In this month's *Bulletin*

Web health info fails to reach five-sixths of the world (247–248)

Many health organizations distribute information through web sites, but this approach fails to serve most people in developing countries. In their editorial, Clifford C Missen & Thomas M Cook point out that only one-sixth of the world's population uses the Internet. In another editorial, Tikki Pang writes about the challenge of converting research findings and scientific evidence into action in developing countries.

In the news (249–255)

Theresa Braine reports on WHO's plans to launch an essential medicines list for children. Hannah Brown writes about plans to establish Rwanda's first postmortem programme that will help with the diagnosis of cerebral malaria in children. In this month's interview, Dr Abdel-Razzak Al Gezairy talks about the challenges that he faces at the helm of WHO's Regional Office for the Eastern Mediterranean. The *Bulletin* also reports on the Global Health Histories project and events leading up to WHO's 60th anniversary on 7 April 2008.

Barriers to cervical cancer screening (264–272)

Bhagwan Nene et al. analysed the factors that made women come forward for cervical cancer screening in Maharashtra, India from 1999 to 2003. Screened women were younger and better-educated, and many had used contraception. More screened women were married and fewer had never been pregnant. Barriers to screening uptake include lack of knowledge about the disease, lack of access to care and lack of family support plus poor-quality services.

Counting tsunami deaths in Aceh (273–278)

Shannon Doocy et al. studied surveys of nine districts in Aceh, Indonesia to find out how many people died in the 2005 tsunami. It found the highest tsunami-related mortality in Aceh Jaya, Banda Aceh and Aceh Besar. Of the area's pre-tsunami population, 17% were reported dead or missing in the disaster. The tsunami's long-term demographic result is likely to be a male–female population imbalance.

Costing care

Anders Nordström et al. (246) discusses in an editorial what it will cost to achieve the health-related Millennium Development Goals in 2015. Benjamin Johns et al. (256–263) estimated the cost of scaling up maternal and neonatal health care to achieve universal coverage in 75 developing countries by 2015. They estimated that an additional US$ 39.3 to US$ 55.7 billion would be needed. Karin Stenberg et al. (305–314) estimated the additional resources required to scale up priority child health interventions in 75 countries by 2015 and found that US$ 52.4 billion would be needed.

HIV and breastfeeding in South Africa (289–296)

Ruth M Bland et al. examine the infant feeding intentions of 1253 HIV-infected and 1238 uninfected mothers in KwaZulu Natal, South Africa in August 2001 and September 2004. After counselling and before delivery, 73% of HIV-infected and 82% of non-HIV-infected mothers said they would opt for exclusive breastfeeding, while 9% of infected and 2% of non-infected mothers said they would use replacement feeding. Most HIV-infected mothers did not have the resources for safe replacement feeding such as clean water and access to a refrigerator.

Medicines for chronic diseases (279–288)

Shanthi Mendis et al. assessed the availability and affordability of 32 medicines for cardiovascular disease, diabetes, chronic respiratory disease and glaucoma, and to provide palliative cancer care in Bangladesh, Brazil, Malawi, Nepal, Pakistan and Sri Lanka in 2005. They found that 7.5% of these medicines were available in the public sector in all countries except Brazil, where 30% were available, and Sri Lanka, where 28% were available. Among other findings, median price ratios varied from 0.09 for losartan in Sri Lanka to 30.44 for aspirin in Brazil.

Infections in pregnant women in Botswana (297–304)

High prevalences of trichomoniasis and bacterial vaginosis among pregnant women in sub-Saharan Africa have been linked to preterm delivery, low birth weight and increased HIV transmission. Maria Romoren et al. show in their 2000–2001 study of antenatal care in Botswana that the current management of the two conditions fails to identify infected women, and that treatment guidelines are not being followed. A management strategy is proposed for these conditions in pregnant African women.

HIV testing in Kenya (315–318)

The reporting of voluntary counselling and testing centres (VCT) centres in Kenya has been fraught with challenges due to incomplete data. Kennedy N Otwombe et al. found that more than 50% of records had not been accounted for in the national database through a national VCT data collection exercise conducted in 2004. Among the reasons for the delay in data submission were: a lack of uniform data collection tools, a shortage of counsellors and a lack of a data tracking system. ■