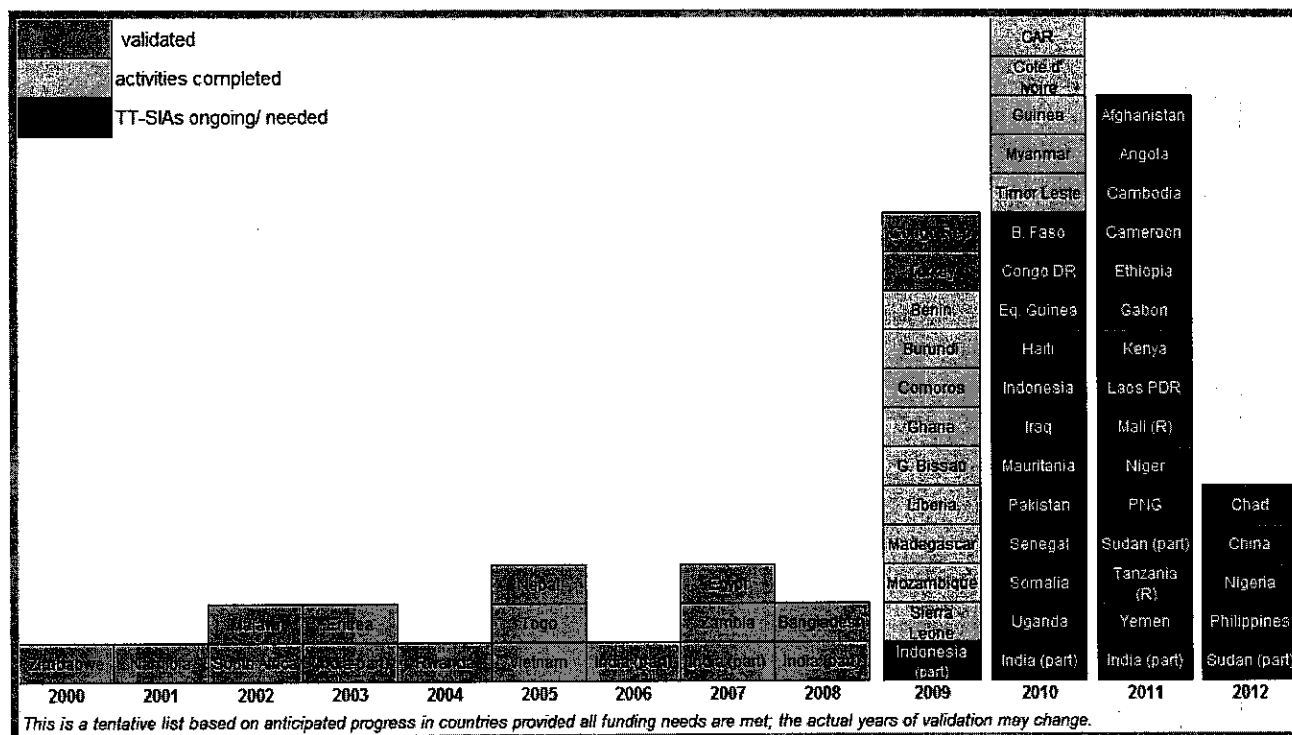


## IMPACT

### MNT Elimination is achievable

Elimination of Maternal and Neonatal Tetanus is achievable and feasible! Most of the 128,000 estimated deaths in newborns in 2004<sup>1</sup> were preventable. The rarity of tetanus cases in the industrialized world especially among newborns and mothers is a testament to this fact. Let us look at why MNT can be made a rarity in the developing world as well.

TEXT BOX 4



First, immunization is one of the most successful public health programmes of the last three decades. Despite all the challenges - of transporting vaccines that require strict cold chain maintenance reaching infants all over the world including the hard-to-reach areas, need for skilled human resources and many other challenges - strong national government and partner commitment has ensured that high coverage is maintained in most countries with 81% of the world's children and more than 80% of the developing world's children in 2007<sup>2</sup> reached with routine childhood vaccines. With the basic health infrastructure, regular supply chains and competent vaccinators available in almost all countries, it has been possible to reach children even in the most remote parts of the world with effective oral and injectable vaccines mostly through routine services; and where these did not work, through well organized campaigns. Maternal TT immunization (for merits of TT vaccine, see text box 3) has also benefited from the success of infant immunization, even though maternal immunization rates usually lag behind the infant immunization rates.

<sup>2</sup> WHO vaccine-preventable diseases- monitoring system – 2008 global summary (This publication is available on the Internet at: <http://www.who.int/immunization/documents/en/>)

Secondly, Maternal TT immunization coupled with hygienic birthing practices has made maternal and neonatal Tetanus unheard of, not only in the industrialized countries, but also in many less industrialized Asian and African countries. National governments, global partners and donors are increasingly focusing on safe motherhood which will further contribute to high coverage of hygienic birthing practices.

Thirdly, the combination of strategies for elimination of MNT has been shown to work in all kinds of settings. Not only have the strategies been successful in reaching more than 80% of the targeted women at risk in post-conflict countries like Liberia and Sierra Leone, but even in countries with security issues and active combat zones like Afghanistan, Pakistan, Yemen, DRC, it has been possible to reach the women at risk.

Global and national commitment to reach elimination remains strong with technically sound national plans for MNT Elimination prepared and approved by Inter Agency Coordination committees. UNICEF and WHO and partners like Pampers remain committed to the goal of global elimination; the only missing ingredient is funding.



© UNICEF/NYHQ2005-1497/Z. A girl is vaccinated inside a tent set up at Abbas Hospital in Pakistan.

## Pampers supports UNICEF programs

Text Box 5

The tetanus vaccines funded by Pampers through this campaign have or will be used to protect women and their babies against maternal and newborn tetanus within the following 32 countries worldwide, including:

<b>Afghanistan</b>	<b>Ethiopia</b>	Pakistan
<b>Angola</b>	<b>Gabon</b>	Papua New Guinea
<b>Burkina Faso</b>	Guinea Conakry	Philippines
Burundi	Haiti	<b>Senegal</b>
<b>Cambodia</b>	<b>Indonesia</b>	Somalia
<b>Cameroon</b>	Kenya	<b>Sudan</b>
<b>Central African Republic</b>	<b>Lao PDR</b>	<b>Tanzania</b>
Chad	<b>Mauritania</b>	<b>Timor Leste</b>
<b>Cote d'Ivoire</b>	<b>Myanmar</b>	<b>Uganda</b>
<b>DR Congo</b>	<b>Niger</b>	<b>Yemen</b>
Equatorial Guinea	Nigeria	

*(Country names in bold reflect that the country had received some Pampers funds by June 2009)*

## STORIES FROM THE FIELD

### Myanmar

In 2003 I was promoted to be a township community health nurse. I was responsible for overseeing the work of public health teams in rural areas in the whole township. I visited all the midwives in the villages and stayed with each of them for two or three days until they felt close enough to trust me and take my advice for their job to heart. One outstanding midwife carried the registers and put together lists of women and children in her area that needed any sort of primary health care including immunization wherever she travelled.

One day I visited one of the farming communities with a midwife. Usually in Myanmar farmers stay with their family members at the paddy field temporarily during harvest time and return home after harvest. Because of this they often miss out on vaccinations. In addition wives and mothers tend to never receive any ante-natal care when they are pregnant and even deliver their babies at their temporary huts.

While I was visiting I found one case of newborn tetanus. Immediately I took hold of the child and told my colleagues and the family about tetanus signs. The baby arched backwards and went silent with lockjaw. It was most likely that tetanus poison was invading his nervous system. I asked the mother about his immunization status she said she didn't have any immunizations. Her delivery had taken place on the ground on a ragged mat. Although a hard working midwife tried to assist all pregnant mothers in the area this woman was not immunized against tetanus during both her present and previous pregnancies. She had three children but none of them was protected. I explained to her that tetanus kills many mothers and children each year. Maternal tetanus is often the outcome of deliveries that are unsafe. The symptoms can appear up to three weeks after an injury including a tight jaw stiff neck and body muscles and difficulty swallowing along with violent and painful spasms. Death is swift but immunization can save both mother and the newborn.

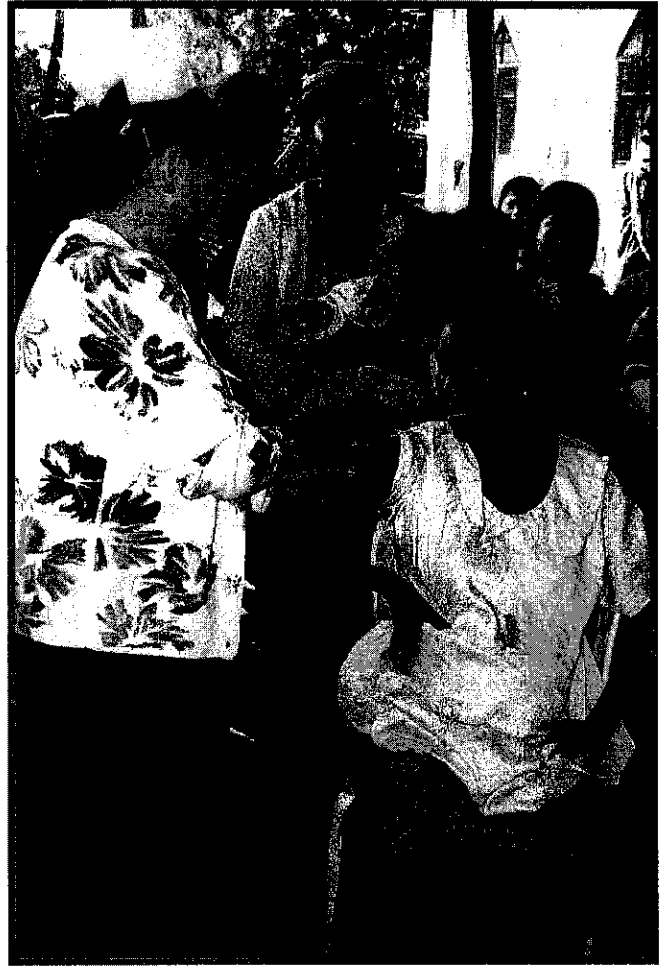


Photo credit: ©UNICEF/2009/ Myanmar/ Y. Hla

I tried hard to convince the mother to go to the hospital though it was 10 miles away. But she did not listen to me and tried to give the baby traditional medicine. Later she managed to reach the hospital travelling on a bullock cart but tragically the baby died shortly afterwards. It was very sad.

Not long afterwards the township Kan Gyi Daunt where the unprotected mother and the tetanus baby were found was designated as one of the high risk townships for tetanus. An immunization campaign started in the area and three doses of tetanus vaccination were given to all of the women of child bearing age. This time we did not miss any eligible women.

*\*Activities in Myanmar were supported by Pampers funds.*

## MORE STORIES FROM THE FIELD



© UNICEF/NYHQ2006-0970/Shehzad Noorani

A woman is vaccinated against tetanus at a health outreach centre in a village which is in the country's remote wetlands area, which is submerged under water for almost half the year. During the flooding period, villages become 'islands' and access to services is limited.

## Bangladesh

### **Success in a country which had one of highest Neonatal Tetanus rates two decades ago**

A survey in Bangladesh in 1994 showed that Neonatal tetanus was responsible for 6 deaths for every 1000 live births representing 23% of all neonatal deaths<sup>i</sup>. The World Health Organization (WHO) estimated that in 1999 in Bangladesh 13575 newborns died of neonatal tetanus. Improvement in TT immunization coverage in pregnant women through regular health services and immunization of women of child bearing age in areas at high risk of MNT through campaign like immunization activities have resulted in an impressive decrease in the Neonatal Tetanus mortality. In 2008 two surveys were done in two of the worst-performing districts and confirmed that MNT was eliminated; i.e. a rate of less than 1 case of neonatal tetanus per 1000 live births was recorded and was no longer a public health problem<sup>ii</sup>. This reduction in neonatal tetanus mortality has contributed significantly to reduction in overall neonatal mortality which has decreased from 52 neonatal deaths per 1000 live births in 1989-1993<sup>iii</sup> period to 37 in 2007<sup>iv</sup>.

- I. World Health Organization (1996) EPI information system. Geneva World Health Organization (WHO/EPI/CEIS 96.07)
- II. WHO: Validation of neonatal tetanus elimination in Bangladesh by lot quality assurance-cluster sampling. WER 34 2008 83: 301-307 (22 August 2008)
- III. [http://www.who.int/making\\_pregnancy\\_safer/countries/ban.pdf](http://www.who.int/making_pregnancy_safer/countries/ban.pdf)
- IV. State of the World's Children (SOWC) 2009

## Liberia and Sierra Leone

### **Successful implementation of TT-SIAs in post-war countries and fragile states**

Tetanus Toxoid (TT) - Supplementary Immunization Activities (SIAs) are the recommended strategy to rapidly reduce deaths due to neonatal tetanus and to achieve MNT Elimination. Such TT-SIAs have also been successfully implemented in post-war countries where health infrastructure was severely damaged during years of conflict. Nationwide TT-SIAs were conducted in Sierra Leone where 1.18 million women of reproductive age were targeted and more than 85% vaccinated with 3 doses of TT. This opportunity was used to also deliver iron/folate supplements and deworming tablets to women during one of the three rounds. In addition children - ages 6 to 59 months - were provided 2 supplements of Vit A and children - ages 12 to 59 months - were provided 2 doses of deworming tablets. The process of MNT validation has begun and Sierra Leone is expected to be validated before the end 2009.

Liberia another post-war country that has successfully implemented TT-SIAs in the last six years is currently undergoing the validation process and is also expected to be validated before the end of 2009.

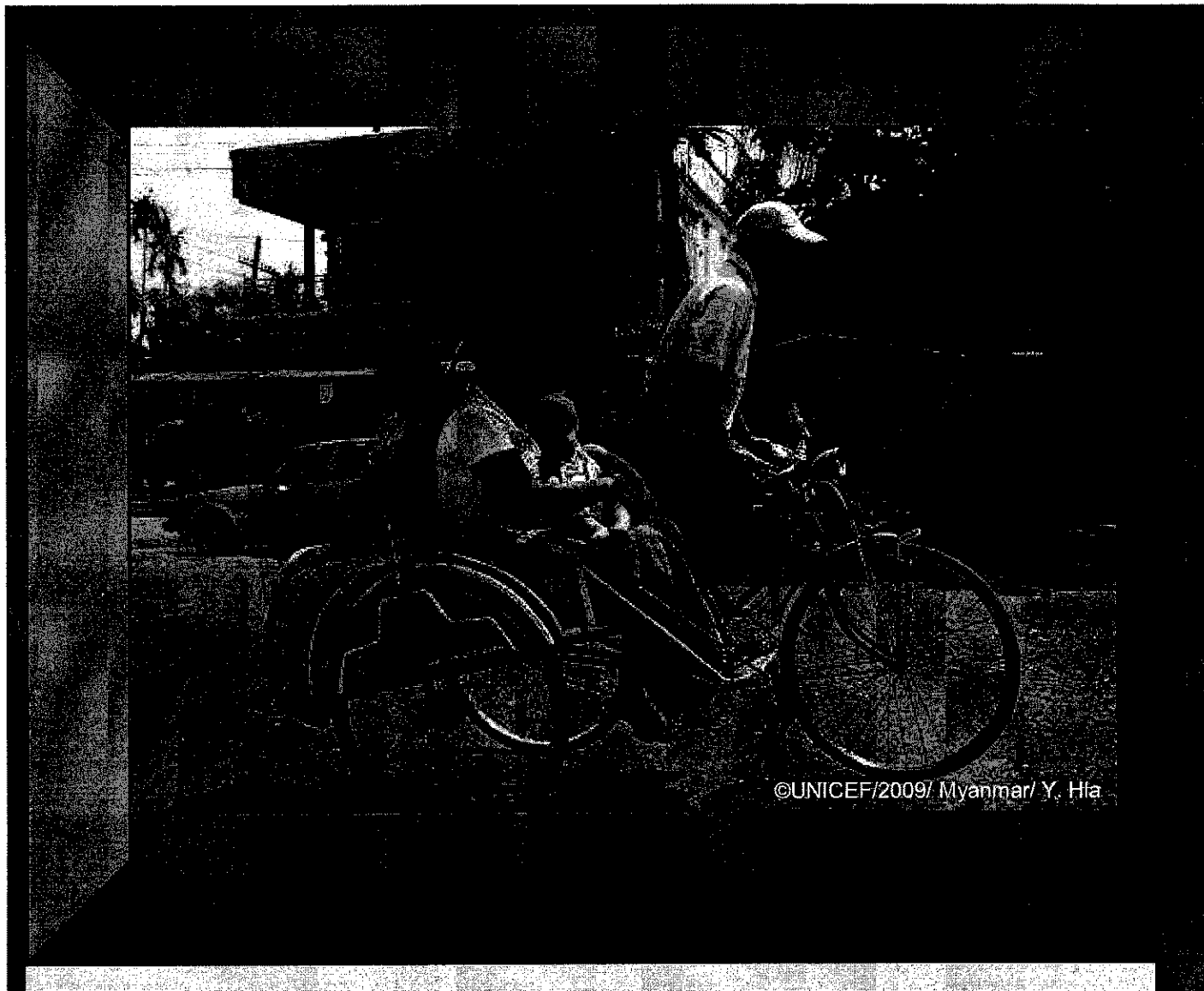


© UNICEF/NYHQ2007-0571/Pirozzi

A health worker vaccinates an infant at Redemption Hospital in New Kru Town, a neighborhood of Monrovia, the capital of Liberia.

# PHOTO ESSAY

## Myanmar



©UNICEF/2009/ Myanmar/ Y. Hla

Daw Thandar Tun 32 years with her daughter Snow 9 ½ months arrive at Thaketa Primary Health Care Centre of Yangon Division by trishaw for check up.

## Myanmar



©UNICEF/2009/ Myanmar/ Y. Hla

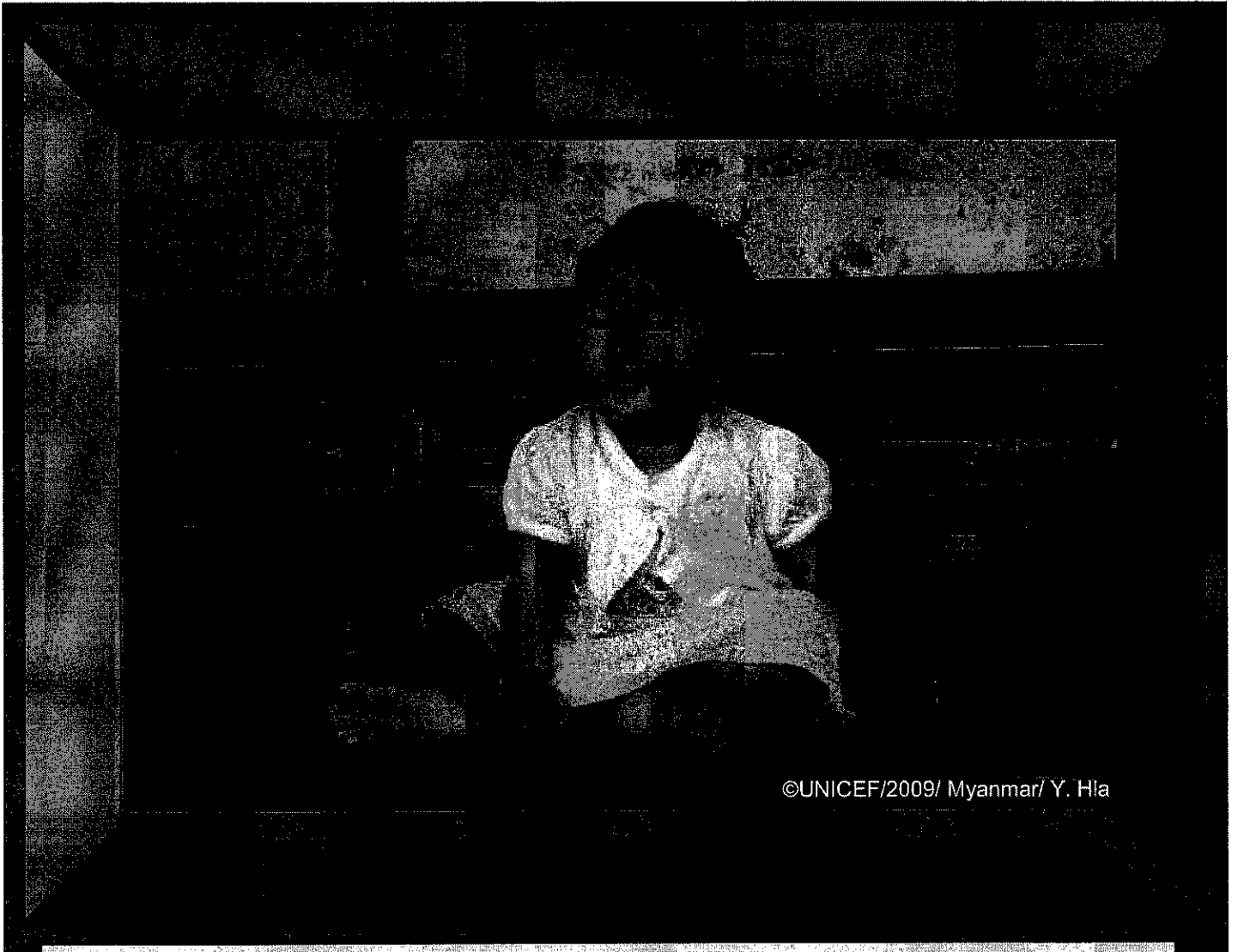
Daw Thandar Tun 32 years and her daughter Snow 9 ½ months are at Thaketa Primary Health Care Centre of Yangon Division. Thandar Tun has received 2 doses of TT during her pregnancy and also another TT dose after her pregnancy while her daughter has also received 3 doses of DPT at 1½ months 2½ months and at 3½ months.

## Myanmar



Daw Thandar Tun 32 years and her daughter Snow 9 ½ months are at Thaketa Primary Health Care Centre of Yangon Division. Thandar Tun has received 2 doses of TT during her pregnancy and also another TT dose after her pregnancy while her daughter has also received 3 doses of DPT at 1½ months 2½ months and at 3½ months.

## Myanmar

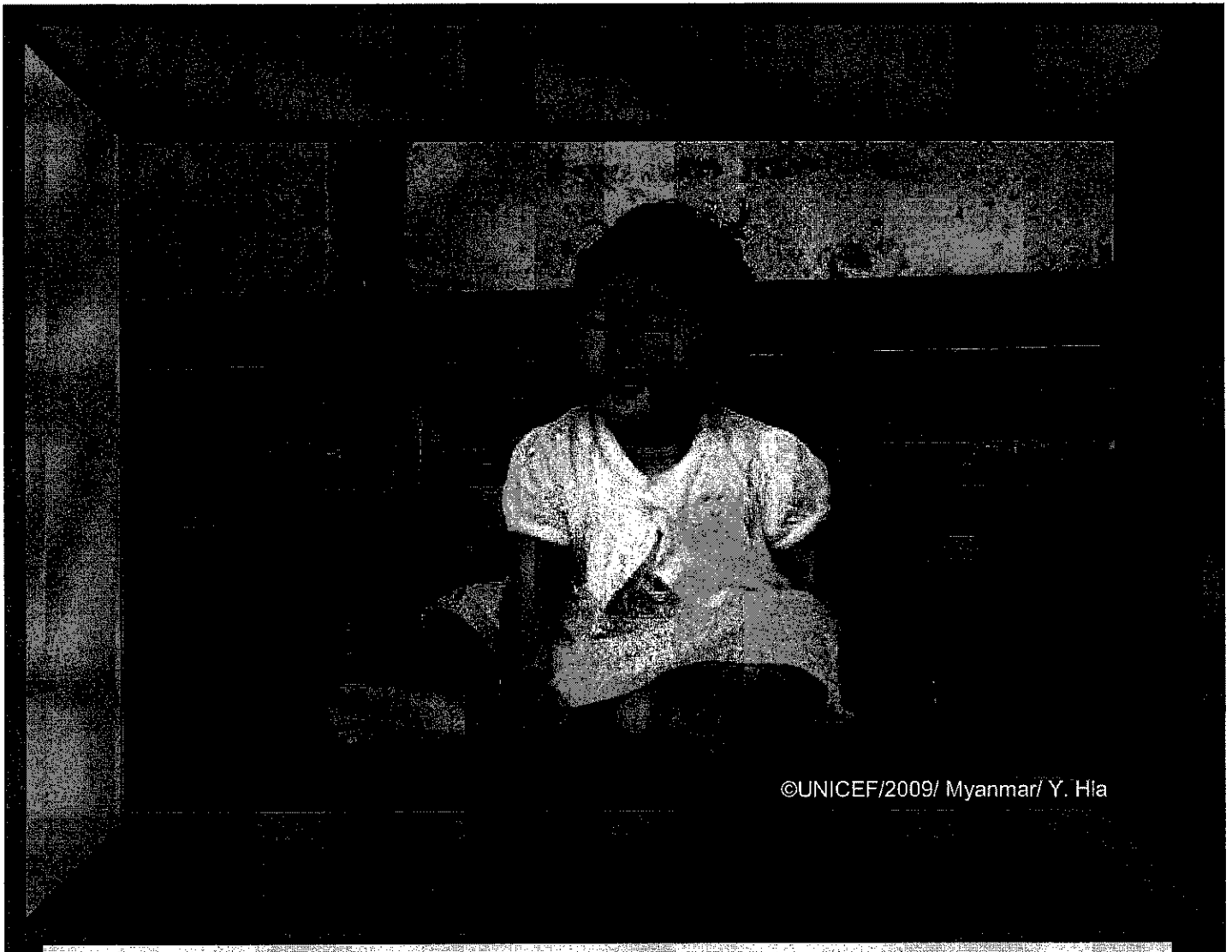


©UNICEF/2009/ Myanmar/ Y. Hla

Snow 9 ½ months is sitting at the visitors' bench of Thaketa Primary Health Care Centre of Yangon Division waiting for a check-up. Snow has received 3 doses of DPT at 1½ months 2½ months and at 3½ months. Her mother Daw Thandar Tun has also received 2 doses of TT vaccines during her pregnancy and another dose after she has given birth to Snow.



## Myanmar



©UNICEF/2009/ Myanmar/ Y. Hla

Snow 9 ½ months is sitting at the visitors' bench of Thaketa Primary Health Care Centre of Yangon Division waiting for a check-up. Snow has received 3 doses of DPT at 1½ months 2½ months and at 3½ months. Her mother Daw Thandar Tun has also received 2 doses of TT vaccines during her pregnancy and another dose after she has given birth to Snow.



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