

SUCCESSFUL LEADERSHIP

*COUNTRY ACTIONS FOR MATERNAL,
NEWBORN AND CHILD HEALTH*



Our Purpose

This document is for heads of state and officials attending the high-level event at the United Nations headquarters on 25 September, 2008. It celebrates success stories from countries with high maternal, newborn and child mortality, and shows specific actions taken towards achieving Millennium Development Goals 4 and 5 on maternal, newborn and child health.

We hope these success stories will inspire you and inform the actions you take to protect the health of mothers and young children in your countries.

Introduction

Investing in health – particularly the health of mothers and young children – is a vital part of social and economic development. Two of the eight Millennium Development Goals (MDGs) concern maternal, newborn and child health:

- Goal 4 is to reduce the mortality rate of children under the age of five.
- Goal 5 is to reduce the mortality rate of mothers and to achieve universal access to reproductive health.

Together these two goals put health in its rightful place at the centre of development.

However, despite progress towards achieving these goals in some areas, the world is well behind schedule. *Countdown to 2015*, published this year, studied the 68 countries with the highest rates of maternal and child mortality. Between them these countries account for 97% of the world’s deaths among mothers and infants, and only 16 are “on track” to achieve MDGs 4. And of all eight MDGs, Goal 5 is the one on which progress is most needed.

The world has just seven more years in which to achieve these goals. To get back on track we urgently need to address the health of women and young children.

Women’s health

Investing in women’s health and education plays a critical part in social, economic and political development. It improves not only the health and education of women and their families, but of whole nations – because of the contribution women make:

- In South East Asia, women do 90% of the work in cultivating rice.
- In rural Africa, it is women – not trucks, boats or aircraft – who transport two-thirds of all goods.
- In developing countries throughout the world, women provide half the food and half the healthcare.

This is why poor maternal health, high mortality rates and costly maternity services often push families below the poverty line and prevent them from investing in their children’s future.

This creates huge problems for whole economies. In Ghana, for example, pregnant women lose an average of 26 days’ work a year because of poor healthcare. In Uganda, the annual cost of these productivity losses is estimated at US\$85 million, and in Ethiopia at US\$95 million. Worldwide, lost productivity from maternal and newborn mortality is estimated at US\$15 billion.

Children’s health

Recent research shows that there is a strong correlation between the health of a country’s children and of its economy. It shows that investing in children’s health leads to better educated and more productive adults, and that poor health can trap families in poverty. Mothers from poorer families often decide not to pay for healthcare, even when they or their children need it most, because they fear being blamed by their partners for spending too much money.

Children born into poor families are likely to be less healthy as adults. As a result, they earn lower wages, making it more likely that their own children will have health problems. To end this vicious circle, it is vital for governments to provide free healthcare to pregnant women and to children younger than five.

Doing right for our mothers and children

If the world is to achieve MDGs 4 and 5, and make good its promise to mothers and children, we must learn from the countries that have achieved most.

The following success stories are not a comprehensive assessment of the progress made by individual countries, but demonstrate the importance of five factors:

1. Successful Political Leadership
2. Sound Health Policies
3. Effective Financing
4. Strong Health Systems
5. Action to Achieve Equity



1 Success through political leadership

THAILAND

Sustained political leadership to provide primary healthcare for the poor

Progress on MDGs

Since the 1990s, Thailand has achieved an impressive reduction of 8.5% a year in deaths of children under five. Between 1990 and 2005, the death rate fell from 31 to just 8 per 1,000 live births. By 2005, Thailand had reduced maternal mortality to 110 for every 100,000 live births.

Thailand is therefore on target to reach MDGs 4 and 5 despite a low per capita income of under US\$3,000 a year.

Supportive policies and interventions

Consistent leadership has been crucial to Thailand's success. Since the 1970s, when the country still had a very low per-capita income, primary healthcare has become the key strategy for improving public health. Local communities have become involved in delivering services that bring care much closer to families. Successive administrations have invested in district health systems to build a solid foundation for delivering comprehensive healthcare to mothers and young children. This includes innovative use of mid-level health workers, and ensuring enough workers are on hand to serve remote areas.

Between 1994 and 2004, Thailand allocated a tenth of all central government expenditure to healthcare. The government protected the poor from catastrophic healthcare costs through exemptions for the poorest families and then exemptions for all MNCH services. Since 1991 a range of insurance schemes has protected middle-income families. The country has also employed innovative approaches to reducing costs, such as early adherence to a national essential drug list and local generic drug production to reduce the cost of antiretrovirals. Use of data nationally and locally has been crucial in strengthening services, as shown in Thailand's rapid response to HIV/AIDS.

Outcome

- Thailand has reduced mortality rates among children under the age of five.
- It has reduced maternal mortality rates; 97 per cent of births are attended by skilled professionals, with no difference for the poorest families.
- Primary healthcare coverage is high; for example for family planning services and vaccination for children.

Key lesson

Political commitment and consistent building of public health programmes accelerate progress for MDGs 4 and 5.

Consistent leadership in efforts to improve maternal, newborn and child health is a vital element in making progress towards MDGs 4 and 5.



2 Success through sound health policies

Effectively designed health, social and economic policies are critical to the improvement of health.

INDONESIA

Basing midwives in every village

Progress on MDGs

In 1989, Indonesia had a maternal mortality rate of over 400 per 100,000 live births, and a neonatal mortality rate of 32 per 1,000 live births. By 2003, these rates had dropped to 307 and 20.

Supportive policies and interventions

Indonesia's government introduced a successful village-based midwife programme. With great financial and political commitment, it set itself a target of placing a midwife in every village to provide skilled care before, during and after birth.

Over seven years, Indonesia selected, trained and certified 54,000 new village midwives. As a result, between 1986 and 1996, the number of midwives rose from 0.2 to 2.6 for every 10,000 people. These midwives, many equipped with small birthing units, provide outreach and reproductive health services, including immunisation and nutritional interventions.

As a result of the programme's feedback system, Indonesia adapted its strategy to improve results. It modified the training curriculum, instigated clinical audits to improve the quality of services and improved the referral system for emergency obstetric care.

Outcome

- By 1997, over 96% of Indonesian people had access to village-based midwives.
- In rural areas, the proportion of births attended by skilled midwives increased from 22% in 1990 to 55% in 2003.
- Inequities in service provision have been considerably reduced.
- In some areas, women's and children's nutrition has improved and the number of infant deaths has fallen.

Key lesson

The rapid deployment of midwives throughout a country is achievable, but there must be a means of ensuring sustainability, the quality of services and availability of a referral system for emergency obstetric care. Governments can ensure different groups have more equitable access to skilled professionals during birth.

TANZANIA

Strengthening health services through decentralization and through strong links with civil society

Progress on MDGs

Though it still has more to do to achieve MDG 4, Tanzania reduced its under-five mortality rate from 141.5 in 1990 to 112 per 1,000 live births in 2004. It also significantly reduced childhood malnutrition from 27 to 17 percent between 1996-2006. Maternal mortality rates for the period 2000-2006 were high (more than 580 per 100,000 live births), so the country has much more to do to achieve MDG 5.

Supportive policies and interventions

Tanzania has very supportive MNCH policies and strategies in place. Among these are the free services offered to all women during pregnancy, delivery and the postnatal period, and to children under the age of five, covering treatment and preventive services. The government has initiated national nutrition policies to decrease childhood malnutrition with civil society, including:

- Doubling public health expenditure and increasing district level funding.
- Sector-wide "basket funding" and strengthening district health services.
- A decentralised health system directly involving civil society.
- High-impact interventions to improve young children survival rates including immunisation and vitamin A, using insecticide-treated nets and promoting breastfeeding.

Tanzania has renewed its commitment to addressing MDGs 4 and 5 by developing the National Road Map Strategic Plan to accelerate the reduction of maternal, newborn and child deaths. The government developed an MNCH plan for 2008-2015, which is expected to improve coordination and access in the next 10 years. The President also launched the Deliver Now for Women and Children Campaign, which seeks to raise awareness about the importance of good health for mothers and children.

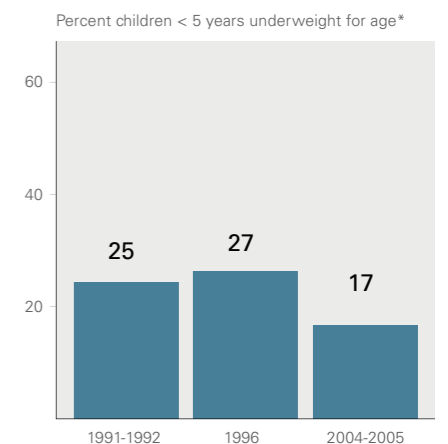
Outcome

- Childhood malnutrition was reduced significantly.
- Tanzania reduced its under-five mortality rate by 40% between 2000 and 2004.
- At the current pace, the death rate for children under five will drop to 47 deaths for every 1,000 live births by 2015. This would achieve MDG 4.

Key lesson

Decentralising health services and involving civil society at the district level rapidly improves children's health and nutrition.

Tanzania : Underweight prevalence



*Based on 2006 WHO reference population
Source: DHS

"For most effective care, a continuum linking maternal, newborn and child healthcare through the lifecycle and between homes and health facilities is needed."

H.E. Jakaya Mrisho Kikwete,
President of the United Republic of
Tanzania, Deliver Now for Women
and Children, April 2008

3 Success through effective financing programmes

MEXICO

Innovative demand-side financing to reduce poverty and improve access to essential services

Progress on MDGs

Mexico has reduced its under-five mortality rate from 53 per 1,000 live births in 1990 to 35 in 2006, and to 27 in 2005 in the Oportunidades poverty alleviation areas (see below). It has also reduced its maternal mortality rate per 100,000 live births, from 110 in 1990 to 60 in 2005.

Mexico is on track to achieve MDGs 4 and 5.

Supportive policies and interventions

Over the past few decades, Mexico has implemented successful public health interventions that have led to a reduction in child mortality. To help increase the access to these services by poorer segments of the population, a new programme of conditional cash transfer (CCT) was established, providing special assistance and helping to reduce poverty. In 1997, Mexico established the largest such programme, Oportunidades, with a budget of US\$3.7 billion. By 2007, this programme was benefiting more than five million families.

Oportunidades alleviates poverty while making long-term investments in people's health. Poorer families are given cash in return for an assurance that they will comply with certain requirements, such as bringing their children for regular medical check-ups and vaccinations. The programme also provides prenatal care, birth attendance and post-partum care, as well as fortified food supplements for pregnant and lactating women and for children aged between 6 and 23 months.

In a further development, in 2008 Mexico's government indicated that mothers from low-income families would no longer have to pay for maternal health services.

Outcome

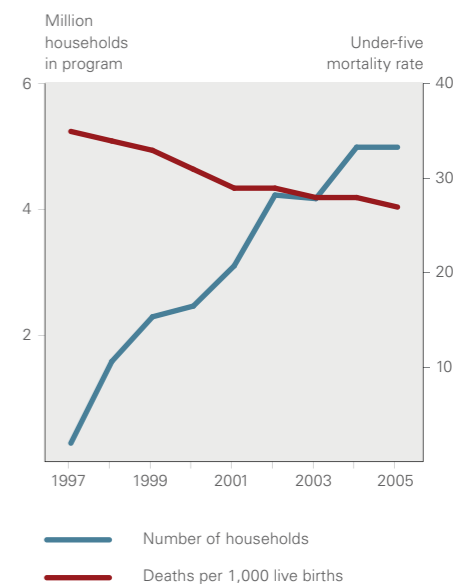
- More Mexican people now use the country's health services.
- Infants and children from low-income families are healthier and have better nutrition.
- Child mortality has decreased.

Key lesson

A well-designed and funded Oportunidades programme increases the take-up of health services and benefits women and children significantly. It also reduces poverty and improves health and nutrition.

Governments can reduce poverty by promoting health services and helping poorer people pay for them. An investment in health is an investment in social and economic development.

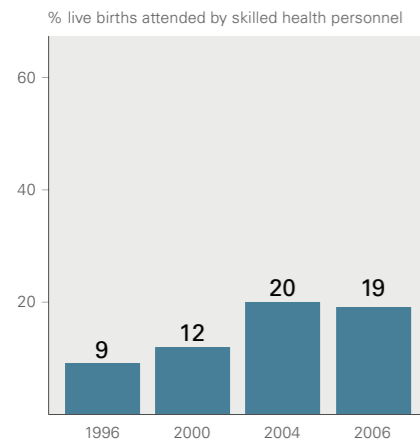
Mexico :
Coverage of Oportunidades and under-five mortality rate, 1997-2005



4 Success through strong health systems

Strong health systems are vital for providing effective services. Involving communities helps to increase the demand for health services, which in turn encourages governments to invest more in maternal, newborn and child health services.

Nepal : Skilled attendant at delivery



Source: DHS, other surveys

NEPAL

Strengthening health systems by working with communities

Progress on MDGs

Despite a significant reduction of maternal deaths, Nepal has a high maternal mortality rate – in 2005, 281 mothers died in every 100,000 live births. The country is on track to achieve MDG 4 after reducing mortality in children under five from 162 to 61 deaths for every 1,000 live births between 1990 and 2006.

Supportive policies and interventions

Nepal is systematically strengthening its health systems by investing in maternal and neonatal services. In the 1990s it established a community mobilisation and training programme that actively involved civil society.

The programme recruited the support of women's groups in different regions, which helped convene monthly mothers' group meetings in which participants discussed how to address and communicate problems with maternal and perinatal health. Cadres of female community health volunteers, maternal and child health workers, and village health workers were trained to support these activities. In addition, mid-level health workers and assistant nurse midwives were appointed to run sub health-posts and health-posts at community level. This increased the number of skilled professionals attending births in remote areas, while a referral system prompted women with complications to get the medical attention they needed. The government also improved health facilities.

Outcome

- Between 1996 and 2006 the proportion of births attended by skilled professionals rose from 9% to 19%.
- A demonstration area reported a reduction of neonatal mortality from 36.9 to 26.2 per 1,000 live births.

Key lesson

Involving communities in stimulating demand for health services encourages the strengthening of health systems and is an important strategy for delivering those services to people in remote areas.

SENEGAL

Contracting civil society to provide preventive services for children

Progress on MDGs

Between 1990 and 2006 Senegal reduced its under-five mortality rate per 1,000 live births from 149 to 116. It now also has West Africa's lowest rates of malnutrition.

However, the maternal mortality rate between 2000 and 2006 was high – more than 430 deaths for every 100,000 live births, and the country is behind schedule for reaching both MDGs 4 and 5.

Supportive policies and interventions

Malnutrition was a major problem in Senegal because of chronic food insecurity. So the government introduced the Community Nutrition Project, which combines public and private finance. Under the project, the government contracted civil society to improve nutrition, rather than trying to do so itself.

The contracting strategy was then used to provide other preventive health services, including health promotion interventions to improve the survival of children. This relieved the pressure on central health services, which performed better as a result.

Several organisations were involved in the programme, each using its comparative advantages to improve MNCH. These included government ministries, community associations, international organisations, the private sector, universities, research institutes and professional organisations. In addition, the government established the key position of an 'Ambassador for Maternal, Newborn and Child Health', and appointed a renowned imam to take on this role.

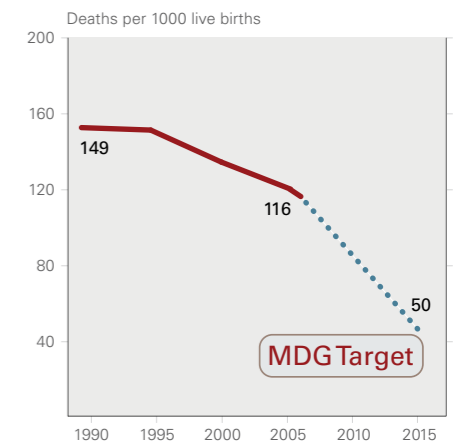
Outcome

- Between 1995 and 2005, malnutrition rates fell from 22% to 17%, and under-five mortality rate decreased significantly.
- Many other measures of the success of healthcare services have improved largely in the field of health promotion.

Key lesson

Senegal reduced malnutrition rates by contracting civil society to manage activities that improve people's nutrition.

Senegal: Under-five mortality rate



Source: UNICEF, 2006

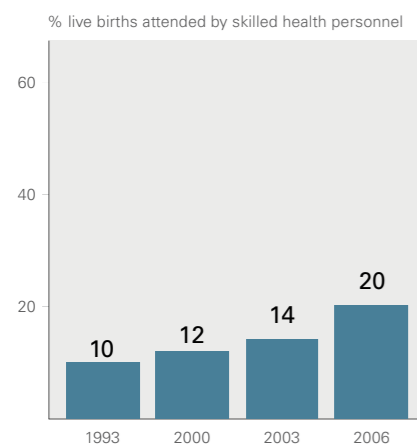
"If instead of collecting the interest generated by the deposits, we kept them for our Member States' development, the expected US \$ 10 billion fund could be used to address the problems of our children and reduce maternal and child mortality."

H.E Abdoulaye Wade, President of the Republic of Senegal, IOC Summit, March 2008

5 Success through action to achieve equity

Inequities in healthcare make it much more difficult to achieve MDGs 4 and 5. It is essential to reach vulnerable groups, such as the poor, the elderly and ethnic minorities, and ensure that they have access to health services.

Bangladesh : Skilled attendant at delivery



Source: DHS, MICS

BANGLADESH

Improving gender indicators by investing in women's health and education

Progress on MDGs

Child mortality has fallen significantly since the late 1980s and Bangladesh is on track to achieve MDG 4. But despite a 38% reduction in maternal mortality between 1990 and 2001 – deaths per 100,000 live births fell from 574 to 322 – the country is behind schedule on MDG 5.

Supportive policies and interventions

The government worked with BRAC, the country's largest non-governmental organisation, on national programmes to educate girls, increase the use of family-planning techniques, enhance access to emergency obstetric care, improve mothers' safety, reduce poverty, and improve communities' wellbeing. It has also introduced poverty-reduction programmes in all districts, focusing on income generation and self reliance for women from the poorest segments of the population.

As a result of these activities, Bangladesh has recently made progress towards achieving MDGs 4 and 5. In addition, the dedicated education programmes for girls have improved literacy rates, and the proportion of mothers having access to skilled professionals while giving birth increased from 14% to 20% between 2003 and 2006.

Bangladesh's approach to social development has now been exported to other Asian and African countries.

Outcome

- Maternal and child mortality rates have declined.
- Programmes to address inequities in access to health services have increased men's awareness of women's education and health issues.
- Lower mortality and morbidity and greater use of health services have increased female employment.

Key lesson

A sustained focus on the needs of girls, women and other neglected groups can reduce health inequities. This is essential for achieving MDGs 4 and 5.

CHILE

Addressing inequities in maternal, newborn and child health

Progress on MDGs

Between 1990 and 2006, Chile's maternal mortality ratio per 100,000 live births fell from 40 deaths to 19.8, infant mortality rate dropped from 16 to 7.6 per 1,000 live births, the mortality under five years decreased from 21 to 9 per 1,000, and the stillbirth rate declined from 6 to 5 for every 1,000 births. Skilled and professional birth attendance remains at 99% of deliveries. Since the 1990s, the largest mortality rates reductions have been among the people living in the poorest districts.

Supportive policies and interventions

Between 1990 and 2006, Chile's government introduced the Social Protection System and implemented several interventions that decreased mortality rates, addressed inequities among socio-economic strata and improved the lives of mothers and their families. Chile's steady economic growth and reduction in poverty levels contributed to health improvements.

The government set itself a target for reducing the difference in major health outcomes between the richest and poorest population subgroups – 10% by 2010. It had four categories of activity:

1. General programmes, including *Chile Solidario*, a wide-reaching social welfare programme that met the needs of people living in extreme poverty, and *Chile Crece Contigo*, a social protection programme for women and children.
2. Preventive and curative measures to protect the lives of newborns, infants and young children and investments in equipment and resources for newborn care.
3. Programmes to improve health among adolescents
4. Programmes to improve the health of mothers, such as free distribution of contraceptives at public primary health care facilities, and the introduction of national guidelines for sexually transmitted diseases prevention and clinical management of childbirth

Outcome

- Chile is on track to achieving MDGs 4 and 5.
- The government's commitment to implement a Social Protection System to reduce inequities has had a big impact on mortality rates.

Key lesson

Significant reductions in stillbirths and deaths among mothers and young children can be achieved by addressing inequities between different sections of society.

"And we have the opportunity to progress in this Summit, and thereby to achieve the MDGs 4 & 5 by significantly reducing childhood mortality and improving maternal health. We have personally committed to this task with President Lula (Brazil) and Prime Minister Jens Stoltenberg from Norway. The protection of infants reaches the realm of equity."

Dra Michelle Bachelet, President, Republic of Chile, XVII Ibero-American Summit, November 2007

Conclusions

Leadership is vital: it shapes a nation's efforts to improve the lives of mothers and their children.

That, we believe, is the main lesson from these inspiring stories. And while the strategies adopted may not have put all the profiled countries on track to achieve MDGs 4 and 5, they have certainly helped to save lives.

Clearly, the five factors listed in this document – successful political leadership, sound health policies, effective financing, strong health systems and action to achieve equity – are key to achieving success in developing countries.

We know that there are other success stories in the making. These will be documented in future.

We hope that by publicising and celebrating these stories we have inspired leaders of other countries to create new and innovative ways to tackle such problems.

It is our belief that nothing breeds success like success.

References and Websites

Introduction

Freedman L. P. et al., Transforming Health Systems to Improve The Lives of Women and Children. *The Lancet*. March 12, 2005; 365: 997-1000

Countdown to 2015: Tracking Progress in Maternal, Newborn & Child Survival – The 2008 Report.

Belli PC, Bustreo F, Preker A. Investing in Children's Health: What are the economic benefits. *WHO Bulletin*, 2005, Oct; 83(19):777-84.

Thailand

Rohde J, Cousens SN, Chopra M, Tangcharoensathien V, Black R, Bhutta Z, . . . Lawn J. 30 years after Alma Ata: has primary healthcare worked in countries?. *The Lancet*, Alma Ata special issue, Sept 2008 (in press)

Tangcharoensathien V, et al. Knowledge-based changes to health systems: the Thai experience in policy development. *Bulletin World Health Organization*, 2004 Oct; 82(10):750-56.

Houweling TA, Ronsmans C, Campbell OM, Junst AE. High poor-rich inequalities in maternity care: an international comparative study of maternity and child care in developing countries. *Bulletin World Health Organization*, 2007; 85(10):745-754.

UNICEF, <http://www.childinfo.org/> accessed on 4 August 2008.

Tanzania

Singh A. Strengthening Health Systems to Meet MDGs. *Health Policy and Planning*. 2006. 21(4):326-328.

http://www.unicef.org/infobycountry/tanzania_statistics.html (accessed 17 June, 2008).

Masanja H, de Savigny D, Smithson P, Schellenberg J, John T, Mbuya C, Upunda G, Boerma T, Victora C, Smith T, Mshinda H. Child Survival Gains in Tanzania: Analysis of Data from Demographic and Health Surveys. *The Lancet*. 12 April 2008. 371: 1276-1283.

Pokharel B. Decentralization of Health Services – Assignment report: 20 August – 17 October 2000. Regional Office for South-East Asia, New Delhi, India. World Health Organization. SEA-HDS-245. 12 April 2001.

Indonesia

Shankar A, Sebayang S, Guarenti L, Utomo B, Islam M, Fauveau V, Jalal F. The village-based midwife programme in Indonesia. *Lancet*. 2008 Apr 12;371(9620):1226-9.

Ministry of Health. Indicators for the third evaluation of HFA 2000. Jakarta: Government of Indonesia, 2000.

The Supplementation with Multiple Micronutrients Intervention Trial (SUMMIT) Study Group. Effect of maternal multiple micronutrient supplementation on fetal loss and infant death in Indonesia: a double-blind cluster-randomized trial. *Lancet* 2008; 371: 215-227.

Mexico

Fernald LCH, Gertler PJ, Neufeld LM (2008) Role of cash in conditional cash transfer programmes for child health, growth, and development: an analysis of Mexico's Oportunidades. *Lancet*, 371: 828-837.

Gertler P (2004) Do conditional cash transfers improve child health? Evidence from PROGRESA's control randomized experiment. *American Economic Review*, 94: 336-341.

Lagarde M, Haines A, Palmer N (2007) Conditional cash transfers for improving uptake of health interventions in low- and middle-income countries: a systematic review. *JAMA*, 298: 1900-1910.

Rivera JA, Sotres-Alvarez D, Habicht J-P, Shamah T, Villalpando S (2004) Impact of the Mexican program for education, health and nutrition (ProgresA) on rates of growth and anemia in infants and young children: a randomized effectiveness study. *JAMA*, 291: 2563-2570.

Sepulveda J, Bustreo F, Tapia R, Rivera J, Lozano R, Olais G, Partida V, Garcia L, Valdespino JL. Improvement of child survival in Mexico: the diagonal approach. *The Lancet*, vol 368, Dec 2, 2006.

Nepal

Mahandhar DS, Osrin D, Shrestha BP, et al. Effect of a participatory intervention with women's groups on both outcomes in Nepal: cluster-randomized controlled trial. *The Lancet*, 2004, 364: 970-979.

UK Government: Maternal Health Strategy: reducing maternal deaths: evidence and action. Third progress report by the UK Department for International Development, June 2008.

MDG progress in country health profile: http://www.searo.who.int/LinkFiles/Nepal_Profile-Nepal.pdf (accessed on 20 August 2008).

Senegal

http://www.unicef.org/infobycountry/senegal_43516.html (accessed on 11 June, 2008).

Countdown to 2015: Tracking Progress in Maternal, Newborn & Child Survival – The 2008 Report.

Alderman H, Ndiaye B, Linnemayr S, Ka A, Rokx C, Dieng K, Mulder-Sibanda M. Effectiveness of a community-based intervention to improve nutrition in young children in Senegal: a difference in difference analysis. *Public Health Nutrition*, 2008, Jun 18:1-7.

Marek T, Diallo I, Ndiaye B, Rakotosalama J. Successful contracting of prevention services: fighting malnutrition in Senegal and Madagascar. *Health Policy Plan*, 1999 Dec;14(4):382-9.

Chile

Gonzalez R, Requejo J, Nien JK, Merialdi M, Bustreo F, and Betra AP. Forthcoming. Tackling Health Inequities in Chile: reduction in maternal, newborn, and child mortality between 1990 and 2004. *American Journal of Public Health*.

Casas JA, Dachs NW, Bambas A. Health disparities in Latin America and the Caribbean: the role of social and economic determinants. (www.paho.org/english/dbi/Op08/Op08_03.pdf), 2001.

Bahr J, Wehrhahn R. Life expectancy and infant mortality in Latin America. *Soc Sci Med* 1993;36:1373-82.

Chile. Pan American Health Organization (Internet communication of 10 January 2008

at <http://www.paho.org/HIA/archivosvol2/paisesing/Chile%20English.pdf>), 2007.

Gonzalez R, Merialdi M, Lincetto O, et al. Reduction in neonatal mortality in Chile between 1990 and 2000. *Pediatrics* 2006;117:e949-e954.

Donoso, E, 2004b, [Inequalities in infant mortality in Santiago]: *Rev. Med Chil.*, v. 132, p. 461-466.

Jimenez, J, M I Romero, 2007, Reducing infant mortality in Chile: success in two phases: *Health Aff. (Millwood.)*, v. 26, p. 458-465.

Bangladesh

BRAC, Annual Report 2007. Bangladesh.

UK Government: Maternal Health Strategy: reducing maternal deaths: evidence and action. Third progress report by the UK Department for International Development, June 2008.

Effect of breast feeding on infant and child mortality due to infectious diseases in less developed countries. WHO Collaborative Study Team on the role of Breastfeeding on the prevention of infant mortality. *Lancet* 2000, Vol 355:451-55.

Prenatal screening in rural Bangladesh: from prediction to care. AM Vanneste, C Ronsmans, J Chakraborty, A de Francisco. *Health Policy and Planning*, 2000, 15(1): 1-10.

National Institute of population Research and Training, Mitra and Associated, ORC Macro, Bangladesh Demographic and Health Survey 2004. Dhaka, Bangladesh and Claverton, MD, USA: Niport, Mitra and Associates, ORC Macro, 2005.

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