

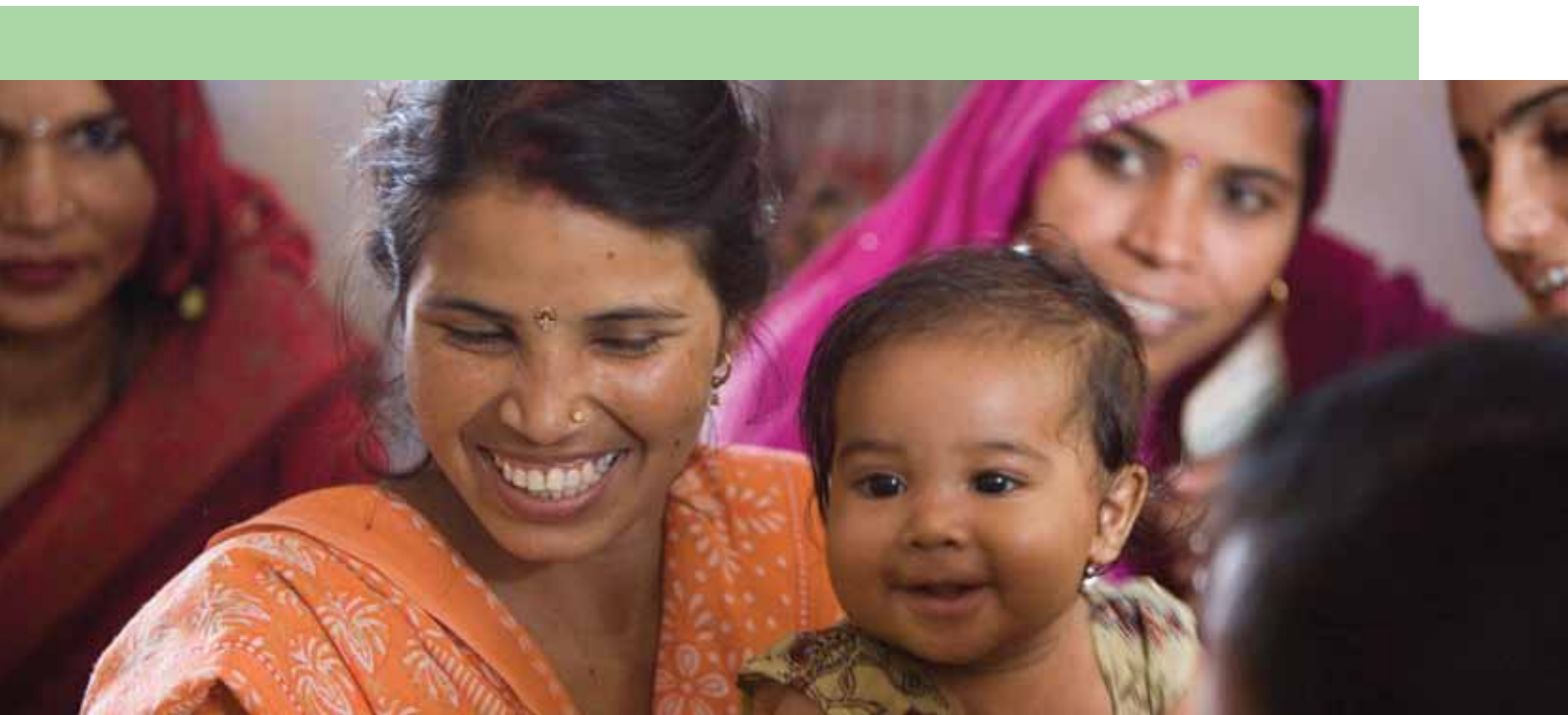
Annual Report  
**2010**



# From Hope to Action

**improving**

maternal, newborn and child health  
through active partnership



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# Foreword by Dr Julio Frenk

Chair of The Partnership Board and Dean of Harvard School of Public Health

The past year was one of the most encouraging I can remember in terms of improvements in the health of women and children. After many years when reducing the terrible toll of deaths in infants, small children and their mothers seemed frustratingly elusive, at last we saw evidence of real progress. We cannot and should not put too much faith in numbers alone, but when those numbers emerge from painstaking research by reputable scientists, they deserve our respect and attention. The numbers published in 2010 tell us that maternal and child deaths are going down, year by year, especially among some of the most vulnerable populations in the poorest countries of the world.



Understanding why these welcome reductions are occurring is key to accelerating them. This can best be achieved through a vibrant and continuous exchange of knowledge and expertise among the global health community, through working together, through searching unceasingly for ways to apply new knowledge and skills efficiently at the front-line of primary health care. This is the *raison d'être* of The Partnership for Maternal, Newborn & Child Health. In 2010 its contribution was demonstrated as never before. In facilitating the development of the Global Strategy for Women's and Children's Health, initiated by United Nations Secretary-General Ban Ki-moon and launched at the Millennium Development Goals (MDGs) Summit in New York on 22 September 2010, The Partnership has helped take the entire movement a great step forward.

As this report articulates, 2010 was a year of hope, and a year of action. There is a wonderful synergy between the two: hope spurs action, and action spurs hope. Evidence of real progress is the foundation for both. The Partnership, in its short lifespan, has found a place at the heart of this dynamic and is poised to act as a vital catalyst for future progress.

The evidence is not just numerical. It can also be seen in the increased commitment of governments, multilateral agencies, non-governmental organizations, health care professional associations, academic, research and training institutions and the private sector, and in increased funding from international donors. And behind the statistics and the politics lies the reality – scientifically proven interventions applied by dedicated health care workers are saving the lives of children and their mothers.

Very few of us ever have the chance to save a life, and yet for those across the field of public health, and especially in maternal and child health, it is a daily challenge. It is both a responsibility and a privilege. Those of us who make up The Partnership – our almost 400 members, representing many thousands of individuals – share that responsibility and that privilege.

As the Chairman of The Partnership Board, I welcome this report and the messages it conveys to everyone who has a role to play in one of the greatest public health missions of the 21<sup>st</sup> century. We owe it to every woman and every child at risk in the world today to redouble our efforts to protect them in the year ahead and for many years to come.

A handwritten signature in black ink, appearing to read 'Julio Frenk', written in a cursive style.

# Foreword by Dr Flavia Bustreo

Assistant Director-General for Family and Community Health, World Health Organization, and Former Director of The Partnership



**Dreams** do sometimes come true, but often only with hard work, commitment and belief. In September, the launch of the United Nations Secretary-General's Global Strategy for Women's and Children's Health, backed by more than US\$40 billion in commitments, capped an extraordinary year. June had seen the launch of the Muskoka Initiative at the G8 Summit in Canada – a direct outcome of Canadian Prime Minister Stephen Harper's personal drive to boost attention and resources for maternal, newborn and child health – Women Deliver, the Global Health Council conference and the Pacific Health Summit, which lay the groundwork for private sector commitments to the Global Strategy in September. And July had witnessed the African Union's Summit on Maternal, Newborn and Child Health, which produced a robust list of commitments, including the creation of a Task Force to report annually on progress on the continent.

It is all, indeed, a dream come true – the culmination of years of effort and advocacy work. The Partnership's Board deserves great credit for steering our contribution towards all of these achievements.

We must build on the momentum generated by the Global Strategy, which is the start of further pledges to come. As this report demonstrates, 2010 was truly a year in which the whisper of hope became the roar of action. So much happened in 2010 to encourage and revitalize our work. It has happened in the corridors of power at the United Nations and the G8. And it is happening on the ground, where scientific studies show that real progress is being made in reducing maternal and child deaths and safeguarding the health of women and children.

It has been my privilege to be Director of The Partnership from 2009 to very recently, and to witness our accomplishments – a personal dream come true. I am further deeply honoured to have been appointed by Dr Margaret Chan, Director-General of WHO, as her Assistant Director-General for Family and Community Health, from 1 October 2010. With other initiatives also announced recently within the Organization, it is wonderful to see WHO's heightened commitment to maternal, newborn and child health.

It is a pleasure to welcome my successor, Dr Carole Presern, as the new Director of The Partnership. With her excellent leadership skills and immense experience at the GAVI Alliance, DFID and its forerunner organization ODA, and in Nepal, Pakistan and Zimbabwe, I am confident that Carole will take The Partnership to new levels of achievement.

For me, as a new Board member of The Partnership, I look forward to a new relationship with our members, in which I am sure we will all work together more closely than ever for the fulfilment of the greatest dream of all – the health and well-being of every mother and every child in the world today. We can make this dream come true – together.

A handwritten signature in black ink that reads "Flavia Bustreo". The signature is fluid and cursive, with a large initial 'F'.

# How Country Partners see The Partnership today

## Shri Ghulam Nabi Azad

Minister of Health and Family Welfare, India



*Our meetings with The Partnership in India in 2010, to discuss MDGs 4 and 5 on reducing child mortality and improving maternal health, have been extremely valuable both nationally and internationally. Together we have also tackled some of the most important related issues in India. These include the importance of increasing midwifery training, improving the strength and coherence of advocacy messaging to reduce maternal and child deaths, promoting community and media monitoring, and addressing social determinants of maternal and child mortality in India, such as early marriage. During this year of very significant events, The Partnership has made a tremendous contribution towards progress. We look forward to even closer engagement with it in 2011 and beyond.*

## Professor C.O. Onyebuchi Chukwu

Minister of Health, Nigeria



*In many developing countries, women and children constitute about 70% of the population. Therefore maternal, newborn and child health addresses the greater proportion of the population. Our collective future depends on the health of our women and the healthy growth and development of our children. Unfortunately, both women and children continue to suffer preventable deaths. The Partnership for Maternal, Newborn & Child Health is part of the global response to this tragedy. It responds to a call for collective effort in addressing the neglect of the health needs of this constituency.*

*Fortunately, the intervention of The Partnership has contributed significantly to the gradual decline of the high maternal and infant mortality rates in several African countries. In Nigeria, we work closely with The Partnership on this noble mission, to do all we can to build on progress and to double our efforts in the coming years to further reduce maternal, newborn and child mortality.*

## Professor David Mwakyusa

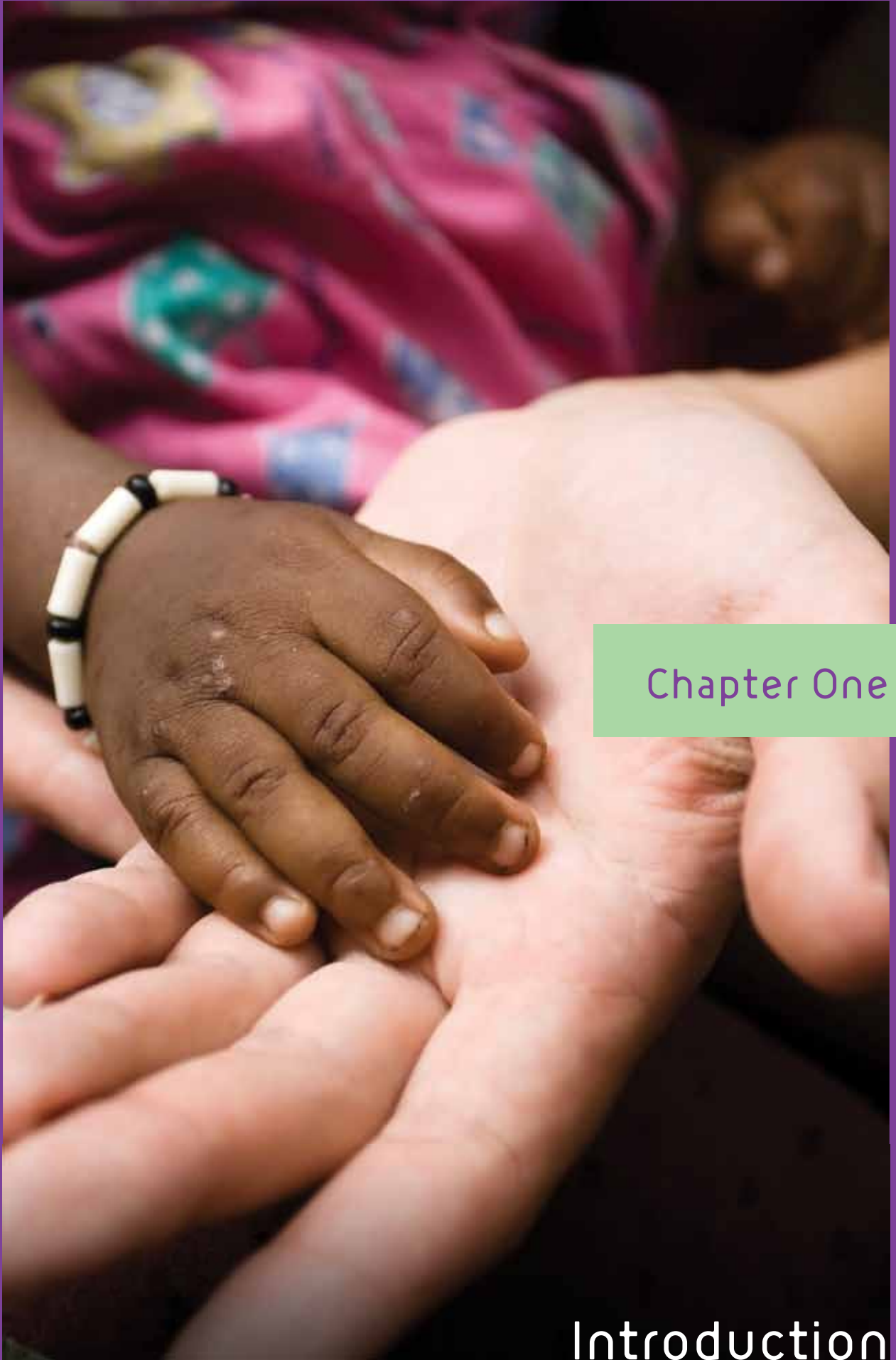
Former Minister of Health and Social Welfare, Tanzania



*There are good reasons to believe that further big improvements in maternal, newborn and child health can be achieved in the near future. We in Tanzania are in close collaboration with The Partnership to help bring these aspirations to reality. In our country, we have observed that the toll among children from HIV/AIDS, malaria and tuberculosis has been dramatically reduced during the last decade. These are among the most serious threats to mothers as well as children under five.*

*In the case of malaria, the use of insecticide-treated bed nets, a low-cost and relatively simple intervention, has helped reduce child mortality in the last few years. Tanzania will continue to advocate for donors to provide more life-saving funding, which has shown such encouraging results, and to lend its support to the expanding work of The Partnership for Maternal, Newborn & Child Health.*





## Chapter One

Introduction



# Introduction

**For millions** of the world's most vulnerable children and their mothers, 2010 was a year of hope. The Partnership for Maternal, Newborn & Child Health is witnessing – and helping to shape – historic developments. For The Partnership itself, 2010 was a breakthrough year. Its global status has risen dramatically. It has been more involved than ever in the key issues and events that affect women and children. And its work is winning support and appreciation among its partners at all levels, from international agencies to ministries of health to grassroots organizations.

## *A year of progress*

The year saw compelling evidence of real progress in the health of women and children. It also saw the launch of exciting new initiatives that promise further progress in the next few years.

Studies published in 2010 by United Nations agencies show encouraging progress on reducing maternal and child mortality. The estimated global number of deaths among children under five has fallen from 12.4 million in 1990 to 8.1 million in 2009. This represents a decline of one third, from 89 deaths per 1,000 live births in 1990 to 60 in 2009.<sup>1</sup>

These results largely confirmed the findings of a study by the Institute for Health Metrics and Evaluation (IHME) which found that the number of deaths among children under five had decreased from 11.9 million in 1990 to 7.7 million in 2010.<sup>2</sup>

At the same time, the number of women dying due to complications during pregnancy and childbirth has decreased by 34% – from an estimated 546,000 in 1990 to 358,000 in 2008.<sup>3</sup> This estimate is very similar to the findings of an IHME study published earlier in the year. It found a 35% reduction in maternal deaths between 1980 and 2008, from 526,300 to 342,900.<sup>4</sup>

In a commentary, the editor of *The Lancet*, Dr Richard Horton, said: *“The overall message, for the first time in a generation, is one of persistent and welcome progress. Women have long delivered for society, and, slowly, society is at last delivering for women. This is a moment to celebrate.”*<sup>5</sup>

Few years in recent memory have held such promise. Seldom have such opportunities beckoned. And at the heart of events during this year of accelerating action, striving to push the health of women and children to the very top of the development agenda, was The Partnership for Maternal, Newborn & Child Health.

This publication seeks to show what The Partnership is – its vision, its mission, its objectives. It sets out to demonstrate The Partnership's relevance at the centre of one of the greatest health challenges of the 21<sup>st</sup> century. And it aims to describe the work of The Partnership amid the fast-moving global developments in maternal, newborn and child health (MNCH) today – citing the latest available research, outlining the most recent initiatives and covering the outcome of the biggest “milestone” meetings of 2010. In short, this report illustrates how The Partnership is active and responsive wherever it hears the voices of women and children calling for help.

*“Women have long delivered for society, and, slowly, society is at last delivering for women. This is a moment to celebrate.”*

Dr Richard Horton, *The Lancet*

# The Partnership

was launched in September 2005 after a period of several years during which international attention on the health of women and children had grown steadily. The increased attention was partly due to the work of previous partnerships such as the Child Survival Partnership, Partnership for Safe Motherhood and Newborn Health, and the Healthy Newborn Partnership, which merged into The Partnership. Other important processes included the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995. A growing consensus about the need for action and increasing levels of advocacy and political engagement culminated in the MDGs and in The World Health Report 2005 – Make Every Mother and Child Count as well as *The Lancet* Series on Child Survival, Maternal and Newborn Survival, and Sexual and Reproductive Health. The work of leading experts in the field, such as Zulfiqar Bhutta, Jennifer Bryce, Wendy Graham, Joy Lawn, and Cesar Victora, was reported in *The Lancet* series and was another critical piece in building awareness of the health of women and children.

### *Collaboration*

There was also a growing recognition that real advances required much closer collaboration among the numerous communities dedicated to one aspect or another of MNCH. These groups – ranging from donors and funding agencies to doctors, midwives and nurses, scientists and academics – seldom worked together in an organized way. The result was that a wealth of individual knowledge, experience and expertise was often inadequately shared and that great potential benefits were being wasted.

### *Leadership*

Many leaders in the MNCH community saw the need for closer collaboration, including Kul Gautam of UNICEF, The Partnership's founding Chair, Joy Phumaphi, then Vice President at the World Bank, who became its Chair from 2007 to 2009, and Francisco Songane, The Partnership's first Director.

Launching The Partnership was therefore a determined effort to forge an alliance of key organizations and groups. Its six main constituencies, represented on its Board, are:

- (i) donors and foundations
- (ii) partner countries
- (iii) multilateral organizations
- (iv) non-governmental organizations
- (v) health care professionals; and
- (vi) academic, research, and training institutes

Constructing such a Partnership – bringing together partners with different comparative advantages and strengths to row in the same direction and towards the same set of goals – was challenging but also highly rewarding. It has taken time, energy and patience for all the constituencies to learn to trust, share and work together, arriving at the current high levels of cooperation.

## Vision, mission and objectives

**The vision** and goals of The Partnership were first outlined in the Delhi Declaration of 2005 – a landmark statement produced by Lives in the Balance: The Partnership Meeting for Maternal, Newborn and Child Health, held in New Delhi, India, in that year. Participants included ministers and delegations from 12 governments, United Nations agencies, the World Bank, foundations, national and international NGOs, professional bodies, academic institutions and civil society representatives.

The Partnership's *vision* is a world where all women and children receive the care they need to live healthy, productive lives.

The Partnership's *mission* is to support the global health community in working successfully towards achieving MDGs 4 and 5. This is to be done by promoting collaboration between partners, drawing on their comparative advantages and ensuring maximum use of shared knowledge in the pursuit of three main *objectives*:

- *Build* consensus on and promote evidence-based, high-impact interventions and means to deliver them through harmonization;
- *Contribute* to raising funds to improve maternal, newborn and child health through advocacy; and
- *Track* partners' commitments and measure progress.



## Conceptual and institutional framework

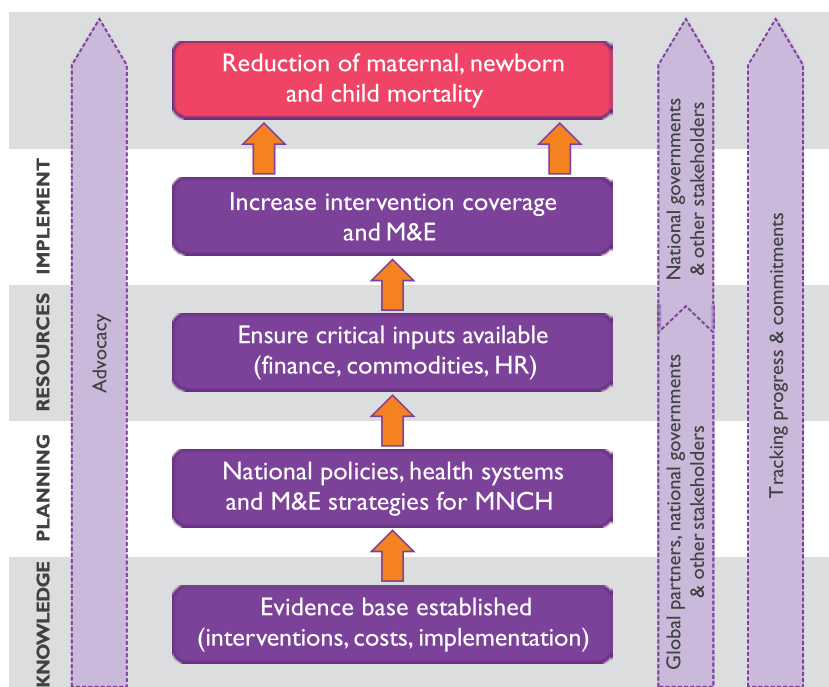
**The Partnership** works within internationally agreed frameworks, including the International Conference on Population and Development (ICPD) Programme of Action, the Fourth World Conference on Women (FWCW) Platform for Action, the Convention on the Rights of the Child (CRC), the United Nations Special Session on Children, and the MDGs. The Partnership approved its Conceptual and Institutional Framework and Guiding Principles in 2005.

## The “partner-centric” approach

**The Partnership** has now almost 400 members, representing: (i) donors and foundations; (ii) partner countries; (iii) multilateral organizations; (iv) non-governmental organizations; (v) health care professionals; and (vi) academic, research, and training institutes. It is committed to a “partner-centric” approach, which means that partners take the lead in implementing elements of the workplan approved by the Board. This approach is fully reflected in the 2009-11 workplan, which was approved after an external review of The Partnership in 2008. This led to a number of strategic changes in the structure, operational principles and activities. In this workplan, the Board defined the types of activity that The Partnership would undertake during 2009-2011 as follows:

- Defining **core packages of interventions**, including identification of the funding levels needed to achieve universal coverage of these interventions (feeding into the “knowledge” step of the framework for action shown in Figure 1);
- Carrying out an **advocacy drive** to promote policies and resources that advance the achievement of MDGs 4 and 5 (feeding into the “resources” step); and
- Focusing on **accountability**, in order to monitor whether partners and countries follow through on commitments made and to track the coverage and impact of MNCH programmes.

Figure 1. Framework for stakeholder action



## Priority action areas

**In order** to give the best support to global action for MDGs 4 and 5 and to streamline contributions by its members, The Partnership identified six priority action areas for 2009-2011:

1. MNCH knowledge management system
2. MNCH core package of interventions
3. Essential MNCH commodities
4. Strengthening human resources for MNCH
5. Advocacy for increased funding and for better positioning of MNCH in the development agenda
6. Monitoring of commitments and progress towards MDGs 4 and 5.

The progress The Partnership has made in these areas during 2010 is summarized in Chapter 2.

## The continuum of care

**The cornerstone** of The Partnership's work is the concept of a "continuum of care", where all aspects of MNCH are addressed in an integrated fashion, rather than as separate and unconnected elements. It provides an invaluable framework for assessing health services and for identifying resource shortages and gaps in provision. This concept also recognizes the essential linkages between the health of women, newborns, and children. It reflects the need to make services more responsive to the needs and priorities of women and their families, as well as recognizing the greater efficiency and effectiveness that can be achieved through integrated services. Providing MNCH services through a continuum of care approach is more cost-effective and brings about a greater impact on health.<sup>6,7</sup> The continuum concept is at the heart of The Partnership's approach to the challenges of MDGs 4 and 5.

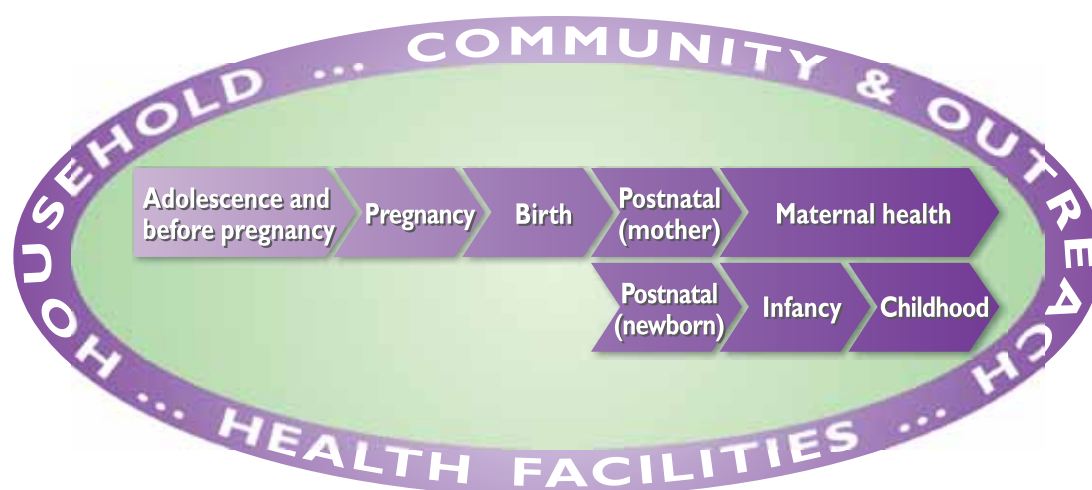
These issues were discussed in The Partnership's Strategy and Workplan 2009-2011. It described how MNCH policies and interventions are often developed independently of each other and are not properly integrated in national health development plans. This leads to MNCH services – for example nutrition supplementation programmes, or reproductive health advice – being planned and delivered vertically, as a series of separate interventions. Understanding that these services are part of a single continuum can yield enormous benefits – in greater efficiency and reduced costs, and in more coherent and comprehensive provision.

Figure 2 shows the continuum of care and illustrates its two key dimensions: *time* of caregiving, and *place* of caregiving.

The **time dimension** emphasizes the continuity between the different phases in the lives of women and their children – from adolescence through pregnancy and birth, into the neonatal and post-neonatal periods (the most dangerous time of infants' lives) and on into childhood. Interventions throughout the life-cycle need to be linked.

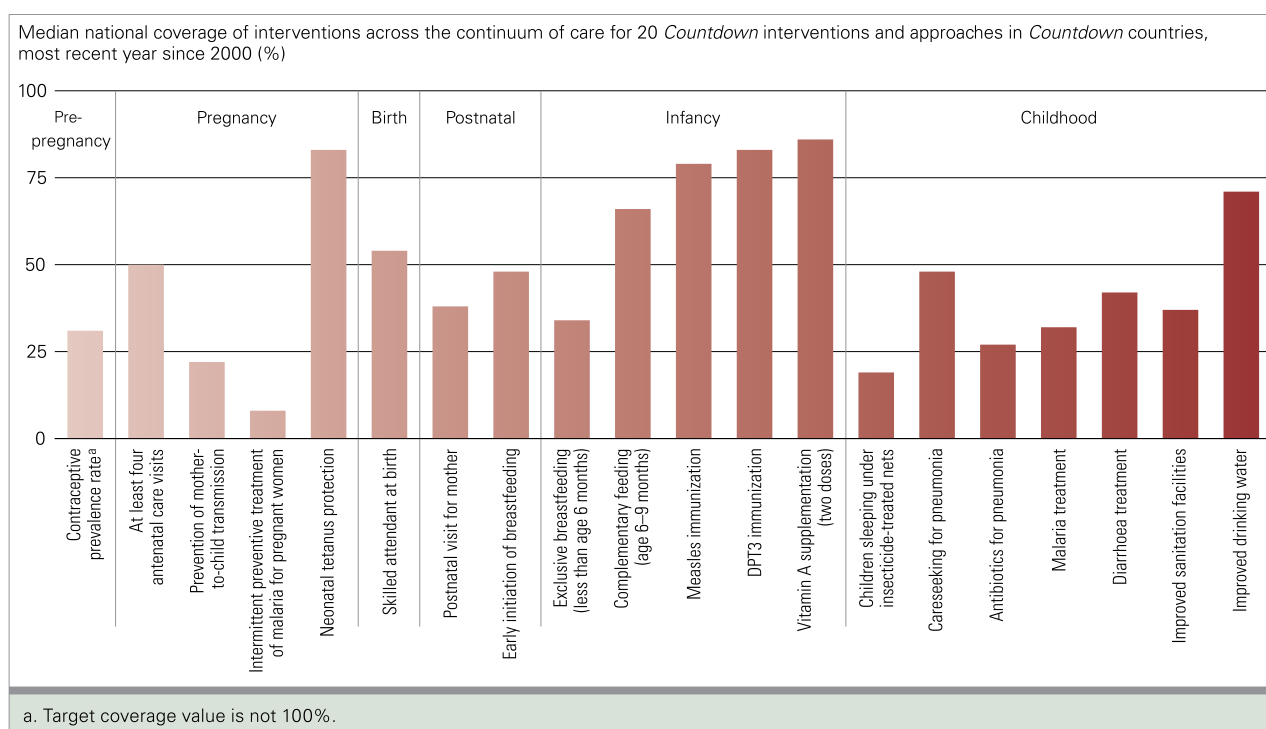
The **place dimension** of the continuum is about linking together the different settings in which MNCH interventions take place – households, communities, and health facilities. The needs of women and children should be understood and provided for at each of these levels.

Figure 2. The continuum of care



The continuum of care concept is crucial not only for planning and implementing interventions, but also for **policy and advocacy**. It provides a clear framework for the development of messages and strategies and can bring much-needed cohesion to the wide range of groups engaged in the effort of persuading policy-makers to act. Finally, the continuum of care can help in **mobilizing increased investment in health** by identifying gaps in programmes and shortfalls in resources. Increased investment in health systems is needed to improve the **coverage of interventions** across the continuum of care.

Figure 3. Coverage for interventions across the continuum of care<sup>8</sup>



Source: Countdown to 2015

## Reasons for hope

**Advocacy** for MNCH – the very essence of The Partnership – is at last beginning to pay off, and closer international collaboration in this field is producing life-saving results.

Whether working discreetly behind the scenes or joining global health leaders on centre stage, The Partnership was extraordinarily active throughout 2010, as the next chapter and the annex to this report illustrate. It carried out important work in reviewing evidence, in building consensus, in carefully documenting and disseminating valuable country case studies and in promoting the development and sharing of knowledge. It made its mark across the globe, in Bangladesh, Canada, India, Italy, Uganda, the United States and many other countries, strengthening existing networks and building important new ones, raising money and awareness in equal measure.

The following chapters show that many individual Partnership partners, as well as The Partnership as a whole, were crucially involved in shaping many developments in MNCH during 2010. These included the vital funding commitments of the G8 Summit in Canada through the Muskoka Initiative; the important steps forward that emerged from the African Union Summit on Maternal, Infant and Child Health and Development in Uganda via the Kampala Declaration; and the drafting and launch of the United Nations Secretary-General's Global Strategy for Women's and Children's Health.





## Chapter Two

Our Core Areas of Work



# Our Core Areas of Work

**This chapter** sets out the major accomplishments in 2010 in The Partnership's major areas of work.

See the annex to this report for a month-by-month recap of events and activities.

These milestones were founded on the effective work of many partners over the five-year history of The Partnership. Just a few of the instrumental moments during the previous years have included:

- The development and launch of the MNCH Consensus (2009), forging widespread agreement on the key pillars to be achieved to reach the health MDGs, and the inclusion of MNCH in the G8 Communiqué at L'Aquila in June 2009.
- The successful positioning of MNCH as an important investment target at G8 meetings in Japan (2008) and Italy (2009). This was followed by an all-party resolution in the Canadian parliament (2009) that promoted Canadian support for the Muskoka Initiative at the 2010 G8.
- Support to the work of the High-Level Taskforce on Innovative International Financing for Health Systems (2009), which outlined the financial resources needed to reach the health MDGs targets, as well as new financial mechanisms to channel resources towards those goals.
- The development and launch of the Asia-Pacific Investment Case at the Annual Meeting of the Asian Development Bank (2009). The investment case, which positions the importance of investing in MNCH to accelerate socioeconomic development, was developed in collaboration with the MNCH Network for Asia and the Pacific.
- Support to the Countdown to 2015 report and meeting (2008), where the latest Countdown findings were presented to the Inter-Parliamentary Union annual assembly meeting in Cape Town, highlighting the important role of national parliaments in reaching our goals.
- The costing tools review (2008), facilitated by The Partnership, brought together developers and users to address the harmonization of costing tools. This catalyzed agreement that the United Nations agencies and partners would develop a joint tool for estimating costs and impact of health interventions, which will be useful to the H4+ (UNFPA, UNICEF, WHO, World Bank, UNAIDS) support provided at country level.
- Four successful regional capacity-building workshops (2007-2009) in Bangladesh, Burkina Faso, Jordan, and Malawi to support more than 200 health care professional associations to engage in national planning and budgeting processes related to MNCH.

## Priority Area 1:

### The MNCH knowledge management system

Lead partners: India, World Bank, Harvard School of Public Health

By synthesizing the evidence and making relevant knowledge products accessible to stakeholders within the MNCH community, we can inform the design and implementation of policies and programmes for moving high-burden countries closer towards achieving MDGs 4 and 5. Currently information on MNCH is scattered over diverse sources, is of varying quality, and is not always easily accessible. A knowledge management system is being developed to share consensus on the content, delivery strategies and utilization of a core package of MNCH interventions to be delivered at each level of the health system across the continuum of care. The system comprises several products, including:

**Knowledge Summaries** In 2010, the publication *Sharing Knowledge for Action on Maternal, Newborn and Child Health* was developed with the University of Aberdeen and other partners. The publication covers 12 topics cutting across the continuum of care and was launched at the Partners' Forum in New Delhi on 13-14 November 2010. The MNCH knowledge portal (see below) is intended as a vehicle for sharing updated summaries and new summaries as additional topics are identified.

**MNCH Knowledge Portal** A web portal has been developed and launched: <http://portal.pmnch.org/>. Through this portal, The Partnership provides a systemic mechanism or gateway, giving partners access to MNCH knowledge resources and expert networks, such as the Maternal Health Task Force<sup>9</sup> and Saving Newborn Lives<sup>10</sup>, and builds on the commitment of partner organizations to share and translate knowledge to promote policies and practice that in turn promote MNCH.

#### Activities in 2011:

- Multi-country and multi-disciplinary policy analysis and synthesis study, including quantitative analysis and case studies. The study aims to identify what constitutes successful leadership in making progress towards MDGs 4 and 5.
- Expansion of MNCH knowledge portal, bringing together knowledge summaries of evidence on essential interventions and strategies required to achieve MDGs 4 and 5. This includes the development of decision-support resources and tools to support MNCH planning, implementation, and evaluation.
- A "South-South" learning workshop focusing on MNCH management and implementation challenges to facilitate learning across countries and strengthen policies and programmes for women's and children's health.

## Priority Area 2:

### MNCH core package of interventions

Lead partners: WHO and Aga Khan University, Pakistan

**Effective** evidence-based interventions that can be delivered through proven delivery mechanisms are fundamental to improving MNCH outcomes. Evidence on the effectiveness of interventions is readily available today. However, there is no classification of these interventions based on the strength of the evidence that proves their effectiveness and the soundness of their delivery mechanisms. In resource-constrained areas, service providers should be in a position to identify and focus resources on delivering the most effective interventions. As such, in 2010 The Partnership sought to build consensus on effective interventions for MNCH by establishing a multi-constituency team to undertake this work, consisting of WHO, researchers, developers of national health plans, and service providers.

The team classified levels of evidence for MNCH interventions using only published systematic reviews. They used the following widely recognized categorization system: A = interventions that are beneficial; B = interventions likely to be beneficial; C = interventions with a trade-off between beneficial and adverse effects; D = interventions of unknown effect, including absence of reviews; E = interventions likely to be ineffective or harmful. The A-graded interventions can be accessed through the following link:

[http://www.who.int/pmnch/activities/interventions/20100720\\_pa2meeting\\_conclusions.pdf](http://www.who.int/pmnch/activities/interventions/20100720_pa2meeting_conclusions.pdf)

The team classified interventions at the following three levels of delivery: (i) community level/home; (ii) first level/outreach; and (iii) referral level.

The multi-constituency team recommended packages of A-graded interventions at the three delivery levels. It also identified gaps in evidence and has commissioned systematic reviews of the evidence on case management of childhood meningitis for infants aged 2-59 months, continued breastfeeding up to 2 years, case management of severe acute malnutrition and post-abortion care, and landscape reviews of training in emergency obstetric care and financial support platforms.

#### Activities in 2011:

- Studies will be commissioned to help strengthen and sharpen recommendations for core packages of MNCH interventions, and their implementation, that can deliver the most effective care for women and their children.

## Priority Area 3:

### Essential MNCH commodities

Lead partners: UNFPA and UNICEF

**Commodity** security is an essential dimension of health systems. Investing in the provision of inexpensive and safe drugs for acute respiratory infections, diarrhoeal diseases, tuberculosis, and malaria could save up to 10 million lives in developing countries. Yet the availability of commodities remains low. In Africa, 50% of the population does not have access to essential drugs. A lack of drugs, medical devices, and equipment, as well as inefficient use of available resources, compromises the ability of health systems to provide efficient and quality health care to women and children. There are several points in the supply chain at which barriers to availability and efficient use of resources can develop: manufacturing, forecasting, purchasing, transporting, and storing commodities.

Knowledge about MNCH-related commodity bottlenecks exists, but is not systematically available in one space and has not been analyzed to define the most salient issues related to MNCH procurement and supply. To respond to this gap, UNFPA and UNICEF are developing a resource library on MNCH commodity research and information, which will be integrated into The Partnership's knowledge portal.

Partners are also undertaking a review and analysis of existing procurement and supply management (PSM) tools related to MNCH, including reproductive health. The study is gathering and making available information on all available PSM tools and also identifies gaps, which will inform better use of existing tools and make recommendations on the development of new tools and further research.

The Partnership has also supported Population Action International in conducting studies on critical barriers to accessing maternal health supplies in Uganda and Bangladesh. The studies trace the availability of four commodities that reduce maternal mortality: oxytocin, misoprostol, magnesium sulphate and manual vacuum aspirators, and assess the policy environment, financing, procurement and partnership. The studies identify key issues related to commodity security and provide advocacy entry points for addressing some of these bottlenecks and continuum of care issues in policy and service delivery.

#### Activities in 2011:

- Support to countries for adoption of country-specific minimum packages of MNCH commodities and implementation of PSM guidelines and tools.

## Priority Area 4:

### Strengthening human resources for MNCH

**Lead partners: WHO, International Federation of Gynecology and Obstetrics (FIGO), International Confederation of Midwives (ICM), International Pediatric Association (IPA)**

#### Effective planning and management of human resources is a key component in the success of MNCH strategies.

Insufficient quantity and quality of human resources is considered one of the major impediments to reaching the health MDGs. Achieving universal coverage of MNCH services will require an additional 2.5 to 3.5 million health care workers globally.<sup>11</sup> Delivering any in-country strategy on improving MNCH will require not only additional quantities of health workers, but also strengthened human resources capacity. Priority Area 4 works towards integrated human resources planning as part of national MNCH plans to ensure that MNCH skills and knowledge gaps within human resources management are adequately addressed.

A systematic review of human resources for health (HRH) interventions to improve MNCH, and a mapping of the integration of HRH for MNCH in national health planning, commissioned by The Partnership, identified a lack of integration of MNCH HRH dimensions in planning.<sup>12</sup> The Royal Tropical Institute in Amsterdam is defining a checklist to be used by planners in countries to ensure consideration of MNCH dimensions in HRH planning, such as incentives for skilled birth attendants.

The Partnership has also collaborated with the Global Health Workforce Alliance (GHWA) to ensure visibility and increased understanding of human resource issues in Countdown to 2015 and the Global Strategy for Women's and Children's Health.

The Partnership also promotes and supports increased and sustained involvement of health care professional associations (HCPA) in national health planning and programming processes by bringing together associations for capacity-building and knowledge-sharing through regional workshops. The Partnership's fifth regional workshop took place in 2010 in Latin America. For details, see the August section of the annex to this report.

FIGO, IPA and ICM have supported follow-up meetings in selected countries that participated in the workshops. These meetings have assessed progress on the implementation of workplans and revised them accordingly. Countries have reported differing levels of progress. For example, Niger has completed implementation, while the Democratic Republic of Congo has not continued joint activities in countries as planned. Key constraints identified have been the lack of funding and technical support, over-committed focal points, and weak institutional capacity. An impact evaluation of the first three workshops is currently under way and will define the added value of the regional workshops and make recommendations about how to strengthen the process.

#### **Activities in 2011:**

- Country-level piloting of the checklist for human resources for MNCH.
- Support for national implementation of HCPA workplans.

## Priority Area 5:

### Advocacy for increased funding and better positioning of MNCH in the development agenda

Lead partners: Family Care International, Norad (2009, 2010), UK Department for International Development (2011)

**The Partnership's** vigorous advocacy for improved funding during 2010 is documented in subsequent chapters. The following points summarize some of this work. The Partnership has contributed significantly to the increased visibility of MNCH and its movement towards the top of the development agenda. Through its participation in the High-Level Taskforce on Innovative International Financing for Health Systems and other forums, The Partnership has helped identify and call for the health systems investments needed to achieve MDGs 4 and 5. This work by the High-Level Taskforce was instrumental in the financial analysis of the Global Strategy for Women's and Children's Health. Effective channels for funding and innovative ways to increase financial resources for MNCH are continuously being identified and promoted. The Partnership has helped to develop and implement global, regional and national advocacy strategies. By mobilizing partners and serving as a platform for greater coordination, it has promoted greater consistency in messaging, more effective collaboration among advocacy partners, and more effective targeting of key actors and policy-makers around high-level global events and regional and national events.

In addition to working closely with the MNCH advocacy community, The Partnership in 2010 cultivated deeper relationships with parliamentarians and the media.

The Inter-Parliamentary Union (IPU) has been an important partner in this process. Following successful presentations of Countdown to 2015 data at the IPU's 2008 and 2009 annual assemblies, The Partnership was invited by the IPU to organize a plenary panel at the 2010 annual assembly in Bangkok, in which the important budgeting, legislative and representational roles of parliamentarians were highlighted in relation to the needs set out in the MNCH Consensus. This was followed in July 2010 by the co-publication of *Taking the Lead – Parliamentarians Engage with Maternal, Newborn and Child Health*,<sup>13</sup> a report based on joint field research and analysis in 2009-2010. This report was launched at a global meeting of women speakers of parliament, hosted by the Swiss parliament in Bern in July 2010.

Media engagement was another major theme of this past year. Capitalizing on the many important advocacy events and data reports of 2010, The Partnership launched a series of dedicated press campaigns to highlight new evidence of progress and collaboration, both at global and regional levels. Results included coverage of The Partnership in a wide range of top newspapers and media outlets, including the front page of *The New York Times*, as well as a global public service announcement screened around the world on CNN International.

#### Activities in 2011:

- To advance the aims of the Global Strategy, The Partnership will seek to mobilize additional financial, policy and service delivery commitments for MNCH. This will include, for example, the opportunity of key events on the advocacy calendar such as the G8/G20 in France, the World Health Assembly and the 2011 UN General Assembly to highlight the implementation of current commitments and new pledges.
- Increasing focus on country and regional advocacy, including greater capacity development for advocacy in support of the Global Strategy.
- Analysis of the aid architecture for MDGs 4 and 5 and options for more efficient funding channels for MNCH, with key academic and development partners.
- Support for the secondment of a dedicated MNCH officer to the IPU secretariat. This officer will be responsible for leading the planning and execution of joint projects, including work on capacity building involving national parliamentarians.
- Media campaigns linked to key moments on the advocacy calendar, including the launch of new global stillbirth data in the Lancet (April 2011), the 10<sup>th</sup> anniversary of the Abuja Declaration (April 2011), the release of the State of the World's Midwifery Report (June 2011), and the launch of The Partnership's own research report on the Global Strategy commitments (September 2011).



## Priority Area 6:

### Tracking progress and commitment for MNCH

Lead partners: World Bank, UNICEF, Aga Khan University

## Funding commitments

are frequently made at meetings and high-level forums. With regards to funding for MNCH, however, there has been little or no systematic follow-up on the delivery of these pledges. The Partnership is well placed to facilitate tracking of pledges and link with global and national advocacy partners to hold donors, agencies and governments accountable. The Partnership's role in tracking and accountability is discussed further in the following chapters on progress in 2010 relating to the G8, Africa, and the Global Strategy for Women's and Children's Health.

A fundamental element of The Partnership's accountability effort is its investment in, and commitment to, Countdown to 2015.<sup>14</sup> Countdown is an independent network of experts from academia, United Nations agencies, donors, governments, health care professional associations, and civil society organizations. The objectives of Countdown are to support effective scaling up of MNCH interventions and to contribute to holding governments, donors and other stakeholders to account. It does so by providing data on intervention coverage, equity, financial flows, and policies and systems to inform monitoring and decision making in 74 priority countries (accounting for 97% of maternal and child mortality).

Every 2-3 years it publishes the Countdown report, including country profiles, and organizes a conference to present findings and stimulate dialogue with policy-makers, scientists and other stakeholders. The next conference will be held in 2012. The Countdown also publishes articles in *The Lancet* and other high-impact journals.

The Partnership has several roles in Countdown to 2015:

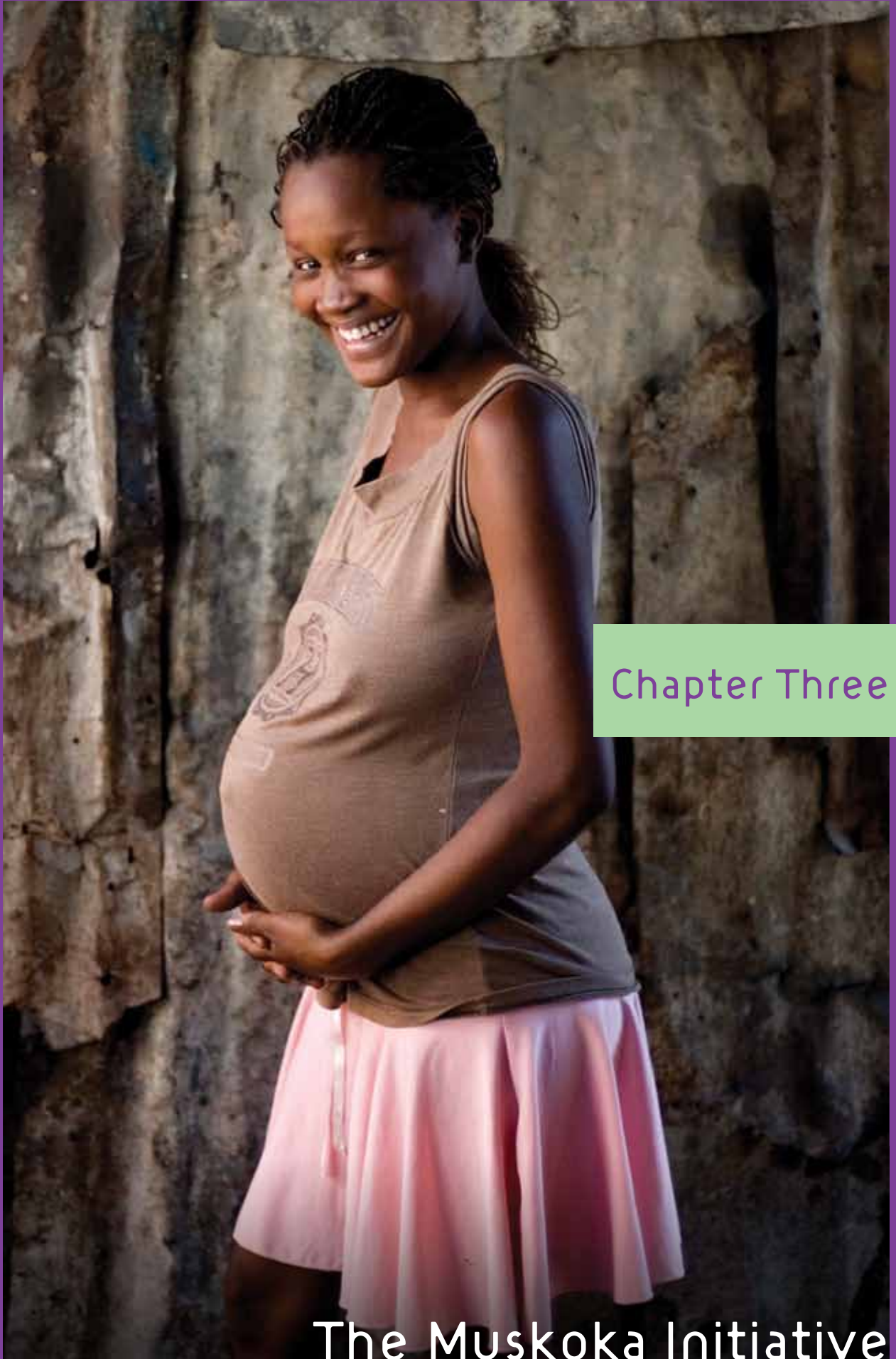
- It assists with the dissemination of findings and policy recommendations by supporting the production of the Countdown report, the organization of the conference, and the development of advocacy and media materials.
- It contributes to research carried out by the technical working groups.
- It links the Countdown with the constituencies of The Partnership itself. For example, the 2008 Countdown conference was organized in conjunction with the annual assembly of the Inter-Parliamentary Union (IPU) in Cape Town. In 2010, the Countdown conference was held in conjunction with Women Deliver, enabling interaction with a diverse and broad-based audience committed to strengthening the health of women and children.
- It performs many secretariat functions for the Countdown, including the facilitation of meetings of the Countdown coordinating committee, the technical subcommittee and its working groups, and the advocacy and event subcommittee.



**Activities in 2011:**

- The Partnership will develop a progress report on the financial, policy, and service delivery commitments made to the Global Strategy in 2010, which will be launched at the time of the United Nations General Assembly in September 2011. The report will complement the work of the Commission on Information and Accountability for Women's and Children's Health.<sup>15</sup> The report takes forward The Delhi Declaration 2010, agreed at the Partners' Forum held in November 2010, which affirmed that The Partnership "is an active participant to track commitments and results and thus ensure mutual accountability".
- The Partnership will also contribute to accountability for women's and children's health through the ongoing work of Countdown to 2015, and through its collaboration with the Inter-Parliamentary Union.





## Chapter Three

The Muskoka Initiative

# The Muskoka Initiative

**In January** 2010, Canadian Prime Minister Stephen Harper announced that Canada, as host of the 2010 G8 Summit, would lead a major initiative to improve the health of women and children around the world.

This was a moment savoured by The Partnership, which had worked steadily over the previous three years to elevate G8 and Canadian attention to MNCH issues. Beginning with advocacy at the 2008 G8 Summit in Japan and continuing through the 2009 G8 Summit in L'Aquila, Italy, which succeeded in the recognition of the Maternal, Newborn and Child Health Consensus in the outcome communiqué, The Partnership was instrumental in focusing the attention of G8 member states on the need to accelerate progress on MDGs 4 and 5.

Specific contributions were made in Canada, where Partnership board members and partners such as Andre Lalondé (Society of Obstetricians and Gynaecologists of Canada) and Bridget Lynch (International Confederation of Midwives) lobbied successfully for an all-party resolution in June 2009 calling for greater Canadian support to MNCH. Then, to maximize attention to MNCH issues on the eve of the Canadian G8 presidency, The Partnership held its December 2009 board meeting in Ottawa, which included a parliamentary briefing breakfast on MNCH issues.

The January 2010 announcement of MNCH as the top issue of the Canadian G8 presidency in 2010 was therefore a significant marker of success for The Partnership's advocacy efforts. Dorothy Shaw, appointed as The Partnership's spokesperson in Canada during the run-up to the June 2010 Muskoka Summit, was instrumental in leading the advocacy effort within Canada, advising and informing civil society partners, the media, and the Canadian government during the development of the initiative.

To support the implementation of the Muskoka Initiative, The Partnership has seconded Sonya Rabeneck, formerly of The Partnership secretariat in Geneva, as Special Adviser to the President of the Canadian International Development Agency (CIDA).

The Muskoka Initiative generated pledges of US\$5 billion of additional funding for MNCH for disbursement in 2011-2015. The Initiative also drew the support of non-G8 countries, including the Netherlands, New Zealand, Norway, the Republic of Korea, Spain and Switzerland, and of the Bill and Melinda Gates Foundation and the United Nations Foundation. These countries and organizations together pledged US\$2.3 billion of additional funding over the same period.

Based on estimates from WHO and the World Bank, the G8 leaders stated that the accumulated funding for 2010-2015 would help developing countries to achieve the following:

- Prevent 1.3 million deaths of children under five years of age
- Prevent 64,000 maternal deaths
- Enable 12 million additional couples to access modern methods of family planning

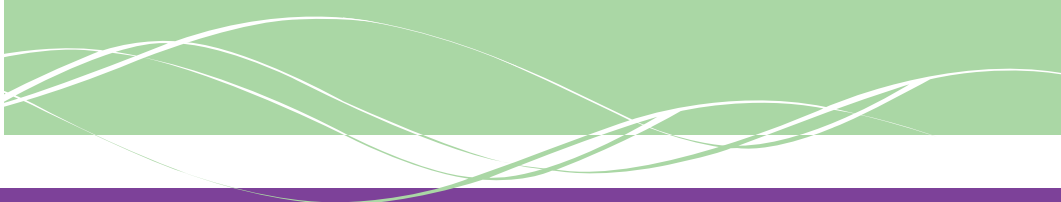
*In January 2010, Canadian Prime Minister Stephen Harper announced that Canada, as host of the 2010 G8 Summit, would lead a major initiative to improve the health of women and children around the world.*

The Initiative relates to MDGs 4 and 5, and to elements of MDGs 1 (nutrition) and 6 (HIV/AIDS, malaria and tuberculosis). It focuses on strengthening health systems in developing countries facing high burdens of maternal and under-five child mortality and unmet need for family planning.

The Initiative will support efforts by the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance to implement – in close coordination with WHO and others – a joint platform for health systems funding.

*“We reaffirm our strong support to significantly reduce the number of maternal, newborn and under five child deaths as a matter of immediate humanitarian and development concern. Action is required on all factors that affect the health of women and children. This includes addressing gender inequality, ensuring women’s and children’s rights and improving education for women and girls. Support from the G8 is catalytic. We make our commitments with the objective of generating a greater collective effort by bilateral and multilateral donors, developing countries and other stakeholders to accelerate progress.”*

The official communiqué of the G8 Muskoka Summit  
(June 2010)





## Chapter Four

The Kampala Declaration:  
Moving Ahead on MNCH by 2015

# The Kampala Declaration: Moving Ahead on MNCH by 2015

## For the African continent, and particularly for the countries of sub-Saharan Africa, there

are signs that the health of women and children is improving. Research published in 2010 showed progress on MDGs 4 and 5, with evidence of declines in maternal and child mortality levels. These declines are long overdue. Africa accounts for just 11% of the world's population, but it suffers more than half of the world's maternal and child deaths.

The maternal mortality ratio in sub-Saharan Africa decreased from 870 per 100,000 live births in 1990 to 640 in 2008.<sup>16</sup> The absolute number of women dying due to complications during pregnancy and childbirth increased slightly – from an estimated 199,000 in 1990 to 204,000 in 2008. These deaths stem from four major causes: severe bleeding after childbirth, infections, hypertensive disorders, and unsafe abortion. The mortality rate among children under five in sub-Saharan Africa fell from 180 per 1,000 live births in 1,990 to 129 in 2009.<sup>17</sup> The absolute number of deaths remained at 3.9 million in 2009.

MDGs 4 and 5 were the focus of the African Union Summit on Maternal, Infant and Child Health and Development, held in July 2010 in Kampala, Uganda. The Partnership was engaged from the beginning of 2010 in preparing for the Summit. This meant forging new relationships with many organizations and participants, including ambassadors and ministers of health, women's affairs, finance and foreign affairs. The aim throughout was to build the case for greater investment in the health of African women and children.

Among the most important of these new links was the collaboration between The Partnership and the African Public Health Alliance (APHA). APHA leads the 15%+ Campaign, which lobbies national governments to keep to their 2001 Abuja commitment to invest 15% of national budgets in health spending. Through APHA and its coordinator, Rotimi Sankore, The Partnership became actively involved in the lead-up to the Summit and contributed to shaping the messages that came out of the various pre-Summit meetings.

The Partnership also joined forces with the Harmonization for Health in Africa group – which includes the African Development Bank, UNAIDS, UNFPA, UNICEF, USAID, WHO, JICA and the World Bank – to develop an African Investment Case known formally as Investing in Health for Africa. This document seeks to bridge the communication gap between health and non-health actors by positioning spending on health as an investment as opposed to a cost; outlining the required additional investment in sub-Saharan Africa for meeting the health MDGs, including MDG 6 on HIV/AIDS, malaria and tuberculosis; and recommending means of increasing the impact of investment and efficiency of health spending. The Investment Case aims to:

- *Focus* attention and resources on health investments that work, to assist African leaders and their regional and global partners;
- *Provide* an evidence-based resource for ministries of health as they make the case to finance ministries, national parliaments and other key stakeholders for health sector investment; and

*The African Union Summit ended with a decisive move forward that should contribute to further notable improvements in the health status of women and children on the continent.*

- *Mobilize* leadership at the national, regional and global levels to support national health systems in their efforts to achieve better health and economic development outcomes for the people they serve.

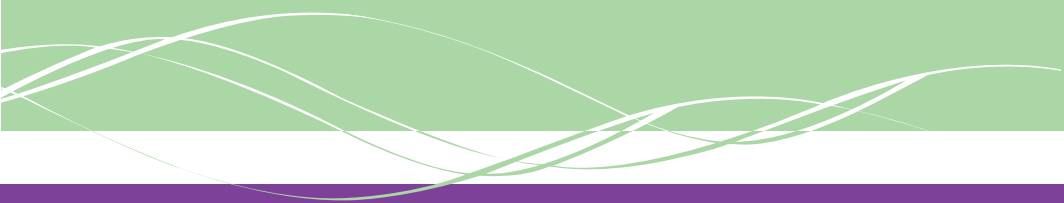
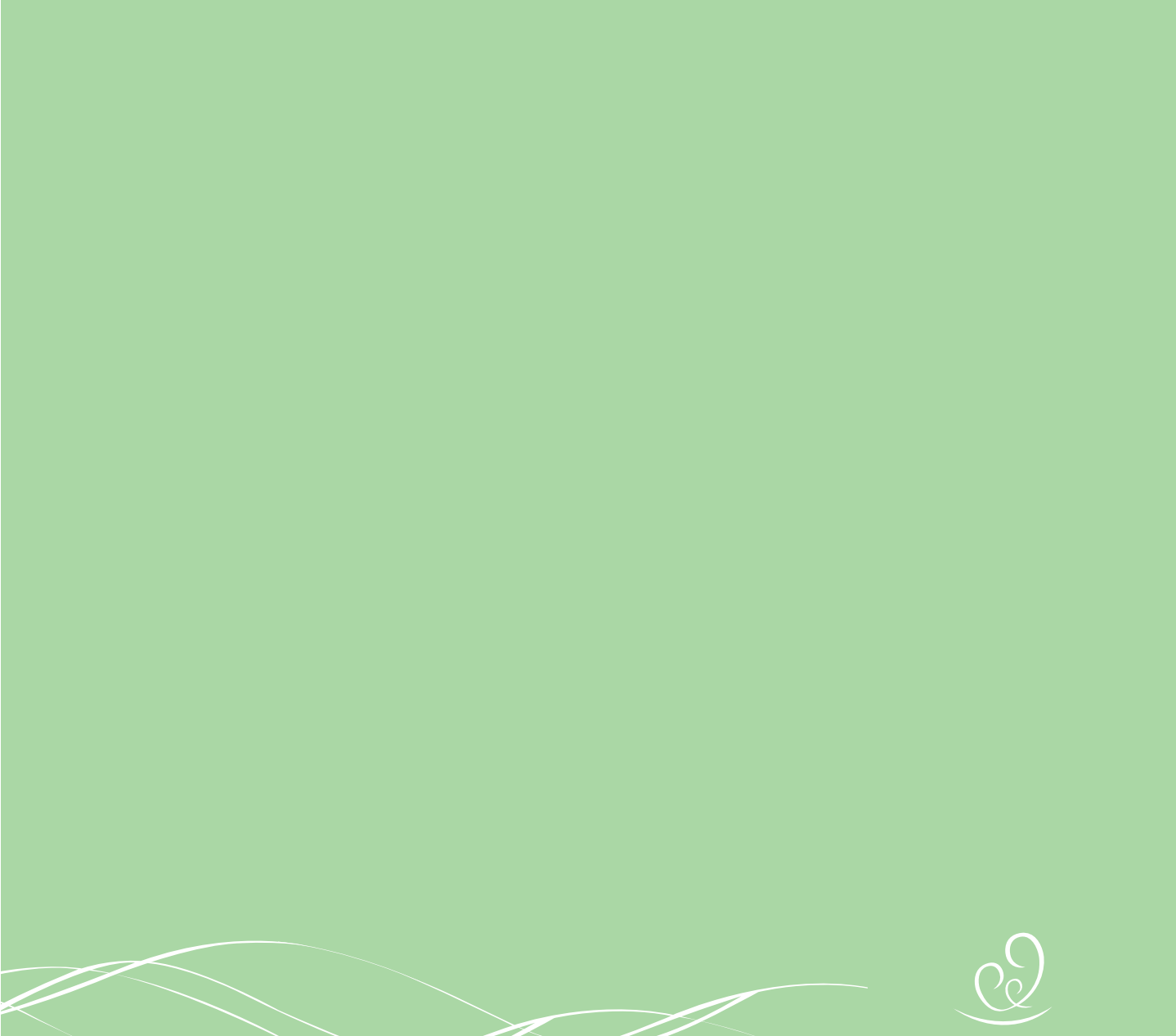
The Investment Case was presented as a draft document to a satellite event on health financing at the African Union Summit. A press release on investment figures received wide international attention – from the BBC World Service and its French, Chinese and German equivalents, Voice of America, BBC Africa, and major international news agencies and health-related web sites.

A concerted effort was made to reach out to African leaders, including ministers of health, ministers of finance, and heads of state, at events such as the World Health Assembly in Geneva in May, the Women Deliver conference in June, and various meetings at the United Nations headquarters in New York. As a result, governments represented at the African Union Summit in Kampala had already had the opportunity to be briefed on the Investment Case, the Global Strategy and the key investment issues related to MNCH. The Summit ended with a decisive move forward that should contribute to further notable improvements in the health status of women and children on the continent. In the Kampala Declaration, African leaders committed themselves to the following urgent actions:

- *Provide* sustainable financing, by enhancing domestic resource mobilization, developing public-private partnerships and instituting national health insurance, while reducing out-of-pocket payments through initiatives such as waiving user fees for pregnant women and children under five.
- *Appeal* to the Global Fund to Fight AIDS, Tuberculosis and Malaria to create a new window for MNCH, ensuring that the resulting pledges to the Fund are earmarked for MNCH.
- *Launch* the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in all countries, broaden it as an advocacy strategy for the promotion of maternal, infant and child health involving all key stakeholders, and institute an annual CARMMA week in solidarity with the women and children of Africa for the next four years.
- *Underline* African Union leaders' commitment to greater accountability for policy and financing decisions through a pledge to report annually on MNCH and to develop an African Union MNCH Taskforce.

In August, The Partnership supported the APHA in making a presentation to the Pan African Parliament of Health and Finance on the African Union Summit outcomes. In response, the committees adopted a resolution pledging to work with Regional Economic Communities and national parliaments towards implementation of the Summit outcomes, through support for national MNCH strategies and an annual review of progress.







## Chapter Five

The Global Strategy  
for Women's and Children's Health

# The Global Strategy for Women's and Children's Health

*“Together we must make a decisive move, now, to improve the health of women and children around the world. We know what works. We have achieved excellent progress in a short time in some countries. The answers lie in building our collective resolve to ensure universal access to essential health services and proven, life-saving interventions as we work to strengthen health systems.”*

With these words, United Nations Secretary-General Ban Ki-moon launched the Global Strategy for Women's and Children's Health at the MDG Summit in New York on 22 September 2010. Facilitated by The Partnership in close collaboration with all its constituents and many others, the Global Strategy is a clear call for action to accelerate progress on MDGs 4, 5 and 6 before 2015.

The facilitation of the Global Strategy was the most significant project that The Partnership has ever undertaken, spanning 10 months of intensive work beginning in December 2009. To initiate the process, the Secretary-General convened a high-level meeting in New York in April 2010 to develop a joint effort that would accelerate progress towards the health MDGs. This joint effort included the development of the Global Strategy and a broad-based effort to mobilize new financial, policy and service delivery commitments in line with the goals of the Strategy.

The Partnership's role was two-fold: to act as a platform for the development of the content of the Global Strategy and, through its constituency groups, to support advocacy for new commitments. Other key partners in this effort included the United Nations Foundation and the H4+.<sup>18</sup> The joint effort led to an announcement on 22 September 2010 of US\$40 billion in financial commitments, as well as policy and service delivery commitments from national governments, private business, NGOs, health professionals, the United Nations and multilateral groups, donors and academic institutions to the Global Strategy. The announcement was accompanied by a high-profile event during the MDG Summit in New York with world leaders, chaired by Secretary-General Ban Ki-moon. The event also attracted substantial attention from the global media, bloggers, and the development community, with more than 3,000 articles published to date.

The Global Strategy took shape during a gradual process of development and refinement. The Partnership facilitated the drafting of what would become the final high-level document, the executive summary and the associated background papers. This meant consultations with a huge number of contributors, including The Partnership's own almost 400 member organizations, some 40 governments, a dozen international organizations including United Nations agencies, numerous academic, research and teaching institutions, and a number of foundations and nongovernmental organizations. In addition, extensive outreach to the private sector yielded important contributions to the Global Strategy and commitments.

The Strategy has been the catalyst for many new commitments, relating to finance, policy and service delivery. These will support work on the ground to reduce maternal and child deaths and increase the rate of progress towards MDGs 4, 5 and 6. It is clear

*“With the right policies, adequate and fairly distributed funding, and a relentless resolve to deliver to those who need it most – we can and will make a life-changing difference for current and future generations.”*

United Nations  
Secretary-General Ban Ki-moon

that the Global Strategy is an important step towards better health for the world's women and children. But it is equally clear that it is only the first step. To achieve its potential, it must rapidly be translated into solid action and measurable results.

### *A focus on results*

Accountability for national and global commitments and action, results and outcomes, and impact, is a core component of the Global Strategy. In the Global Strategy, the United Nations Secretary-General requested WHO to chair a process to “determine the most effective international institutional arrangements for global reporting, oversight and accountability on women’s and children’s health, including through the UN System”. In response to this request, the Commission on Information and Accountability for Women’s and Children’s Health was announced in December 2010 and officially launched on 26 January 2011. The Commission is co-chaired by His Excellency Jakaya Kikwete, President of Tanzania, and His Excellency Stephen Harper, Prime Minister of Canada.

Recognizing that lack of information capacity is a major impediment to progress in countries, the Commission’s objectives are to:

- (i) propose a framework for global reporting, oversight and accountability on women’s and children’s health
- (ii) identify a core set of indicators on women’s and children’s health
- (iii) propose actions to improve health information and registration of vital events – births and deaths – in low-income countries; and
- (iv) explore opportunities for innovation in information technology to improve access to reliable health information.

The Commission will produce a report, including a plan of action, by May 2011.

To complement the work of the Commission, The Partnership will develop a progress report on the financial, policy, and service delivery commitments made to the Global Strategy in 2010, which will be launched at the time of the United Nations General Assembly in September 2011. The report will complement the work of the Commission. The report takes forward The Delhi Declaration 2010, agreed at the Partners’ Forum held in November 2010, which affirmed that The Partnership “is an active participant to track commitments and results and thus ensure mutual accountability”.

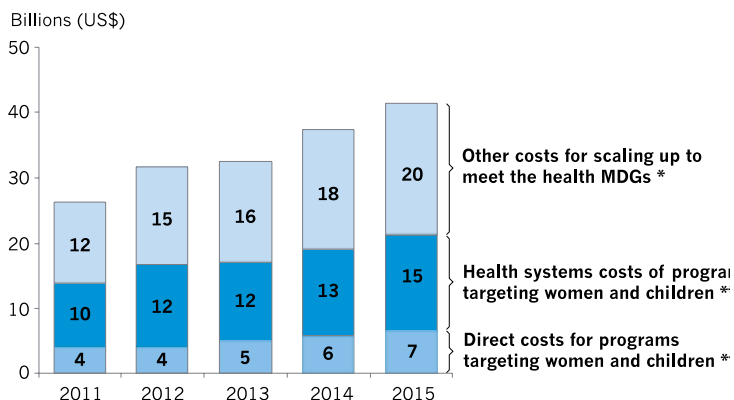
## How large is the financing gap?

There is a broad agreement on what must be included in a package of key, low-cost interventions – from vaccines and medicines to family planning and micronutrients – that can mean the difference between life and death for many vulnerable women and children. In order to deliver this essential package and ensure that countries are able to sustain their efforts over the longer term, scaled-up investment in health systems is critical. Strong health systems require sustained investment over time. In many countries, there remains a large funding gap that must be filled in order to reach women and children with basic health services.

The United Nations Secretary-General's Global Strategy for Women's and Children's Health estimated the overall funding gap for the health MDGs among the 49 lowest-income countries. According to these estimates, the gap stands at US\$26 billion for 2011 (US\$19 per capita), rising to US\$42 billion for 2015 (US\$27 per capita) as countries scale up their programmes.

The direct costs of programmes relating to reproductive, maternal, newborn and child health (including malaria and HIV/AIDS), and the proportional health systems costs to support their delivery, account for almost half of the estimated funding needed: from US\$14 billion in 2011 (US\$10 per capita) up to US\$22 billion in 2015 (US\$14 per capita), which amounts to US\$88 billion in total.

*Estimated annual funding gap for women's and children's health in 49 developing countries, 2011-2015*



\* Remaining half of health-systems costs plus: costs for diagnosis, information, referral and palliative care for any presenting conditions; remaining treatment costs for major infectious diseases, such as TB, HIV/AIDS and malaria; and costs associated with nutrition and health promotion.

\*\* Allocated health-systems costs, including half of costs associated with human resources, infrastructure, supply chain/logistics, health information systems, governance/regulation and health financing costs.

\*\*\* Family planning and maternal and newborn health services, including emergency care, treatment of malaria, child nutrition, immunization, HIV/AIDS treatment, PMTCT, and a portion of water and sanitation costs.

Source: Global Strategy for Women's and Children's Health (2010)





Chapter Six

From Pledges to Action:  
The Partners' Forum

# From Pledges to Action: The Partners' Forum

*To recap an active year and to further develop approaches to advance the Global Strategy, The Partnership held a global forum of partners on 13-14 November in New Delhi, together with the Ministry of Health and Family Welfare of the Government of India.*

**To recap** an active year and to further develop approaches to advance the Global Strategy, The Partnership held a global forum of partners on 13-14 November in New Delhi, together with the Ministry of Health and Family Welfare of the Government of India.

More than 1,200 participants from 33 countries attended the Pledges to Action meeting, which was inaugurated by the President of India and included the participation of more than 20 national ministers of health and state-level ministers and governors from within India.

The closing session of the Delhi meeting featured statements from all of The Partnership's constituency groups about next steps in further mobilization and accountability for the Global Strategy. The session also featured agreement on a follow-up meeting in 2015 to evaluate progress, which was captured in a revised Delhi Declaration 2010 (see next page).

The Forum featured three interrelated themes: (i) *Voices and accountability*: supporting communities to speak out about MNCH issues and ensure accountability of all stakeholders; (ii) *Innovation for change*: highlighting innovation in MNCH – political, financial, delivery of interventions, technology; and (iii) *Engaging all actors*: expanding partnerships beyond the MNCH community to include other health communities as well as other sectors that determine MNCH outcomes (water and sanitation, nutrition, education, gender, etc).

Guided by these three themes, plenary and breakout sessions featured success stories in financing, delivery and accountability; identified innovative strategies, policies and programmes that can be scaled up for change; and promoted consensus on actions and next steps in mutual accountability across diverse stakeholder groups represented by The Partnership.

For the first time, roundtable events with parliamentarians and the media were held as part of the Forum, underlining the important contribution of these groups in advancing progress towards achieving our goals.

Similarly, a special session was organized prior to the main meeting with the International Business Leaders' Foundation, the United Nations Foundation and the India-based Community Business Forum to introduce private sector companies to the Global Strategy and encourage their commitment to women's and children's health.

Underlining the theme of innovation and private sector contribution, the Forum also featured an Innovation Showcase – a gallery space highlighting 15 global and Indian innovations that have been successful (or have the potential) in contributing to improvements in maternal, newborn and child health.

The Delhi meeting was held five years after the 2005 Lives in the Balance conference, at which the Delhi Declaration was launched and The Partnership for Maternal, Newborn & Child Health was conceived. The first full meeting of The Partnership was held in April 2007 in Dar es Salaam, co-hosted by the Ministry of Health of Tanzania.

## Delhi Declaration 2010: From Pledges to Action and Accountability

*We the partners of The Partnership for Maternal, Newborn & Child Health:*

- *Welcome the commitments and outcomes that world leaders agreed to in the Global Strategy for Women's and Children's Health launched at the MDG Summit in September 2010; and encourage further commitments to funding fully costed national plans for achieving MDGs 4 and 5.*
- *Shall work with governments and other key stakeholders to transform into action the pledges made in the Global Strategy.*
- *Will act on the emerging consensus on priority, evidence-based interventions, and ensure these are articulated in the form of national plans and implemented equitably at scale through the continuum of care, in order to achieve the agreed results for women's, newborns' and children's health.*
- *Agree to shared principles for advocacy, action and accountability:*
  - *A core set of indicators, integrated into country monitoring and evaluation mechanisms, so all partners are accountable for the commitments and results agreed to in the Global Strategy.*
  - *A multi-stakeholder process to ensure inclusiveness and participation, including the most vulnerable and marginalized.*
  - *Harmonization of existing efforts to ensure that there is complementarity between partners' work.*
  - *Regular progress reports to the World Health Assembly and United Nations General Assembly.*
- *Shall collaborate with WHO to speedily implement the role it was tasked with in the Global Strategy, to: "chair a process to determine the most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health".*
- *Affirm The Partnership for Maternal, Newborn & Child Health is an active participant to track commitments and results and thus ensure mutual accountability.*
- *Agree to regularly monitor and report on progress, and meet again in 2015, in Delhi, to evaluate the achievement of our shared global commitments to women's, newborns' and children's health, development and human rights.*





*Delegates at the inaugural session of the Partners' Forum*





Conclusion

Moving Ahead:  
Realizing the Promise

# Moving Ahead: Realizing the Promise

This publication, our inaugural annual report, has documented a year in the life of The Partnership for Maternal, Newborn & Child Health. It was a year of great hope, of vigorous action, and of encouraging results. Now is not the time for complacency. Now is the time for action. In 2011, The Partnership is building on the momentum generated in 2010 to help translate the political and financial commitments into results: improved women's and children's health. And, in 2011 The Partnership will determine its strategy and role in the crucial years leading up to the 2015 MDG Summit.

The Partnership is committed to bringing hope closer to reality in 2011 and beyond, drawing on all levels of the organization and by providing a platform for active engagement with the global health community. By working together, we can meet our collective responsibility of ensuring that every pregnancy is wanted, every birth is safe, and every newborn and child is healthy.





Annex

Month by month:  
The Partnership in 2010

# Month by month: The Partnership in 2010

## January

- Canadian Prime Minister Stephen Harper names MNCH as the key priority for the 2010 G8 meeting, to be hosted by Canada.
- The government of Canada consults with The Partnership, WHO and others to seek support for what will become known as the Muskoka Initiative. Dr Dorothy Shaw of the University of British Columbia is appointed to act as The Partnership's spokesperson in Canada during the G8 process.
- The Executive Office of the United Nations Secretary-General invites The Partnership to join a small group for preliminary discussions about the development of a major new strategy on women's and children's health.

## February

- Italian parliamentarians meeting in Geneva pledge continuing support and action for MNCH issues, including drafting parliamentary resolutions on international aid. The seminar, with The Partnership among its organizers, highlights the success of the earlier Italian initiative which endorsed the MNCH Consensus at the G8 meeting at L'Aquila in June 2009.

## March

- The Partnership works with the United Nations Secretary-General's Executive Office to plan a retreat for global health leaders to discuss the development of a major new strategy document, accountability framework and advocacy drive for enhanced commitments to women's and children's health to be launched at the September MDGs Summit in New York.
- The Partnership hosts an all-stakeholder meeting in New Delhi, facilitated by the All India Institute of Medical Sciences and the White Ribbon Alliance for Safe Motherhood, India, to exchange knowledge and ideas on policy implementation and accountability on MNCH in India, ahead of the Partners' Forum meeting in New Delhi in November 2010. Dr Julian Schweitzer, The Partnership's outgoing Chair, and K. Sujatha Rao, Secretary of the Ministry of Health and Family Welfare of the Government of India, agree to act as Steering Committee Co-Chairs.
- The Partnership and the Inter-Parliamentary Union co-host a plenary session on the role of parliamentarians in achieving MDGs 4 and 5 at the IPU Assembly in Bangkok. More than 400 parliamentarians from around the world attend.

## April

- *The Lancet* publishes new estimates by the Institute for Health Metrics and Evaluation, which show a 35% reduction in maternal deaths between 1980 and 2008. "*These encouraging results are no reason for complacency. Now is the time to redouble our efforts,*" Partnership Director Dr Flavia Bustreo says. "*We are writing a new chapter in the story of maternal health, and The Partnership*

*will continue to harness the power of our partners to achieve our common goals.*" The study generates significant media coverage and The Partnership is quoted in more than 500 news articles commenting on the new estimates, including – for the first time – an appearance on the front page of the *New York Times*.

- Partnership Director Dr Bustreo and incoming Board Chair Dr Julio Frenk, Dean of Harvard School of Public Health, participate in a strategy retreat in New York hosted by United Nations Secretary-General Ban Ki-moon. The Partnership is assigned a key role in facilitating the development of the new strategy under the Secretary-General's auspices.
- The Partnership Board meets at the BRAC Centre in Dhaka, Bangladesh, and confirms that The Partnership will accept the United Nations Secretary-General's invitation to facilitate the development of the proposed Joint Action Plan (later renamed the Global Strategy for Women's and Children's Health) and agrees to mobilize the development of commitments to the effort. The Board elects Professor Vinod Paul of the All India Institute of Medical Sciences as Co-Chair for the next two years. This is the last Board Meeting chaired by Dr Schweitzer. He welcomes incoming Chair Dr Frenk, who will chair The Partnership's Ninth Board Meeting in New Delhi, India, in November 2010.
- Ahead of the June G8 meeting in Canada, a Partnership-facilitated G8 task team, led by Dr Shaw and the Maternal Mortality Campaign, launches a Call to Action to double resources for MNCH.

## May

- The Partnership meets ministers and participants at the World Health Assembly in Geneva to discuss the emerging African Investment Case, developed under the auspices of the Harmonization for Health in Africa group. A draft of the United Nations Secretary-General's Global Strategy is shared in a series of technical meetings, bilateral meetings and special consultation sessions.
- Partnership Director Dr Bustreo is on the panel at a special symposium in Washington, DC, organized by the Kaiser Family Foundation, on new evidence for a reduction in child mortality in studies by Rajaratnam and colleagues, and Black and colleagues, both published in *The Lancet*.

## June

- At the Women Deliver conference in Washington, The Partnership and several partners release the Countdown to 2015 Decade Report (see chapter 2), which presents findings on progress towards MDGs 4 and 5 and data on MNCH coverage, equity, financing and policies. The report clearly shows the progress made by some countries, but emphasizes the remaining challenges in increasing coverage of key MNCH interventions.
- Also at the Women Deliver conference, the United Nations Secretary-General launches a draft for consultation of the Global Strategy, following input from The Partnership's almost 400 member organizations and extensive country consultations co-organized by The Partnership.

- The Partnership applauds the commitment of more than US\$5 billion of new resources for MNCH announced at the G8 meeting in Canada. The overall G8 pledge of US\$1 billion per year comes halfway to meeting the need for a doubling of resources for MNCH set out in The Partnership's Call to Action for the G8. At the same time, an additional US\$2.3 billion is promised by non-G8 countries and donors (the Netherlands, New Zealand, Norway, South Korea, Spain, Switzerland, the Bill and Melinda Gates Foundation and the United Nations Foundation) to make a total of US\$7.3 billion.
- At the Global Health Council and Pacific Health Summit meetings in Washington and London, The Partnership and partners such as the mHealth Alliance organize special sessions on the role of innovation and the private sector in advancing the goals of the United Nations Secretary-General's Global Strategy, laying the groundwork for private sector commitments to be announced at the MDGs Summit in September.

## July

- WHO Director-General Dr Margaret Chan announces the appointment of Partnership Director Dr Bustreo as Assistant Director-General, Family and Community Health, with effect from 1 October 2010. In consultations with the Chair of The Partnership Board, it is agreed that Dr Bustreo will also remain as Director of The Partnership until the end of 2010 *"to ensure continuity of actions at such a critical and visible time for maternal, newborn and child health"*.
- The Partnership and the Inter-Parliamentary Union (IPU) launch their joint publication, Taking the Lead: Parliamentarians Engage with Maternal, Newborn and Child Health, at the 6<sup>th</sup> IPU Meeting of Women Speakers hosted by the Swiss Parliament in Bern. Research and analysis is based on 2009-2010 visits by Partnership and IPU colleagues to Zambia, Tanzania, Cambodia and Vietnam. The publication highlights parliamentarians' critical role in advancing the MNCH agenda and in improving health outcomes for women and children.
- The Partnership and various partners, including the H4+, organize or participate in several sessions at the XVII International AIDS Conference in Vienna to highlight the links between MNCH and HIV/AIDS, TB and malaria. In addition, a special session is held to brief the HIV/AIDS community on the Global Strategy.
- The African Union Summit on Maternal, Infant and Child Health and Development in Kampala, Uganda, ends with a strong list of action points. These include broadening the Campaign for the Accelerated Reduction of Maternal Mortality in Africa as an advocacy strategy, strengthening national health systems, appealing to the Global Fund to Fight AIDS, Tuberculosis and Malaria to launch a new window to address MNCH, and creating a taskforce to report on annual progress against MNCH goals. The Partnership is represented at the meeting by Dr Bustreo, Professor Babatunde Osotimehin (former Minister of Health, Nigeria) and Rotimi Sankore (of the Africa Public Health Alliance/15%+ Campaign). They urge regional support for the United Nations Secretary-General's Global Strategy. Extensive regional media coverage is generated in the process.

## August

- With the support of its six constituency groups and hundreds of partners, The Partnership concludes its facilitation work on the final draft of the Global Strategy for Women's and Children's Health. The document and an executive summary are translated into all six official United Nations languages and produced for distribution at a special launch event at the MDG Summit in September. Technical background papers are commissioned and edited, to be published online in September.
- The fifth regional workshop on the role of health care professionals in achieving MDGs 4 and 5 is held in Santa Cruz, Bolivia, under the auspices of The Partnership. Sixty health care professionals from national associations of obstetrics and gynaecology, paediatrics, midwifery, nursing and pharmacy attend the three-day meeting, along with representatives of ministries of health, the Pan American Health Organization and nongovernmental organizations such as Save the Children and Family Care International. Key issues that impede the improvement of the health of women and children in the region are discussed, together with ways in which health care professionals can help support the implementation of national MNCH plans. During the event, each country group of health care professionals develops a joint workplan for implementation over the next two years. In previous years, workshops have been held in Malawi, Burkina Faso, Bangladesh, Jordan and Niger.

## September

- WHO, UNICEF, UNFPA and the World Bank release Trends in Maternal Mortality: 1990 to 2008, revealing a decrease of 34% from some 550,000 estimated deaths in 1990 to around 350,000 in 2008. The Partnership says this new, hopeful report *"strengthens our resolve to improve women's health and make their health a priority in the world"*.
- At the invitation of the Canadian government, Partnership Director Dr Bustreo and Partnership G8 spokesperson Dr Shaw hold meetings in Ottawa to offer ongoing technical support to the elaboration of the Muskoka Initiative, as Canada defines its specific inputs and channels for investment (see chapter 3).
- On 22 September in New York, United Nations Secretary-General Ban Ki-moon launches the Global Strategy for Women's and Children's Health in the presence of world leaders including Chinese Premier Wen Jiabao, US Secretary of State Hillary Clinton, UK Deputy Prime Minister Nick Clegg and the heads of state of Ethiopia, Malawi, and Rwanda. More than US\$40 billion is pledged from governments, donors, civil society organizations and the private sector to advance progress on women's and children's health. Of particular note is the contribution by developing country governments of more than US\$8 billion – one third of the total government pledges collected. The Partnership is quoted in more than 500 media articles about the historic importance of the Global Strategy (see chapter 5).
- The Partnership supports the organization of a special meeting of the Countdown Financing Working Group at the London School of Hygiene and Tropical Medicine to discuss how the Countdown initiative can support the accountability process of the Global Strategy and the G8 Muskoka Initiative. The meeting includes



participation from the Canadian International Development Agency, the Institute for Health Metrics and Evaluation, the Organisation for Economic Co-operation and Development, the US Agency for International Development, the UK Department for International Development, WHO, and the World Bank.

## October

- The Partnership co-organizes on 1-2 October a meeting of the Chairs of National Budget, Finance and Health Committees and members of the Pan African Parliament (PAP) to explore how national parliaments can contribute to the implementation of the African Union Summit Declaration on Maternal, Infant and Child Health. During the meeting, the Chairs develop an action plan for parliamentary policy and budget support for MNCH, which was subsequently adopted as a resolution by the PAP General Assembly on 15 October.

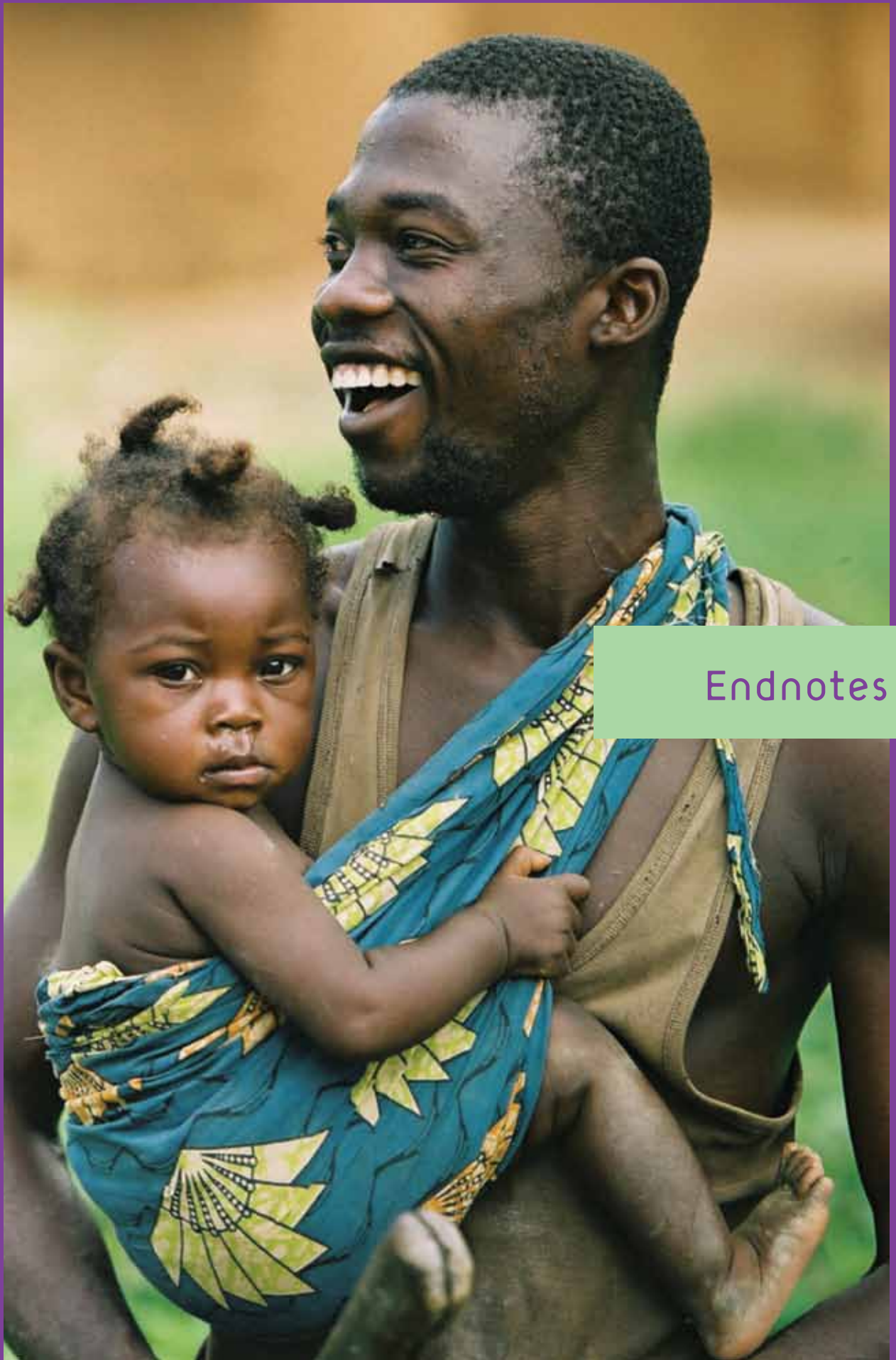
## November

- From Pledges to Action, the Partners' Forum of The Partnership, is held on 12-14 November in New Delhi, followed by a meeting of the Partnership board. This high-level political meeting, hosted by the Ministry of Health and Family Welfare of the Government of India, consolidates commitments to the Global Strategy and catalyzes accelerated progress towards MDGs 4 and 5. More than 1,200 participants, including health and development ministers, senior government and United Nations officials, donors, health care professionals, civil society representatives and academics, attend the meeting.
- The publication Sharing Knowledge for Action on Maternal, Newborn and Child Health is launched at the Partners' Forum in New Delhi on 13-14 November. The knowledge summaries were developed with the University of Aberdeen and other partners and cover 12 topics cutting across the continuum of care.

## December

- MNCH Knowledge Portal is launched. The portal provides a systemic mechanism or gateway, giving access to MNCH knowledge resources and expert networks. It builds on the commitment of partner organizations to share and translate knowledge to promote policies and practices that in turn promote MNCH.





Endnotes

# Endnotes

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18. The H4+ refers to the UN agencies addressing maternal, newborn and child health, including UNICEF, UNFPA, WHO, the World Bank, and UNAIDS.

# Partnership Members

(officially approved as of 31 January 2011)

34 Million Friends of the United Nations Population Fund; Abantu for Development; Academia Nacional de Medicina; Academy for Educational Development (AED); Action Canada for Population and Development; Action Group on Adolescent Health (The Campaign Against Unwanted Pregnancy); ActionAid USA; Action for Sustainable Health (ASH); Advanced Life Support in Obstetrics Advisory Board (ALSO); Advocacy Initiative for Development (AID); Africa Public Health Rights Alliance and "15% Now!" Campaign; Africa solutions, Inc.; Africa Youth for Peace and Development Organization; African Medical and Research Foundation (AMREF); Aga Khan Development Network; Aga Khan University; Aisedup; Alexandria University, Faculty of Medicine, High Institute of Public Health (HIPH); Alianza Argentina para la salud de la madre, recién nacido y niño (Argentine Partnership for Maternal, Newborn & Child Health); All India Institute of Medical Sciences (AIIMS); Alliance for Reproductive Health Rights (ARHR); American Academy of Pediatrics; American College of Nurse-Midwives; Anayetpur Mohila Kallyan Society; Aria International; Asociación Benéfica PRISMA; Association of Maternal and Child Health Programs (AMCHP); Association of Safe Motherhood Promoters Nigeria; Australian Agency for International Development (AusAID); Averting Maternal Death and Disability (AMDD), Columbia University; Azad India Foundation; Bangladesh Rural Advancement Commission (BRAC); Batool Welfare Trust (BWT) Rawalpindi Pakistan; Ben Gurion University of the Negev Medical School for International Health, Faculty of Health Sciences; Benevolent Healthcare Foundation dba PROJECT C.U.R.E.; Bethlehem Foundation For Safe motherhood; Bhartiya Mahila Evam Gramin Utthan Sansthan; Bhoruka Public Welfare Trust; Bill & Melinda Gates Foundation; Breastfeeding Promotion Network of India, Ludhiana District Branch; BRIDGEWISE; Cameroon Christian Welfare Medical Foundation (CAMCWEMEF); Canadian International Development Agency (CIDA); Canadian Public Health Association; Canadian Society for International Health (CSIH); Cara International Consulting Ltd; Care International- Zambia; Care USA; Carolina Breastfeeding Institute; Catalan Agency for Health Technology Assessment (CAHTA); Centers for Disease Control and Prevention, Division of Reproductive Health (CDC); Centre for Counselling, Nutrition and Health Care (COUNSENUTH); Centre for Development and Population Activities (CEDPA); Center for Global Health and Development - Boston University; Centre for Global Health, Population, Poverty & Policy (CGHP3), University of Southampton; Centre for Health and Population Studies (CHPS); Centre for Health and Social Justice; Centre for Health Policy and Innovation; Centre for Health Sciences Training, Research and Development (CHESTRAD); Centre for Healthworks, Development and Research (CHEDRES); Centre for Pregnancy and Childbirth Education (CEPACE); Cercle des Amis du Cameroun (CERAC); Chalmeda Anand Rao Institute of Medical Sciences; Chelma Advisory Institute; Chetna; Child & Family Research Institute; ChildFund India; Child Health and Nutrition Research Initiative (CHNRI); Child Link Foundation; Child Maternal & Adolescent Life Project (CIMALP); Children's Project International; Choices and Challenges on Changing Childbirth (CCCC), Regional Research Network, American University of Beirut; Christian Community Development Programme (CCDP); CIAM Public Health Research & Development Centre; CLAN (Caring & Living As Neighbours); Coalition for Rational and Safe Use of Medicines (CORSUM); Columbia University, Mailman School of Public Health; CommonHealth Coalition on Maternal Neonatal Health and Safe Abortion; Commonwealth Secretariat, UK; Compassion Service Society; Community Transcultural Support Services (CTSS); Concept Foundation; Concern Worldwide US; CORE Group; Council of International Neonatal Nurses (COINN); DALIT; Deepak Foundation; Department for International Development, UK (DFID); Department of Global Health Policy, Graduate School of Medicine, The University of Tokyo; Destiny Enablers Foundation (DEF); Deutsche Stiftung Weltbevölkerung (DSW); Development Assistance for Farmers & Farm Labors Bangladesh (DAFF - Bangladesh); Development Communications Network; Development Gateway Foundation; Development Organisation of the Rural Poor (DORP); Doctors with Africa (CUAMM); Doris Duke Charitable Foundation; Eakok Attomanobik Unnayan Sangstha; Edem Children Foundation (ECF); EKJUT; Elizka Relief Foundation; Emory University Rollins School of Public Health; Empowering Women For excellence Initiative (EWEI); Enfants du Monde; EngenderHealth; Extending Service Delivery Project (ESD); Family Care International (FCI); Family Health Development Organization (FHDO); Fatherhood Institute; Federal University of Pelotas, Brazil; Federation of Asia and Oceania Perinatal Societies (FAOPS); FHI; Foundation Josiaslive; French Ministry of Foreign and European Affairs; Future Group International; G.M.Khan Memorial Medical Centre & maternity Home; Gavi Alliance; GDS-Grameen Development Society; Georgetown University Institute for Reproductive Health; German Federal Ministry for Economic Cooperation and Development (BMZ); Gharbbarakshambigai Fertility Centre p ltd; GICAR -CAM - Organisation de Developpement et de Droits de l'Homme; Global Alliance to Prevent Prematurity and Stillbirth (GAPPS); Global Fund to Fight AIDS, Tuberculosis and Malaria; Global Health Council; Global

Movement for Children; Global Network for Perinatal and Reproductive Health; Global Network for Women's and Children's Health Research; Government of Bangladesh; Government of Bolivia; Government of Cambodia; Government of Chile; Government of Ethiopia; Government of India; Government of Indonesia; Government of Mali; Government of Mozambique; Government of Nepal; Government of Nigeria; Government of Pakistan; Government of Senegal; Government of Tanzania; Government of the Netherlands; Government of Uganda; Gram Bharati Samiti (GBS); Granti-Med Medical Clinic; Green Cross Welfare Organization; Gynuity Health Projects; Gulu University - Department of Reproductive Health; Harvard Humanitarian Initiative and Massachussets General Hospital; Hasaan Foundation; Hayfords Global Foundation; Health Alliance International; Health and Development International (HDI); Health Right International; Health Vigilance Programme Cameroon (HVP); Healthcare Links; Health System Plus; Healthy Mothers Healthy Babies Coalition of Hawaii; Heidelberg Christian Community & Medical Centre; Helen Keller International; Himalayan Inland Mission CHDP Programme; Hindustan Latex Family Planning Promotion Trust (HLFPPT); Hoc Mai Australia Vietnam Medical Foundation; Human Advancement, Reorientation and Empowerment for Environment & Health (HAREETH); Indian Council of Medical Research; Infante Sano; Institut National de Sante Public; Institute for Clinical Effectiveness and Health Policy (IECS); Institute for OneWorld Health; Institute of Child Health; Integrated Rural Development Programme(IRDP); Integrated Social Development Effort (ISDE) Bangladesh; Integrated Village Development Society (IVDS); Interact Worldwide; Interchurch Medical Assistance (IMA) World Health; International Association for Maternal and Neonatal Health (IAMANEH); International Baby Food Action Network (IBFAN); International Baby Food Action Network (IBFAN) Africa; International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B); Centre for Health and Population Research; International Centre for Reproductive Health - Ghent University; International Children's Center; International Confederation of Midwives (ICM); International Council for Control of Iodine Deficiency Disorders (ICCIDD); International Council of Nurses; International Federation of Gynaecology and Obstetrics (FIGO); International HIV/AIDS Alliance; International Initiative on Maternal Mortality and Human Rights; International Institute for Health Care Professionals; International Institute for Population Sciences (IIPS); International Labour Organization (ILO); International Pediatric Association (IPA); International Planned Parenthood Federation (IPPF); International Planned Parenthood Federation/Western Hemisphere Region; International Pharmaceutical Federation (FIP); International Pregnancy Advisory Services (IPAS); International Relief and Development; International Society of Ultrasound in Obstetrics and Gynecology (ISUOG); International Union Against Tuberculosis and Lung Disease; Interprea; IntraHealth International, Inc.; Istituto per l'Infanza IRSS Burlo Garofolo (WHO Collaborating Centre for Maternal and Child Health); Italy: Development Cooperation (Directorate General for); Jaipur Zila Vikas Parishad; Japan International Cooperation Agency; Japanese Organization for International Cooperation in Family Planning (JOICFP); Jhpiego; John Snow, Inc.; Johns Hopkins Bloomberg School of Public Health; Kalpavriksh; Kano Station CTV67; Karolinska Institute; Kenya Association for Maternal and Neonatal Health (KAMANEH); Kisumu Kids Empowerment Organization; Krityanand Unesco Club, Jamshedpur; Kulwanti Hospitals & Research Centre; Kyabugimbi Community Based Health Care Association (KCBHC); La Leche League International; Latin American Maternal Mortality Reduction Initiative; Legal Aid Centre for Women; Libyan Society for Safe Childhood (LSSC); Lifeline Foundation Nigeria; Life Saving Organization for Afghanistan (LSOA); Little Big Souls; Live Alive Foundation; London School of Hygiene and Tropical Medicine (LSHTM/IDEU); MacArthur Foundation; Mahatma Gandhi Institute of Medical Sciences; MAMTA - Health Institute for Mother and Child; Management Sciences for Health; Manav Kalyan Pratishthan; Mant Kolkata; MARCH Centre; March of Dimes; Marie Stopes International; Maternal and Child Health Integrated Program; Maternal and Newborn Health in Ethiopia Partnership; Maternal Health Task Force; Maternity Worldwide; Medical Women's International Association; Metis National Council; Micronutrient Initiative; Minnesota International Health Volunteers; Moi University; Mother & Child Health Care (MCHCare); Mother Health International; MotherNewBorNet; Mothers2mothers International; MY-HEART (March of Youth for Health, Education and Action for Rural Trust); Nagaad Umbrella Organization; Nari Unnayan Sangstha (NUS); National Committee for Maternal Health (NCMH); National Institute of Child Health and Human Development, US (NICHD); National Research Center of Maternal and Child Care; Nepal Social Marketing and Franchising Project; National Institute of Applied Human Research & Development (Niahrd); Norway, NORAD; Norwegian Afghanistan Committee (NAC); Obstetric Anaesthetists' Association (OAA); Obstetrical and Gynaecological Society of Bangladesh; ONE; Options Consultancy UK; Options Consultancy, South Africa; Organisation pour la Sante des delaissees (OSAD); Organization for Good Life of the Marginalized; Orphans Relief Services Tanzania (ORES); Osaka Medical Center and Research Institute for Maternal and Child Health; Oslo University Hospital Norway, Department of Maternal and Child Health; Osservatorio Nazionale sulla Salute della

Donna (O.N.da) (National Observatory for Women's Health); Parish Nurse Ministry; Pathfinder International; Perinatal Education Trust; Petcom Integrated Training Consult; Pharmed Trade News; Philippine NGO Council on Population Health & Welfare, Inc. (PNGOC); Plan International USA; Polli Dustha Kallyan Shangstha (PKKS); Population Action International; Population Council; Population Media Center; Population Reference Bureau; Population Services International; Prince Leopold Institute of Tropical Medicine Antwerp; Program for Appropriate Technology in Health (PATH); Program on Forced Migration and Health, Columbia University; Project Concern International; Project HOPE (Health Opportunities for People Everywhere); PSI; Qazvin Medical University, Health Deputy Department; Rainbow Nari O shishu Kallyan Foundation; Rakiya Rural Approach Network; RDRS Bangladesh; Redeem Community Health Consult; Regional Prevention of Maternal Mortality Network; Religions for Peace; Reproductive Health National Council; Reproductive Health Response in Conflict (RHRC) Consortium; Reproductive Health Supplies Coalition; Research Triangle Institute; Réseau Ensemble pour le Développement Durable du District d'Arta (E.D.D.A.); Rotarian Action Group for Population & Development (RFPD); Royal College of Nursing; Royal College of Obstetricians and Gynaecologists; Rural Integrated Relief Service-Ghana; Rural youth development and cultural society; Rurowa Laue Tathang (RLT); Rutgers Nisso Groep/Youth Incentives; Safe Motherhood Network Federation Nepal; Safe Motherhood Programs, Bixby Center for Global Reproductive Health, University of California San Francisco (UCSF), Dept of Obstetrics, Gynecology, and Reproductive Sciences; Sahar Relief and Development Organization; Santé Globale Développement Intégré (SDI), VIH-SIDA; Saraswathy Shanmugam Public Charitable Trust; Save the Children, India; Save the Children UK; Save the Children US; Save the Children, Saving Newborn Lives; Save Visions Africa (SVA); School of Human Sciences / Osaka University; Seattle Home Maternity Service; Serve Train Educate People's Society (STEPS); SingHealth IMPACT (Singapore Health Services Pte Ltd's Program of International Medical & Public Health Development Assistance Activities); Social Development & Management Society; Social Fund for Development Egypt; Social Welfare and Community Development Society; Society for Advancement of Health, Education and Research (SAHER); Society for Anti AIDS Among the Nigerian Students (SANS); Society for Developmental Action; Society for Education, Action, and Research in Community Health (SEARCH); Society of Obstetricians & Gynaecologists of Pakistan (SOGP); Society of Obstetricians and Gynecologists of Canada (SOGC); Space Allies; SPECTRA.ORG; SRUSTI; St Francis Health Care Services; Student Campaign for Child Survival (SCCS), USA; Students' World Health Assembly Nijmegen (SWHAN); Suez Canal University, Faculty of Medicine; Swami Ram Krishna Paramhansa Maa Sahrda Sewa Samiti (SRKM Civil Society); Saraswathy Shanmugam Public Charitable Trust; Swasti; Swaasthya Trust; Swat Youth Front; Sweden, Ministry of Foreign Affairs; Tamil Nadu Federation of Obstetricians & Gynecologists; Task Force for Child Survival and Development; The Manoff Group; Tribhuvan University, Institute of Medicine; U.S. Agency for International Development (USAID); Uganda Protestant Medical Bureau (UPMB); Umeå International School of Public Health; UNAIDS Secretariat; United Nations Children's Fund (UNICEF); United Nations Foundation (UNF); United Nations Population Fund (UNFPA); Universal Versatile Society; University of Aberdeen, Initiative for Maternal Mortality Programme Assessment (IMMPACT); University of Bergen, Priority Setting and Planning in Global Health Group; University of KwaZulu-Natal, Department of Public Health Medicine, School of Family and Public Health, Nelson R Mandela School of Medicine; University of Lagos, Department of Population Geography; University of Limpopo, Department of Nursing Sciences, Medunsa Campus; University of the Western Cape School of Nursing; University Research Co., LLC, Center for Human Services (URC-CHS); US Coalition for Child Survival; Vaah Junior Foundation for Better Maternal and Child Health; Vanderbilt University Medical Center: Center for Evidence-Based Medicine and Institute for Global Health; WaterAid; Wellbeing Foundation Nigeria; White Ribbon Alliance USA; White Ribbon Alliance Zambia; Women Acting Together for Change (WATCH); Women Advocates Research and Documentation Center; Women an Community Livelihood Foundation; Women and Children First; Women and Health Alliance International; Women Deliver; Women United for Economic Empowerment (WUEE); Women's Global Health Imperative at RTI; Women's Health and Action Research Centre (WHARC); Women's Initiative for Self-Actualization (WISA); World Bank; World Federation of Societies of Anaesthesiologists (WFSA); World Health Organization; World Vision International; Youth Empowerment for Development Ministries International (YEDEM); Youth Front Pakistan (YFP); Youth Peer Education Network (Y-PEER); Zimbabwe Grace Trust.



## Partnership Board Members

### Board Chair

Julio Frenk, Harvard School of Public Health

### Board Members as of 31 December 2010

#### *Academic, research and training*

José M. Belizán, Institute of Clinical Effectiveness and Health Policy

Vinod Paul, All India Institute of Medical Sciences

Jane G Schaller, University of British Columbia

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France Donnay, Bill & Melinda Gates Foundation

Helga Fogstad, Norwegian Agency for Development Cooperation

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H.E. Ghulam Nabi Azad, Union Minister for Health and Family Welfare, Government of India

H.E. C. O. Onyebuchi Chukwu, Minister of Health, Government of Nigeria

H.E. Hadji Hussein Mponda, Minister of Health and Social Welfare, Government of Tanzania

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André Lalonde, International Federation of Gynecology and Obstetrics

Bridget Lynch, International Confederation of Midwives

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Mary Anne Mercer, Health Alliance International

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Flavia Bustreo, WHO

Mickey Chopra, UNICEF

Purnima Mane, UNFPA

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Benedict David, AusAID, Australia

Stefan Germann, World Vision International

Gustavo González-Canali, Ministry of Foreign and European Affairs, France

Judith Helzner, John D. and Catherine T. MacArthur Foundation

Diane Jacovella, Canadian International Development Agency

Pius Okong, International Federation of Gynecology and Obstetrics

Rajiv Tandon, Save the Children India



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