



2015

and beyond:

**the unfinished agenda of
MDGs 4 and 5 in South-East Asia**

Report of a regional meeting

29 April –1 May 2014, Kathmandu, Nepal



**World Health
Organization**

Regional Office for South-East Asia

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Acronyms

CHW	community health workers
CB-NCP	community-based newborn care programme
CoIA	Commission on Information and Accountability for Women's and Children's Health
CQI	continuous quality improvement
EmOC	emergency obstetric care
EPMM	ending preventable maternal mortality
GAPPD	Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea
H4+	Health 4+
HBCI	High-burden countries Initiative
ICPD	International Conference on Population and Development
iERG	Independent expert review group
IHP+	International Health Partnership
IMCI	integrated management of childhood illness
MAF	MDG acceleration framework
MCTS	Mother and child tracking system
MDG	Millennium Development Goal(s)
MDSR	maternal death surveillance and response
MMR	maternal mortality ratio
QI	quality improvement
RKSK	<i>Rashtriya Kishor Swasthya Karyakram</i> (India)
RMNCAH	reproductive, maternal, newborn, child and adolescent health
RMNCH	reproductive, maternal, newborn and child health

SCANU	special care newborn unit(s) (Bangladesh)
SNCU	special newborn care unit(s) (India)
SOP	standard operating procedure(s)
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
TQM	total quality management
UHC	universal health care
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization



Background and objectives

There has been significant progress among Member States of the World Health Organization (WHO) South-East Asia Region in reducing maternal and child mortality from preventable causes (Millennium Development Goals (MDG) 4 and 5, however, acceleration in reducing mortality is required to achieve the targets for MDGs 4 and 5 by 2015.

Countries recognize the need for delivering well-known evidence-based life-saving interventions at different levels of the health system and across the continuum of pregnancy, newborn, child and adolescent periods using a life-course approach. However, much progress in improving the coverage of evidence-based interventions to reach all people, especially the vulnerable, is required. The focus on good quality of services is important, while striving for high equitable coverage.

Variable progress in maternal, newborn and child health in the Member States of the Region may be due to interplay of several factors related to health system as well as sociocultural and economic factors. It is noted that some countries in the Region have done much better than others by using a variety of strategies to address these factors.

Inadequate progress in MDGs 4 and 5 in the Region has received attention at the highest level in WHO. The Regional Director has announced "Ending preventable maternal, newborn and child deaths in the South-East Asia Region" as a flagship area to accelerate reduction in maternal and under-five mortality through scaling up life-saving interventions and good quality of care for mothers, newborns and children.

At the global level, the UN Secretary-General's Strategy for Women's and Children's Health "Every Woman, Every Child" has provided a push for accelerated actions towards achievement of MDG 4 and 5. In follow

up, several initiatives like "A Promise Renewed - Call to Action for Child Survival", UN Commission for Lifesaving Commodities, Family Planning 2020 and Every Newborn Action Plan have been launched globally. These need to be understood and assimilated by the national governments in the Region. Coordinated approaches need to be pursued to prevent any risk of fragmentation of the existing reproductive-maternal-newborn-child and adolescent health programmes in the countries.

UN Strategy has also established an accountability mechanism through the Commission on Information and Accountability for Women's and Children's Health (COIA) and the Independent Expert Review Group (iERG). COIA framework has been formally introduced in five high burden countries in the Region. This framework provides opportunity and directions for other countries as well since they have endorsed the UNSG Strategy. Progress for COIA indicators is expected to be reported and monitored regularly.

This report presents the proceedings of the regional meeting convened to review progress in MDG 4 and 5, success factors and challenges for further progress, as well as share a common understanding on the post-2015 development agenda.

Objectives

The overall objectives of the meeting were to review progress in MDG 4 and 5 and the ColA framework, and bring together key stakeholders from ministries of health, civil society and the partner community to reach a common understanding on approaches that are likely to improve coordination and make a large impact on country efforts for accelerating or sustaining movement towards MDG 4 and 5, and in progressing beyond 2015.

The specific objectives of the meeting were:

- to review progress in Member States towards achieving MDG 4 and 5 using the accountability framework for the UN *Global Strategy for Women's and Children's Health*, and identify and plan country-specific actions to accelerate progress towards achieving MDG 4 and 5;

- to share successful experiences and best practices for scaling up implementation, and agree upon evidence-based and high-impact approaches for improving maternal, newborn, child and adolescent health;
- to deliberate on global initiatives for MDG 4 and 5, and mechanisms to promote their coordination and implementation in countries; and
- to strengthen the regional monitoring mechanism for tracking progress on MDG 4 and 5.

(See Annex 2 for agenda of the meeting)



Inaugural session

Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, highlighted that the South-East Asia Region has made significant progress in reducing the maternal mortality ratio (MMR) from 590 per 100 000 births in 1990 to 200 per 100 000 live births in 2010. The progress in achieving MDG 4 and 5 in the Region has been variable and uneven, both among and within the countries. There is an urgent need to address economic and social inequities as well as health system challenges that adversely affect maternal, newborn and child health and have impacted the progress of MDG 4 and 5. A coordinated approach among national governments and partners within the health sector and other related sectors is required to accelerate progress.



Looking beyond survival, it is necessary to rapidly expand contraception services and address abortion-related morbidities, cervical and breast cancers, reproductive tract infections and gestational diabetes in order to ensure the overall health and well-being of women. The need to invest in early childhood development through age-appropriate care is also necessary to foster improvement in nutrition and health outcomes of growing children, as well as contribute to improved quality of life in the Region. The Regional Director hoped that the deliberations in the meeting would help forge accelerated actions in the countries to improve the health of women and children in the Region. (See full text of RD's message at Annex 1).

Ms Karin Hulshof, Regional Director, UNICEF (ROSA) reiterated that nothing is more important than giving every child a healthy life, and ensuring the mother's health during and after pregnancy. However, while a lot has been achieved in South-East Asia, there is much that still needs to be done. Many babies still die during the first year of life, mainly from preventable causes including pneumonia, diarrhoea, sepsis and so on. South-East Asia is now polio-free, and this is a good example of the changes that can be made by working together. Ms Hulshof described the challenges that require urgent attention, including addressing the needs of the most deprived; turning knowledge into policy change, and ensuring greater investment in overall health expenditure.

Ms Lubna Baqi, Deputy Regional Director, UNFPA shared the results of a global survey on the review of the International Conference on Population and Development (ICPD), undertaken as part of events leading to the twentieth anniversary of the ICPD Programme of Action. The results indicate that people are highly committed to achieving universal health for all, and that concerted efforts since the first ICPD in Cairo, Egypt in 1994 have resulted in reducing maternal deaths by half. However, inequities continue to exist, especially among poor and marginalized groups. In South-East Asia, only 25% of women among the poorest quintile deliver babies in health facilities as compared to 86% in the richest quintile. Adolescents form the most vulnerable group and need urgent attention – especially to meet contraceptive needs and prevent unsafe abortions – through addressing policy requirements and increasing access to information and health-care services. Although there is much to be proud of in terms of what has been achieved in the past two decades, a lot still needs to be done. Maternal deaths can be reduced through cost-effective measures including access to family planning, strengthening skills, and ensuring the availability of

emergency obstetrics care. As the Region is one of the strongest growing economies, there is a reason to push harder to get political and financial support to achieve MDG 4 and 5.

Dr Praveen Mishra, Secretary, Ministry of Health and Population, Nepal welcomed participants to the meeting, which provided a forum to share experiences and lessons learned, as well as challenges faced, in achieving MDG 4 and 5. Nepal is one of the high-performing countries in reducing child mortality and is on track to meet MDG 4. Highlighting the gaps and challenges, Dr Mishra said that not all parts of the country were being reached; gender and social inequalities continued to exist; the neonatal mortality rate had stagnated; quality of care was not universal at all levels of health facilities; health needs of the population living in remote areas were not addressed; undernutrition among children needed attention; task-shifting within the health workforce needed to be further explored; and the health system needed to be strengthened.

Dr Mishra acknowledged that Nepal had been able to achieve the targets because of commitment from the Government of Nepal, as well as support from external development partners. Policies respond to evidence-based needs and data collected through health management information systems; for example, the removal of user fees in accessing health care and provision of financial incentives to access services. The 'Aama' programme for safe motherhood has gone a long way to ensure institutional deliveries. He acknowledged that reduction in maternal and child mortality is not only a health issue, but encompasses several related issues including education, access to water and sanitation, nutrition, roads, and research. Most policy-makers in Nepal still consider health as expenditure and not an investment. Dr Mishra hoped that this thinking would soon change and health will be considered an investment rather than expenditure.

H.E. Mr Adhikari, Honourable Minister of Health and Population, Nepal stated that over the years Nepal has made significant progress and is on track to meet MDG 4, 5 and 6. He reiterated the commitment of the Government of Nepal to meet the MDG targets and acknowledged that this was possible only through collaboration between ministries, external development partners, international nongovernmental organizations and civil society, alongside excellent participation from the community and the people. The Government has implemented evidence-based and context-specific interventions and has been instrumental in mitigating social, cultural and economic barriers, with a specific focus on the poor and the



marginalized groups. The Honourable Minister suggested that health should be at the centre of development, and a multisectoral approach and the acknowledgement that health provision is a collective responsibility would go a long way in ensuring universal health coverage (UHC).

Two publications produced by the WHO Regional Office for South-East Asia were also released, by the Regional Director, Dr Poonam Khetrapal Singh, namely Progress towards MDG 4: Situation of Newborn and Child Health in South-East Asia and Mapping abortion policies, programmes and services in the South-East Asia Region.



Release of Joint UN statement by the regional directors

The Joint Statement on Women and Children signed by the Regional Directors of the WHO Regional Office for South-East Asia, United Nations Children's Fund (UNICEF) Regional Office for East Asia and the Pacific, UNICEF Regional Office for South Asia and United Nations Population Fund (UNFPA) Asia-Pacific Regional Office was released. The Joint Statement reiterated the pledge of the UN agencies to support countries in their resolve to minimize preventable deaths among women and children, and work towards the accountability principles established under the UN Secretary-General's Global Strategy for Women's and Children's Health.





Joint Statement on Women and Children

Kathmandu, Nepal - 29 April 2014

With 510 days remaining until the deadline for the Millennium Development Goals (MDGs), we recognize the tremendous progress on child and maternal health in South-East Asia and jointly commit to the continuing support of the governments to fully achieve MDGs 4 and 5* and progress beyond 2015.

Polio-free certification in South-East Asia has given us the confidence to strive for improved results for mothers and children, but stark challenges remain.

Every hour in South-East Asia more than 200 children under the age of five, including more than 100 newborns, are likely to die, while nine women are likely to die during pregnancy and childbirth. For each woman who dies, a further 20 more suffer serious childbirth injuries or permanent disabilities. More than half of women of reproductive age do not have their needs for modern contraceptive methods fully met. Gender-based violence has emerged as a major public health concern.

Many maternal and child deaths are easily preventable through evidence-based interventions. But the availability of these lifesaving services is profoundly unequal, with the poorest and most vulnerable groups having the least access to them. We need a renewed call to action to collectively drive for improved results for women and children in the South-East Asia countries.

We support countries in their resolve to minimize preventable deaths among women and children, and work towards the accountability principles established under the United Nations Secretary-General's Global Strategy for Women's and Children's Health. Encouraging family planning and investing more in early childhood development and adolescent health, especially for girls, is critical to ensure long-term public health and economic gains for society.

We jointly pledge to continue working with governments and partners to strengthen national capacities to:

- expand coverage of evidence-based interventions to reduce morbidity and mortality of mothers and children using innovative approaches – especially focusing on unreachd and vulnerable populations;
- improve quality of care at all levels and assure efficient use of resources;
- design public health programmes and health systems that take a wide view of the social determinants of health and closely engage with local communities;
- strengthen monitoring and evaluation functions and uphold national commitments on accountability for tracking results for maternal and child health.

Together we call upon South-East Asia Member States to recommit to addressing the unfinished agenda of MDGs 4 and 5 and to continue the progress beyond 2015 so that all women and children in South-East Asia can enjoy the highest standard of health and well-being.

Poonam Khetrapal Singh
Regional Director
WHO-SEARO

Daniel Toole
Regional Director
UNICEF-EAPRO

Karin Hulshof
Regional Director
UNICEF-ROSA

Nobuko Horibe
Regional Director
UNFPA-APRO

* Millennium Development Goal 4: Reduce child mortality. Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. Millennium Development Goal 5: Improve maternal health; Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. Target 5.B: Achieve, by 2015, universal access to reproductive health.



Proceedings

MDG 4 and 5: so close, yet so far

Dr Mikael Meyer Ostergren, Programme Manager, Department of Maternal, New born child and Adolescent Health, WHO headquarters highlighted the progress made and challenges faced in reducing maternal and child mortality rates in the Region. Globally, as many as 6.6 million children die before their fifth birthday. Although there has been a global decline in under-five mortality and the rates of decline in South-East Asia are close to the global average, the Region still has the second highest share of global under-five deaths. The South-East Asia Region has the highest decline in MMR, and some estimates indicate that MMR in some countries in the Region is the same as the global average.

Highlighting the causes of maternal and under-five child deaths, Dr Ostergren emphasized the need for effective, timely and relevant interventions as well as availability of commodities and guidelines, if these deaths are to be prevented. Although interventions are present, their coverage is very low; rural–urban inequities and in-country differences are issues that need to be addressed, as interventions do not reach those mothers and children who need them most.

Tracking the process of establishment of CoIA timelines for country-level events following the formation of the UN Secretary-General's Global Strategy, he said that to date, 10 multi-country stakeholder workshops have been organized to sensitize countries to CoIA

New initiatives – opportunities and challenges

Multiple New Initiatives in support of RMNCH Global Strategy

- Born Too Soon;
- Newborn Action Plan;
- A Promise Renewed;
- Pneumonia & Diarrhoea Action Plan;
- IP 2020;
- Commission on Ending Childhood Mortality;
- Nutrition for Growth;
- Global Vaccine Action Plan,
- etc.

EVERY NEWBORN
A COMMITMENT TO PROGRESSIVE POLICIES

FP
FAMILY PLANNING
2020

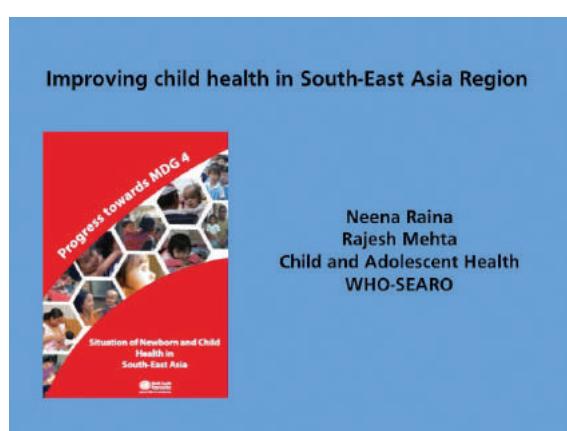
recommendations, and actions prioritized based on an assessment, sixty-eight stakeholder workshops have been held; fifty six Country Accountability Framework (CAF) and roadmaps have been completed, and 12 are in progress. From the US\$ 250 000 catalytic funding that was made available, 55 countries requested funding. While 50 countries have received the funding to date, five are in the process of being disbursed.

Dr Ostergren described each of the indicators included within the CoIA framework and highlighted that although progress has been made, half of the recommendations will be difficult or impossible to achieve by 2015. The challenges include: inadequate use of innovations; limited engagement of multiple sectors; limited capacity in the country to implement innovative techniques; and the need to work with all partners towards one country platform for information and accountability.

Moving ahead, suggestions were made to bring various initiatives and action plans under the umbrella of national health sector plans including: Born Too Soon; Every Newborn Action Plan; A Promise Renewed; Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD); Family Planning 2010; Commission on Life-Saving Commodities for Women and Children; Nutrition for Growth; Global Vaccine Action Plan, and so on.

Dr Neena Raina, Regional Adviser, Child and Adolescent Health, WHO Regional Office for South-East Asia shared regional achievements and gaps in relation to MDG 4, including progress in implementation of the CoIA framework. Although under-five mortality has declined considerably, the Region is unlikely to achieve the MDG 4 target of 39 deaths per 1000 live

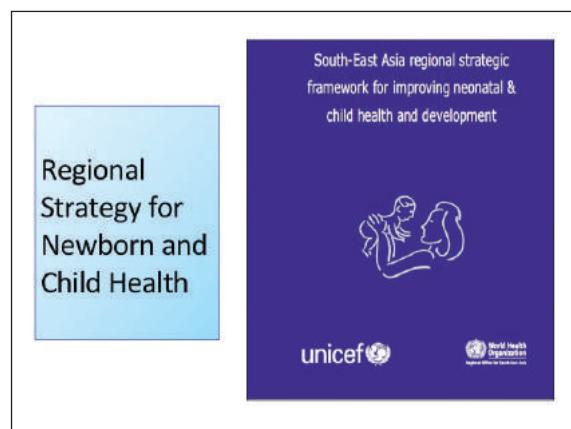
births by 2015. There is a need to address disparities within the countries related to socioeconomic factors such as level of education and place of residence, which impact child mortality. The most deprived are children who are born to poor, uneducated women living in rural areas.



Dr Raina reiterated the guiding principles along the continuum of care, which include a life-cycle approach; addressing issues of equity and child rights; a health system approach to ensure quality of care across different levels of health-care delivery; private sector involvement; integration and convergence; multisectoral and cross-sector partnerships; and community ownership. Strategies include taking action within the health system to ensure effective service delivery along the continuum of care and to strengthen all health-system components, as well as beyond the health system to address the key determinants of maternal and child health, nutrition and development, and to address disparities across population groups.

The challenges in South-East Asia include the uneven status in achieving MDG 4; low coverage of interventions, high inequity and indifferent quality of care. There are issues related to the health systems, including: policy and essential supplies and logistics management, shortage of health workers, weak monitoring and supervision systems; and the challenge of involving private sector in health service delivery. Dr Raina emphasized that as the Region moves from a focus on child survival to the broader concern of child development, the health sector can and must contribute to early childhood development.

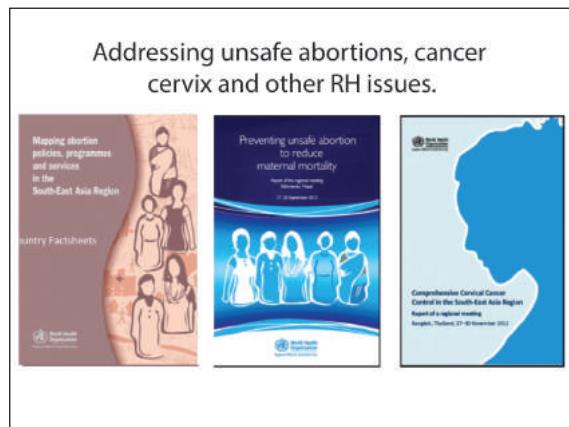
Dr Martin Weber, Regional Adviser, Maternal and Reproductive Health, WHO Regional Office presented the status of MDG 5 in the South-East Asia Region. There has been considerable progress in reducing maternal mortality



rates in the Region, but much still needs to be done. The main causes of maternal mortality continue to be haemorrhage, hypertensive diseases and sepsis.

Dr Weber highlighted the challenges in the Region. While interventions for reproductive, maternal, newborn and child health (RMNCH) are well known, coverage continues to remain poor and varies across the continuum of care. There are widespread differences in equity and there is a human resource crisis. There are other reproductive health conditions that need

more attention; for example, unsafe abortion, cervical cancer and infertility.



Dr Weber highlighted the importance of maternal death surveillance and response (MDSR) within the CoIA framework. MDSR is an effective process for linking the health information system and quality improvement

processes from local to national levels, and for using the information to respond with actions to prevent future deaths. It is very useful in creating district networks and connecting communities to health facilities. The primary purpose of MDSR is to stimulate corrective actions at various levels.

Discussion

Participants expressed concern about stillbirths remaining uncounted as they are neither reported within neonatal mortality or under-five mortality rates, nor do they feature in MDG 4 or 5. Stillbirths can be prevented by cost-effective interventions already available. They are not a part of infant mortality, but are an important reflection of the quality of obstetric care.

A broader issue raised was the need to work together on the multisectoral and financial interventions that will be necessary. Increasing coverage of skilled birth attendants is critical, especially in rural areas, as there is an urgent need to reach those who need services the most.

The issue of exclusive breastfeeding was raised. Even after three decades, only five out of 11 countries are implementing mandatory breast-milk substitute laws/acts. There is a need to strongly advocate for all countries to give it a legal status.

A suggestion was made to include child death surveillance, as this will help in developing a mechanism to understand the pattern of deaths and related health-system issues. It was suggested that near-miss cases should be included in MDSR, as they are more common than maternal deaths. This will help in improving health systems and quality of care. It was clarified that MDSR is only a starting point for maternal mortality assessment – the idea is to start simple and then expand the scope, as it becomes progressively challenging to undertake and manage.

It was acknowledged that there are missed opportunities. Immunization had a lot of advocacy plans, high investments and accountability; in fact, health workers were questioned if a child was missed out. Unfortunately, similar investments or advocacy are not present for other child health interventions and maternal health. In fact, there is hardly any system for accountability and no one questions this state of affairs.

A drafting committee was appointed to develop the meeting declaration, which articulated commitments and the way forward. The following participants were selected as members:

- Dr Md Altaf Hossain, Bangladesh
- Dr Ajay Khera, India
- Dr Rusmiyati, Indonesia
- Dr Theingi Myint, Myanmar
- Dr Padam Bahadur Chand, Nepal
- Dr Rita Thapa, Nepal
- Dr Sanjay Chauhan, India (Secretary).

Dr Rajesh Mehta, Medical Officer, Child and Adolescent Health, WHO South-East Asia Regional Office, informed that the country teams would be expected to identify key country-specific actions based on the deliberations during the meeting. He requested the country delegates to identify a few key actions relevant for their country after each technical session, including why these are suitable for the country and how they will be achieved. Towards the end of the meeting, these session-wise actions would be compiled into a proposed country action plan.



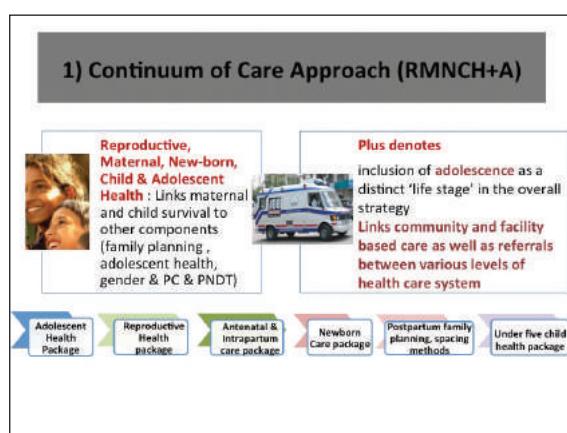
Saving mothers' and children's lives: what worked, where and how?

This session provided the opportunity for countries to share their experiences and the lessons learnt while scaling up RMNCH programmes.

Dr Rakesh Kumar, Joint Secretary, Reproductive and Child Health, MoHFW, New Delhi, India, presented on experiences in accelerating reduction in maternal mortality. He highlighted that India accounts for 16% of global maternal deaths and 22% of global under-five deaths. Although considerable progress has been made in achieving MDG 4 and 5, unless efforts are accelerated, India may not be able to reach the targets by the end of 2015.

A number of interventions have contributed to the steep decline in mortality rates. The Government of India has made concerted efforts to create demand for services through its conditional cash-transfer programme for safe motherhood (*Janani Suraksha Yojana*, launched in 2005) and mother-newborn package (*Janani Shishu Suraksha Karyakram*, launched in 2011). A free-of-cost referral transport system has been put in place, with more than 20 000 ambulances that provide timely access to public health facilities. Access has also been increased by strengthening delivery points

in the maternal and child health wings in health institutions, as well as intensive training of nurses as skilled birth attendants and medical officers in emergency obstetric care. India has also put in place mechanisms to strengthen monitoring systems, including institutionalized maternal death reviews across the country in both

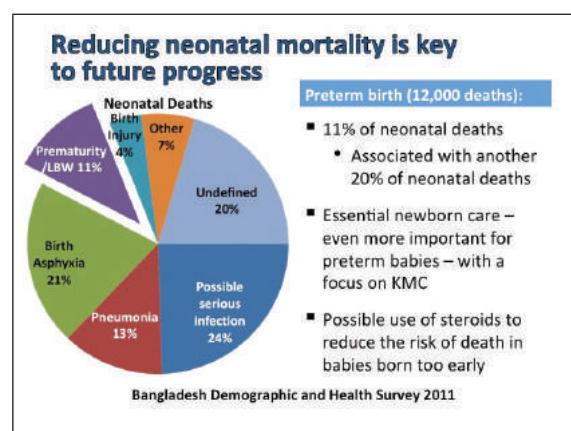


facilities as well as communities. Software has been rolled out to track women and children from pregnancy to two years post-delivery - the mother and child tracking system (MCTS) to ensure no services are missed.

The roadmap for accelerating progress has been developed by adopting the continuum of care approach (RMNCH+A strategy) with a focus on adolescent and reproductive health. Strategies are being implemented to: reach the unreached and hard-to-reach areas; address teenage pregnancies and the problem of unsafe abortions; strengthen human resources availability and skills; use data for decision-making; strengthen monitoring and supportive supervision; focus on quality improvement; and ensure accountability. The Government has identified 184 "high priority districts" for focused attention. Owing to these efforts, India appears on track to achieve MDG 5: the current annual compounded rate of decline is 5.7% (compared to the required 5.5%) to reach the MDG target of 150 maternal deaths per 100 000 live births.

Dr Shams al Arifeen, Director, Child and Adolescent Health, ICDDR,B, Bangladesh shared the experience in accelerating reduction in child mortality. He reported that the under-five mortality rate has been declining by more than 5% per year and that, at this rate of reduction, the current under-five mortality rate may already be lower than the MDG 4 target of 48 deaths per 1000 live births. Bangladesh has been successful in increasing the number of functional facilities providing safe delivery services and comprehensive emergency obstetric (CEmOC) services, and many more people are able to access health facilities than in the past. The country is growing economically; literacy rates are higher than ever before, especially among females aged 15–24 years; fertility is near replacement level; and there was an impressive decrease of 40% in maternal mortality in the past decade. Bangladesh is on track for achieving MDG 5, as the current MMR is 194 maternal deaths per 100 000 live births and the target is 143.

It was highlighted that although gender discrimination and rural–urban disparities have been reduced, disparities by education level and by



wealth have changed little. Thus, programmes and interventions – including increasing access to public health facilities – need to be designed specifically for the poor. Programmes and polices that have contributed to progress in achieving MDG 4 were highlighted. Integrated Management of Childhood Illness (IMCI) has been supported as a full-fledged programme with budget allocations and has been available in most districts. However, neonatal mortality remains a specific challenge. There is a need to find ways of identifying preterm babies in the community and ensuring that they receive all elements of essential newborn care, particularly warmth and feeding support.

Managing pneumonia and serious infections is also a key challenge. There has been limited success with community case-management strategies, as well as deployment of community-based health workers and interventions to improve the quality of care by informal providers. However, there are several donor-supported initiatives in place that address this by improving access to health services, including private sector facilities.

Discussion

Participants expressed concern that adolescents are not receiving adequate attention within the RMNCH programmes. Early marriage and childbearing was not adequately reflected in the Bangladesh presentation. The increasing female literacy rate in Bangladesh offers a good opportunity to address adolescent sexual and reproductive health to break the intergenerational cycle of premature death. It was clarified that adolescent health is a priority in Bangladesh and is being adequately addressed. However, delaying marriage is a complex issue and needs the involvement of society at large. Steps taken by India in addressing adolescence within the reproductive, maternal, newborn, child and adolescent health (RMNCAH) strategy were appreciated.

Bangladesh's experience in reducing maternal and child mortality reflects that the investments made over time in improving the status of girls through their education and empowerment has had a definite impact. Bangladesh identified geographic areas of need and tailored programmes accordingly. Although India has made huge national-level investments in health including human resources, provision of ambulances, and so on, the situation has not changed proportionately. It was suggested that investments made will produce better results once the status of girls and women improves.

Both Bangladesh and India have identified low-performing areas. There is a need to acknowledge that in such districts, the existing health systems are weak and district-level personnel will need capacity-building for better planning and implementation of the plans. Such districts also need additional resources to expand the identified services, and improve access and utilization. There is also a need to address equity-related issues.

A question was raised about the low number of deliveries by skilled birth attendants and high rates of immunization in Bangladesh, and whether immunization is provided by skilled or unskilled providers. It was clarified that as far as IMCI is concerned, Bangladesh considers this as a programme and has adequate funding and regular monitoring mechanisms. The high percentage of immunization is accounted for by deployment of community health workers (CHW) and outreach workers who can reach the hard-to-reach areas.

India further informed that strategies to reduce maternal mortality are in place and acknowledged that interventions need to be scaled up rapidly. The issues of quality and equity need to be addressed when scaling up interventions. India provides additional flexible funding for the identified "high priority districts", and has engaged development partners to provide technical support and supportive supervision in these districts.



Unresolved challenges: newborn mortality

Dr Vinod Paul, Head, Department of Paediatrics, AIIMS, New Delhi, India presented the Challenge of persistence of high newborn mortality. Of the world's 6.6 million under-five deaths, 44% occur during the neonatal period; and in South-East Asia, 55% of the 1.8 million under-five deaths are during the neonatal period. Of the 2.9 million neonatal deaths worldwide, 1 million (35%) occur in the South-East Asia Region. Neonatal mortality is high in the Region, with 27 deaths per 1000 live births as compared to 21 deaths per 1000 live births globally in 2012. The slow reduction in neonatal mortality has retarded progress towards MDG 4 in the South-East Asia Region.

The global community is committed to reducing under-five mortality to 15 deaths per 1000 live births by 2035 (A Promise Renewed – Call to

Action for child health). This implies that the neonatal mortality rate should be reduced to 10 deaths per 1000 live births by 2035. Accordingly, the *Every Newborn Action Plan* aims at achieving this target.

 **Key messages: What works**

- Available interventions can reduce neonatal deaths to under 1 million if universalized
- Maximum gains accrue from
 - Quality care in labor, childbirth and immediate postnatal period
 - Quality care of small and sick neonates
- Half of neonatal survival gains come from maternal interventions



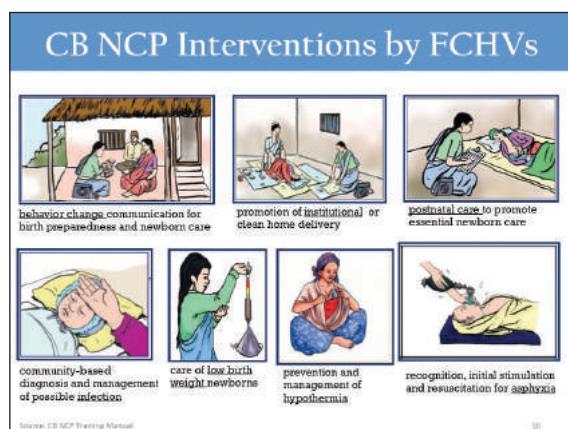
India is the biggest contributor (81%) of neonatal mortality in the Region. Thus, it is clear that if India does not deliver,

the Region will not be able to deliver either. The challenges faced in dealing with this issue using data from India were elaborated. Most neonates in India die due to birth asphyxia and trauma, preterm birth complications and sepsis. Available evidence-based interventions can reduce neonatal deaths globally to under 1 million if universalized. The maximum gains

would accrue from quality care during labour, childbirth and the immediate postnatal period, as well as providing good-quality care for small and sick neonates. It is clear that half of neonatal survival gains come from maternal interventions.

The Government of India considers UHC to be the way forward and is prepared to fully fund it. The aim is to enable all people to access the health services they need without the risk of financial hardship by providing a national health package of essential primary, secondary and tertiary health-care services. There is a need to embed newborn health in the UHC package, although there are concerns about the readiness of the health system to do this.

Dr Shyam Raj Upreti, Director, Child Health Division, Ministry of Health and Population, Nepal shared experiences on community based newborn care programme. While there has been a marked decline in infant and child mortality, neonatal mortality has remained at nearly the same level over the past decade and accounts for most under-five deaths in Nepal. Newborn survival came into focus only post-2000, and since then Nepal has shown significant progress in incorporating newborn care into national maternal, newborn and child health policies and programmes. Two major milestones are the National Neonatal Health Strategy and the Community Based Newborn Care Programme. The programme was implemented through seven interventions including: behaviour change communication; promotion of institutional delivery and clean delivery practices in the case of home deliveries; postnatal visits of mothers and newborns; case management of possible severe bacterial infection; management and care of low-birth-weight newborns; prevention and management of hypothermia; recognition and management of birth asphyxia; and timely referral of sick newborns. Female community health volunteers were trained, and have played a pivotal role in implementation of CB-NCP.



The limitations of the programme are that it is a standalone package for newborns, and uses a blanket approach for all geographic areas with no special or additional effort to reach unreached populations. The initial phase of the programme has been evaluated, but there has been delay in using the results. Issues of quality and scaling up of implementation also need to be addressed.

Community-based intervention improves the access and use of key maternal and child survival interventions. Continuum of care is crucial and there is a need for systematic scale-up. In order to increase programme coverage, there is a need to strengthen existing health systems and integrate CB-NCP into the existing maternal and child health programme.

Dr Ajay Khera, Deputy Commissioner and In-charge, Child Health and Immunization, Ministry of Health and Family Welfare, New Delhi shared experiences on *facility-based newborn care*. India has shown a steady

decline in under-five mortality, which now stands at 52 deaths per 1000 live births (Sample Registration System, 2012), catching up with the global average of 48 deaths per 1000 live births (2012). However, neonatal mortality has declined slowly during the same period and constitutes 56% of total under-five mortality in India.



Ensuring improved access of good quality, skilled care at birth will save the majority of preventable neonatal deaths. A multipronged approach is being pursued that includes: RMNCH+A strategy for acceleration; strengthening of health systems; reaching the population with the highest burden of mortality; increasing institutional deliveries; and child screening and early intervention services. This approach will also include strengthening facility-based newborn care; home visits by CHW (home-based newborn care); and empowering primary health-care workers for detection and management of preterm labour, neonatal sepsis and asphyxia.

The provision of newborn care at various levels of the public health facilities was described in detail. Under the existing programmes, sick newborns are entitled to free health care with the aim to have "nil out-of-pocket" expenses. The Government of India has developed costed operational plans and guidelines for home-based newborn care and facility-based newborn care that are used across the states. Newborn care corners, newborn stabilizing units and special newborn care units (SNCU) are being established, across progressively higher levels of health facilities. While SNCU have strengthened management of sick newborns at district hospitals, newborn stabilizing units and newborn care corners have expanded the reach of special newborn care beyond the district hospital with effective referral linkages. This linkage of care at various levels of the health facilities reduces delays in the initiation of appropriate care for sick newborns, improves outcomes, and reduces the cost of care.

There are challenges, however, in delivering facility-based care for newborn babies. Limited skilled human resources and training pose a major bottleneck in getting the newborn unit operational and sustaining it. Other challenges to providing quality care include: ensuring adherence to housekeeping and clinical protocols; record-keeping and timely reporting of data; quality of follow-up home visits by CHW (known as accredited social health activists, or ASHA); and, post-discharge survival, growth and development. Referral linkages also need to be strengthened. To overcome these challenges, state governments have tried optimizing on contractual positions, along with deployment of regular staff; providing performance-based incentives to trained staff; developing at least one state-based resource centre for sustained capacity-building and on-the-job training; and providing supportive supervision and regular monitoring.

Discussion

It was suggested that studies on morbidity or near-miss cases among newborns should be undertaken, as this is important in understanding the causes of morbidity. In response, India shared its learning experience from district SNCU. Results from operations research undertaken indicated that a number of neonates died at home soon after they were discharged from SNCU and there were developmental delays in the survivors. In response, follow-up home-visits by CHW for all neonates discharged from SNCU for one year, supplemented by mobile phone follow-up, have been instituted.

In response to a question about UHC in India, it was indicated that the UHC package would include RMNCH+A interventions. At present, *Janani Shishu Suraksha Karyakram* (mother–newborn programme) entitles all children up to one year of age to free-of-cost care at hospitals including drugs, food and transport.

Responding to the issue around the challenge of inequity between and within states, India has identified “high priority districts” where reproductive and child health indicators were not good. These districts are given additional funding and special technical assistance through development partners for improving health systems. The National Rural Health Mission is another example of an initiative to help the poor in rural areas, and a component for the urban poor has also been added. The overall direction is pro-equity and pro-poor.

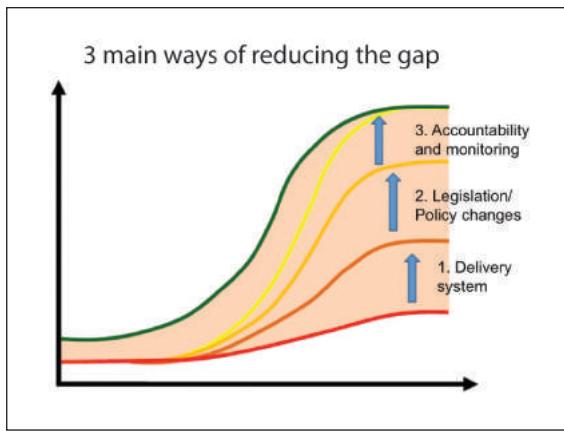


Beyond 2015: call for greater equity

Dr Mickey Chopra, Chief of Health Sector, UNICEF, New York outlined equity issues around ending preventable child deaths. While significant progress has been made towards the MDG 4 target, there is a need to accelerate progress and define a new global agenda and coordinated strategy for child survival beyond 2015. The challenges include variable progress across geographies and populations, and specific causes of mortality that require targeted, high-impact interventions. There is a need to understand how to effectively use new data insights, effective technologies, and country innovations to enable strategic shifts towards ending preventable child deaths.

The annual rate of decline in maternal mortality and under-five mortality is higher than ever before and, if continuous attempts are made, the rate of decline will increase; thereby saving a large number of lives as we move forward. While substantial progress has been made, coverage gains have not been equally distributed across the richest and poorest quintiles. By ensuring that the poorest also receive the benefits of interventions and catch up with the already achieved national averages, MDG 4 will be achieved – and this is a quick way to reach the target.

UHC is the key for addressing issues of inequity, but one needs to be careful because UHC itself may increase inequity if not implemented carefully. The poor and the marginalized face many hurdles in accessing services – usually they are the last to receive the benefits of any investments, and the quality and scope of services provided to them is likely to be inferior. There are other forms of disparities beyond financial status, such as social and cultural issues including gender, mother's education, and age. On the demand side, the urban and rich are better informed and have better networks to access benefits. The poor, on the other hand, have greater opportunity costs in accessing the services and are at risk of discrimination as well as impoverishment.



monitoring of services through regular feedback on quality and coverage – disaggregated by social and economic parameters.

Ways to change delivery systems included shifting an intervention within a channel by improving ways in which services are already being delivered; shifting an intervention to a different delivery channel by task-shifting; and, improving the performance of the delivery channel itself.

On the affordable technology front, innovation appears to be the key; however, little investment has been made in products that could help counter the major causes of premature, under-five and neonatal deaths. There appears to be a lack of concerted effort to expand and make the supplier base healthy. Innovation is also required for efficient planning and implementation. Available tools can be used to assess bottlenecks and barriers on the demand and supply side and to improve the quality based on results.

The UN Secretary-General has two mandates.....

- ❖ High-level Plenary Meeting on the Millennium Development Goals: September 2010.... "*to advance the development agenda beyond 2015"*
- ❖ United Nations conference on Sustainable Development (Rio +20): June 2012.... "*to establish an inclusive intergovernmental process on sustainable development goals..."*

Three steps were suggested to fill the gaps by looking at the supply and demand side. First, to strengthen the delivery systems, including community-based programmes and involving civil society; second, to address legislative and policy barriers faced by the poor; and, finally, to ensure accountability and

Global commitment to end preventable maternal, newborn and child deaths can be achieved in three ways. First, by analysing the available data to sharpen and scale up high-impact strategies, identify barriers and bottlenecks, and align cross-sectoral support for maternal, newborn and child mortality. Second, by

informing the community at large about the political commitments made, and encouraging civil society and other groups to take action and undertake advocacy activities. Third, by focusing on accountability through the use of score cards and reporting subnational progress against national and subnational targets.

Dr Andrew Cassels, Consultant, Geneva, presented the global discussions on the Post-2015 development agenda. Since 2010, the UN Secretary-General has had the mandates “to advance the development agenda beyond 2015” and “to establish an inclusive intergovernmental process” on sustainable development. A number of high-level panels and groups have been set up to develop a roadmap for the post-2015 period and multiple discussions have taken place globally. Until the Rio+20 document was published and made available, there was barely any mention of health. However, civil society actors and various partners have effectively advocated for health to be included.

Global consultations have highlighted that the current MDG should not be abandoned, but the job must be finished. Different groups have come up with a long list of priorities, including: to pay more attention to women, children, newborns and adolescents; sexual and reproductive health and rights; noncommunicable diseases; and communicable diseases. It was also reiterated that health should be embedded within a human rights framework and equity made central to the development agenda. Different groups had different priorities, but – fortunately – they have kept UHC as an overarching goal, or at least a key driver.

There continue to be some troublesome issues in setting health goals. Sexual and reproductive health and rights are controversial issues, especially in the South-East Asia Region, and it has been a challenge to come up with a common agreeable language to define sexual and reproductive health. Intellectual property rights, transfer of resources, competition and institutional rivalry are further issues that need attention.

Dr Kittipong Saejeng, Director, Bureau of Reproductive Health, Department of Public Health, MoPH, Nonthaburi, Thailand shared experiences in ensuring equity through universal health coverage. He described the maternal and child health situation in the country and indicated that Thailand has achieved MDG 4 and 5. However, there are concerns around adolescent pregnancies, low birth weight associated with adolescent pregnancies, and sexually transmitted infection/HIV prevalence

among adolescents. Thailand has online birth defect registration and the data indicate a high prevalence of congenital anomalies among children, with the major anomaly being congenital heart defects followed by limb anomalies.

The first national reproductive health development policy (2010–2014) was formulated with the objective to support every birth to be Desirable, Safe and Good Quality. The strategies used included: strengthening family bonding; promoting appropriate sexual and reproductive health behaviours through provision of comprehensive sexual education; improving sexual and reproductive health services, including provision of youth-friendly health

services (family planning, and safe abortion); and, improving management systems. The family bonding project aimed to enhance maternal and child health through quality services from antenatal care through the child-rearing period, and extend it beyond the hospital to the family and the community.

Expectations of UC Scheme

- Extend coverage to all**
- Universal benefits packages with emphasis on primary care**
- Decrease out-of-pocket payments**
- Harmonize UCS with other government financed insurance systems**

The national UHC programme was formulated with the aim to equally entitle all Thai citizens to quality health care according to their needs, regardless of their socioeconomic status. The hallmarks of UHC include expansion of coverage to all citizens; provision of universal benefits packages with an emphasis on primary care; and a reduction in out-of-pocket payments. Specific activities were included in the UHC programme for pregnant women and for children aged under three years and between 3–6 years. Challenges faced in implementing UHC are around three areas, namely quality monitoring, quality assurance and health technology assessment.

Mr Jayendra Sharma, Planning Officer, Planning and Policy Division, Ministry of Health, Thimpu, Bhutan shared experiences in provision of Primary health care as the basis for equity. Bhutan has a predominantly welfare-led governance. The Government is engaged in health financing and

delivery. Bhutan is unique in its measurement of gross national happiness. In the country's five-year plans, the focus on health has expanded over time.

Bhutan does not have private health-care providers, except for some diagnostics and pharmaceutical stores. The state provides free access to basic public health services in both modern and traditional medicines. The latter is within the mainstream health system and a patient has a choice of traditional or modern services. The existing three-tier service delivery system (primary, secondary and tertiary) is supported by community engagement at the basic level through outreach clinics and village health workers.

Over the years, there has been a decline in the population growth rate and total fertility rates. Pregnancies among adolescents aged 15–19 years have also decreased. There has been an increase in the proportion of institutional deliveries and births assisted by skilled birth attendants and the MMR has declined significantly. Trends for infant mortality and under-five mortality also indicate a significant decrease.

There are variations in the use of health facilities for delivery according to both region and socioeconomic quintile, and there is a direct association between socioeconomic status and health outcomes of children aged under five years. Challenges to service delivery include difficult geographical terrain and a scattered population, which makes progress in moving towards universal quality health services difficult. There is concern about Bhutan's ability to sustain free health-care provision to its people, as there has been a decrease in fund allocations for health over the years. Other emerging challenges that need urgent attention include the emergence of noncommunicable diseases, and new infectious diseases such as H1N1 and H5N1; economic development; the zeal for privatization; and the impact of climate change.

Recent initiative in PHC

- 1. NCD PEN intervention**
- 2. Integrated geriatric care services**
- 3. PHC monitoring through HAMT**
- 3. Tracking mother and child initiative**
- 4. Seven priority districts for MCH interventions (capacity, infrastructure, supplies)**
- 5. Tobacco, NCDs, Nutrition, Climate change**

Discussion

Questions were raised about equity and who actually constitute the marginalized, vulnerable and unreached groups. While the standard has been to define this population by wealth and place of residence, there is a need to include adolescents, unmarried, disabled and different gender identities in the most vulnerable group. Financial and geographical accessibility are important, but it is also necessary to consider social acceptability. There is a need to assess whether the existing systems can provide disaggregated data, and if the existing health management information systems are geared to address this need. Adolescents are a large segment of our population, but does the existing system track age-wise break-up of family planning, for example.

Secondly, India looks at equity in terms of economic class, but India is a caste-stratified society. Castes and sub-castes play a significant role in access to services including health, water, sanitation, electricity, etc. Health workers also visit the richer group first and then come to the poor population. Most of the health burden lies on the less advantaged groups, including the tribal population. The challenge is how to reach such populations. Responding to this concern, India indicated that they have identified 184 high priority districts, and have tried to ensure access to public health facilities through programmes aimed at the poor and the marginalized (such as the National Rural Health Mission).

In addition to addressing geographical, physical or economic barriers to access, there is a need to address issues around citizenship in relationship to displaced people, stigmatized groups and gender, which is a deep social determinant of health-care access. Bhutan responded by saying that a lot needs to be done within an equity framework in the country, including integrating standardized measurements within existing monitoring and evaluation systems.

Innovation takes technology and health care closer to the people. India is the prime example, where neonatal equipment is being manufactured locally at a low cost, enabling the Government to take neonatal care down to the district and subdistrict levels. Acknowledging the need for innovations, it was indicated that investments in technology and cost-effective equipment are necessary.



The missing link: quality of care

Dr Martin Weber talked about quality of care across the continuum of care. Quality can be defined as: doing the right thing to the right person at the right time at the lowest cost. Key components in quality in patient care are that it should be equitable, accessible, available, acceptable and appropriate; comprehensive; efficient; provided at the lowest possible cost; and, finally, efficacious. For this, there is a need to define and agree upon standards, communicate them to users and providers, and monitor their enforcement and adherence.

Dr Weber shared the findings of a seven-country study undertaken to assess quality of hospital care for seriously ill children in less-developed countries. Key findings highlight that emergency triaging is hardly ever done; drug supply is inadequate; knowledge of treatment guidelines is poor; there is limited monitoring of inpatients; little attention is given to malnutrition; and there is poor food supply for children. WHO has brought out a series of documents to provide technical support to manage these issues.

To improve quality, standards need to be developed and communicated, assessment needs to be undertaken to highlight strengths and weaknesses, and a scoring system should evaluate where each standard is positioned and what needs to be improved. Finally, improvements need to be made based on assessments.

Collaborative approach

- Bringing people together periodically to exchange experiences and work on common problems
 - Learning sessions on technical content
 - Skills and knowledge
 - Learning quality improvement methods
 - Learning from useful examples and mistakes
 - Joint advocacy to higher levels
 - Typically every 3-6 months
 - Quality circles more frequently



A number of guidelines developed by WHO are available that address provision of care to women, neonates, infants and children, and obstetrics and gynaecology; however, it is necessary to get the relevant professional association's approval and consent, as they are the guardians of quality of care.

Dr V. Chandramauli, Department of Reproductive Health and Research, WHO headquarters, Geneva, expanded the issue of quality of care in relation to adolescent health. The ICPD Programme of Action recognized adolescents as a special group and adolescent-friendly health services were developed using a standards-based approach. The services need to be

Quality health services for adolescents

Accessible
Adolescents *are able* to obtain the health services that are available

Acceptable
Adolescents *are willing* to obtain the health services that are available

Equitable
All adolescents, not just some groups of adolescents, are able to obtain the health services that are available

Appropriate
The *right health services (i.e. the ones they need)* are provided to them

Effective
The *right health services are provided in the right way*, and make a positive contribution to their health



designed such that they are accessible, acceptable, equitable, appropriate for adolescents' needs, and effective. A three-level systematic process was developed to improve quality and expand the coverage of health services for adolescents: national-level action includes situation analysis and development of standards and guidelines in line with

national policies; district-level action includes orientation of health-care providers at different levels; and health facility-level action is at the local level to implement the national standards.

National standards are used to assess and improve quality. Over the last 10 years, 18 countries, worldwide have carried out a systematic process to improve the quality and coverage of health provision to adolescents. The findings of the assessment are encouraging, and indicate that these actions led by national governments improved the quality as well as the service-utilization by adolescents.

Dr Weber shared that maternal and child health lags behind in terms of advocacy for improving quality of care in comparison to adolescent health programme. A regional framework for improvement of quality of care is being developed by the WHO Regional Office in consultation with Member States based on the "Plan Do Study Act" model. An interesting

comment was posed about the definition of “minimum standards” – does this mean what a patient can expect to be in place all the time and if they are not met, the patient can hold the provider accountable for failing an obligation; or, does it refer to an aspiration/goal to be met in the distant future, and hence there are no obligations to be met nor is there any clear communication of expectations.

In summary, it was highlighted that certain things are already in place, such as a regional framework for hospital improvement; global and country-adapted guidelines; assessment tools for quality of care, and country-level experience to use these tools; and, some countries have national processes for patient safety, quality and accreditation. Global indicators for quality of care are under development. What is needed is systematic use of available tools, embarking on improvement processes in all countries, sharing of experiences, and moving forward.

Dr Rusmiyati, Head, Subdivision of Maternal with Complication Prevention, Directorate of Maternal Health, Directorate General of Nutrition and Child Health, Ministry of Health, Jakarta, Indonesia shared experiences on the assessment of quality of maternal health. Indonesia's national policy looks at the continuum of care, and programmes address different needs at each stage of the life-cycle. There are standards, standard operation procedures (SOP) and tools available for each stage. The main programme in MMR reduction acceleration includes steps to ensure that a midwife works properly; that basic emergency obstetric and newborn care, comprehensive emergency obstetric and newborn care and other services are available 24/7; and that the referral system works effectively. The programme also addresses strengthening governance at district level; strengthening intersectoral and private partnerships; and improving birth preparedness and complication readiness interventions involving the family and community.

Priority interventions include capacity-building for health personnel through training and continuing education;

Quality of MCH Care (slide 1)

- **Compliance Rate to standard of maternal and newborn care (< 60% antenatal care, < 50% delivery care, < 55% post partum care, asphyxia management, < 65 % complication management, etc)**
- **Availability of essential drug for maternal and newborn : MgSO₄, Oxytocin, blood availability (< 30%)**
- **Compliance rate in recording : MR, Partogram (< 45 %)**

Source : Maternal Health Services Assessment (MoH – ObGynAs-WHO, 2012)

provision of equipment, health facilities, drugs and supplies; strengthening primary health care; and UHC. Challenges to implementation include decentralization; disparity between provinces and between districts within a province; limited access to health care, especially in rural and poor areas; and cultural and socioeconomic changes in the community.

The main causes of maternal mortality in Indonesia are haemorrhage and hypertension. The MMR is 359 maternal deaths per 100 000 live births. Findings from a study highlighted the three main causes of delay in seeking care. Of the 474 maternal deaths, 45% and 44% reported delay in decision-making, and hospital management respectively; while 66% were late in reaching a referral facility. Census data show that more than 40% of women died in hospital and 23% at home. Thus, improving the quality of emergency services in hospitals and primary health services is essential. Parity, education level of the women and rural residence are important factors contributing to maternal deaths. A study undertaken in collaboration by WHO and the Indonesian Society of Obstetrics and Gynaecology, to assess quality of care in facilities indicated that the compliance rate to standards of maternal and newborn care including recording partogram is low and there is poor availability of essential drugs for mothers and newborns.

To improve the knowledge and skills of health workers, the pocket book on maternal care developed with WHO support for primary and referral services is used extensively. Further training is provided in basic emergency management of obstetric and neonatal care, facilitative and supportive supervision is provided, and there is a collaborative improvement process. Opportunities were highlighted, including building links to training and accreditation institutes; involving professional societies (obstetrics and gynaecology, paediatric, etc.) as the guardians of quality; and improving "pre-service training" through the review of curricula.

Dr Md. Altaf Hossain, Programme Manager (IMCI), DGHS, Dhaka, Bangladesh shared experiences on total quality management (TQM) for maternal and newborn health care. Bangladesh has made significant progress on various indicators, especially health and population. While demand for health-care services has increased, referral hospitals face a challenge in providing quality services. The Ministry of Health and Family Welfare has constituted a national quality assurance steering committee, chaired by the Health Secretary; a national quality assurance technical committee, chaired by the Director-General of Health Services and co-chaired by the Director-General of Family Planning; a quality assurance task

group, chaired by the Director Hospitals (DGHS); and a quality assurance coordination committee, at the district level.

A “quality improvement” (QI) programme has been instituted into health services using the “5S-CQI-TQM” approach to improve hospital management by initially creating an employee-friendly working environment and positive mind-set. The process starts with the “5S”, which includes steps to: (1) “sort” out and remove unnecessary items from the workplace; (2) “set” everything needed in proper order for easy operation; (3) “shine” by maintaining a high standard of cleanliness; (4) “standardize” by setting the above 3S as norms at the workplace; and (5) “sustain” by training personnel. Once in place, “continuous quality improvement” (CQI) is client-oriented and helps reduce waste and improve efficiency. Finally, the TQM approach improves the quality of services delivered. TQM is oriented towards both clinical and management actions.



The basic concept of CQI cycle is PDCA - “Plan, Do, Check, Act” on one hand; and Problem-finding, Display, Clear, Acknowledge on the other. Strategies, guidelines, protocols, SOP and learning tools are developed and made available to hospitals. Under the programme, specific actions have been taken to strengthen service delivery through capacity-building of existing human resources, including training nurses, doctors and paramedics in various aspects of care. The standard layout of a special care newborn unit (SCANU) was formulated, and 16 hospitals have been upgraded with SCANU.

The 5S-CQI-TQM approach has been put in place in selected hospitals. Training of trainers has been undertaken and the QI monitoring team provides regular monitoring and supportive supervision. To strengthen the existing health management information system, an online individual record system has been put in place that aids service providers and programme managers in real-time tracking of performance and data collection for timely

corrective action. The results of this programme are promising, as the in-hospital neonatal mortality rate has decreased from 4.6% in August 2011 to 0.7% in November 2013.

Challenges remain, however, that need to be addressed. There is inadequate coordination, harmonization and integration among different programmes and agencies for QI; a national strategic framework and comprehensive action plan for QI is not yet in place; the monitoring and supervision system and capacities for QI programme management are inadequate; there is a shortage of human resources; poor motivation of service providers for compliance; inadequate budget and untimely fund allocation. Despite these challenges, Bangladesh plans to scale up the 5S-CQI-TQM approach and undertake specific actions to address the challenges through capacity-building initiatives in implementing QI activities and strengthening QI functions at the central/divisional level.

Discussion

A number of clarifications were sought about Bangladesh's experiences, on: funding required for increasing the number of SCANU; mothers' interpretation of SCANU, and demands that their infants be placed there; frequency of clinical case reviews; and quality assurance, including compliance issues and health management information systems. In response, it was clarified that no new rooms were built, but space was created by clearing up existing spaces and removing clutter. Mothers seem to feel that SNACU are for special infants and that their infants should also be placed there, and this has resulted in increased load. Clinical reviews are held regularly at the local and district levels, with a committee comprising clinical experts, and at the national level if there is a need. Quality and compliance issues are a concern, as those working on SCANU feel that others have a lot more freedom and they do not even get extra remuneration for being on duty 24/7. A process for remuneration is now being considered. Regarding the health management information system, the participants were informed that as soon as a patient enters a facility, all information collected goes to the central level; hence, real-time information is available.



Marketplace/poster session

Country participants were requested to prepare posters to report on progress in implementing the CoIA framework. Suggested topics included: overall maternal and child mortality rates; current status of civil registration and vital statistics; monitoring results; eHealth and innovation; review process; MDSR; advocacy; national health accounts; and, maternal and child health subaccounts.

Participants were also asked to present innovative approaches recently implemented in their country such as eHealth and mHealth to expand RMNCAH services, e-training packages, and so on. The session provided an opportunity for countries to share emerging areas of innovation including early childhood development, prevention of birth defects, preconception care, maternal morbidity, and cervical cancer.



Investing in the health of adolescent boys and girls

Dr Chandramauli focused on the diverse needs of adolescents in his presentation entitled 'It pays to invest in adolescents'. There is a need to invest in adolescents because without them MDG 4, 5 and 6 will not be achieved. Available data highlight the association between a young maternal age and adverse pregnancy outcomes including low birth weight, preterm birth, severe neonatal conditions, and increased risk of early neonatal death. Adolescents undergo unsafe abortions, have large unmet needs for contraception and there are clear differences by age, sex, region and marital status. There is also a need to address issues around gender discrimination, child marriage, sex-selective abortion and female infanticide, withdrawal from school, early marriage, pressure to bear children, and domestic violence and abuse. All of these have a direct impact on the health and development of adolescents, and often on the health of their offspring. Early pregnancy and poor reproductive outcomes among adolescents are determined by a web of micro- and macro-level factors. Individuals make choices to engage in specific behaviours in the context of existing family and community norms and economic circumstances, as well as within existing policy and regulatory frameworks that may at times be restrictive for adolescents.



Some examples of interventions and programmes that have worked, and others that did not were shared. Based on published literature so far, peer educator-based programmes for adolescent health have not been found to be successful. Although comprehensive sexuality

education is an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information, it has not been successfully implemented at scale.

There are many strategies in place, but few countries have moved beyond small-scale projects to large-scale and sustained programmes for adolescent sexual and reproductive health. At programme level, there is inadequate commitment, weak capacity, cash shortages, no real accountability, and discomfort among health workers, teachers and parents about talking on these issues. At the national level, there is a need for strong political will to ensure that adolescent health is housed within at least one national programme with a dedicated budget. At the district level, there is a need for public health leaders to be supported to lead planning, implementation and monitoring. At the community level, the people have to be empowered and supported to drive utilization of services and the QI process. The *Udaan* programme for adolescents implemented by the Government of Jharkhand, India in partnership with the Centre for Development and Population Activities, India, which is implemented in all schools in Jharkhand has reached about 500 000 adolescents in the state. There is a need for collaborative learning from each other's experiences and to capitalize on one another's resources and skills.

In conclusion, it was highlighted that there are sound reasons to invest in adolescents to achieve MDG 4, 5 and 6 (and beyond). Policies and programmes must be based on sound epidemiology and effective interventions. Strong leadership and management at all levels are essential to translate policies and strategies into action.

Dr Wame Baravilala,
Technical Adviser,
Reproductive and Maternal
Health, UNFPA, APRO
presented Unfinished
business: sexual and
reproductive health for
adolescents and young
people. He focused on the
Asia-Pacific region, and
highlighted findings from a
systematic review of how
laws and policies govern



young people's access to sexual and reproductive health/HIV information and services, and the ability of service providers to ensure availability and accessibility of these services to young people. In the Asia-Pacific region, adolescents (aged 10–24 years) account for 1.12 billion and they are generally healthier and better educated than before. However, in nine Asian countries, the vast majority of unmarried, sexually active adolescents either do not use any contraceptives or use a traditional method. As many as 5.4 million girls aged 15–19 years give birth annually, and there are 3.6 million unsafe abortions among women aged 15–24 years in Asia.

The findings of the review highlighted that most countries have conservative laws relating to sexuality and reproduction, reflecting the moral values of the colonial era rather than current understandings of sexual and reproductive health and rights. Laws often lag behind policies, thereby confusing people about the legal rights of youth to access services. Legal and policy barriers prevent adolescents from accessing information as well as services. Laws require marriage or consent of spouse; there are limited privacy rights; laws criminalize sex work, same-sex conduct, and drug use; and there is a constant fear of police abuse/prosecution for illegal conduct. There is a rigid age criteria, and "18" appears to be a magic number. The evolving capacities of a child or the maturity of each child to make decisions is not taken into account, nor is the health worker permitted to use his/her discretion on whether involving parents/guardians is in the child's best interests. The findings also highlighted the diversity in legal approaches to the right to confidentiality, which is often a grey area and a deterrent to services.

Examples of legislative and policy approaches that promote access to services include: recognizing the evolving capacity of a child to make independent decisions on their health; child protection laws that facilitate access to sexual and reproductive health/HIV services; laws that give people (including youth) enforceable rights to access services; laws that prohibit breaches of confidentiality in delivery of health services; and anti-discrimination laws.

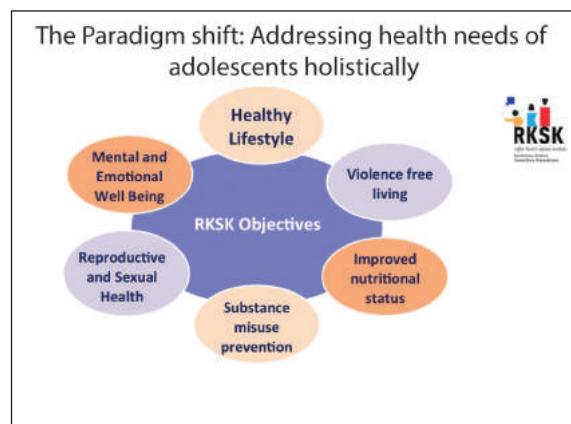
Dr Wame concluded that while some advances have been made in the region, critical gaps between laws and policies continue to exist. There is a need for policies to be supported by legislation that gives young people enforceable rights. Finally, there is not enough technical capacity and operational guidance to support health workers. To overcome these challenges, the way forward includes: engagement of youth in advocacy

and decision-making on legal and human rights issues linked to sexual and reproductive health/HIV; recognition of the evolving capacity of adolescents to make independent decisions regarding their health; improving technical capacity and operational guidance for health workers; improvements to law enforcement practices; and a better evidence base to inform sexual and reproductive health/HIV policies.

Dr Rakesh Kumar shared India's experiences with *Rashtriya Kishor Swasthya Karyakram* (RKS), a programme designed for adolescent health. Dr Kumar noted that adolescents constitute 30% of India's population. Investing in this population – through substantial investments in their education, health and development – represents a huge opportunity that could transform the social and economic profile of the country.

Dr Kumar shared data on selected indicators that highlight the critical need to focus on adolescent reproductive and maternal health. Data indicate that adolescents are at an increased risk of maternal mortality, premature labour, anaemia, neonatal mortality, and risk of poor nutritional status of children.

The RMNCH+A strategy recognizes that adolescent health is directly related to maternal health and child survival. It accepts that maternal and child health cannot be improved in isolation, nor can continuum of care be considered without focusing on adolescent health. Adolescent health forms part of the "5x5 matrix", which looks at high-impact interventions per life stage. It has five main interventions, including: addressing teenage pregnancy and increasing contraceptive prevalence in adolescents; provision of community-based services through peer educators; strengthening adolescent sexual and reproductive health clinics; rolling out the National Iron+ Initiative, including weekly iron-folic acid supplementation; and, promoting menstrual hygiene.



RKSK is a continuum of care approach for adolescent health and development needs, which provides interventions that are effective, appropriate, acceptable and accessible, and includes parents within the dialogue of improving services. It has been a major paradigm shift and addresses the health needs of adolescents holistically through guided interventions, including: interpersonal communication; adolescent-friendly health clinics; formation of partnership and convergence with other departments; and peer education. It uses the "7C" approach, which comprises: "coverage" of all adolescents irrespective of their marital, educational, or residential status; "content", including six strategic priorities; "communities" involvement; "clinics" especially for adolescents and strengthening existing adolescent-friendly health clinics; "counselling" at various levels; "communication" using media channels; and "convergence" with ongoing programmes and schemes. The interventions through RKSK are beyond the individual level, and engagement with parents and community is proposed in order to mitigate risk factors and enhance protective factors. It is a dynamic and evolving programme, with the possibility of mid-course corrective action based on evidence, and is targeted to assist adolescents in the country to realize their full potential by making informed choices and responsible decisions.

Dr ILK Jayarathne, Consultant, Community Physician, Family Health Bureau, Sri Lanka shared the experiences of the preconception care programme for newlyweds. Sri Lanka has high literacy rates and a low MMR (37.7 deaths per 100 000 live births) and infant mortality rate (9.0 deaths per 1000 live births). The goal of the maternal and child health policy of Sri Lanka is to promote the health of women and their partners to enter

pregnancy in optimal health, and to maintain it throughout the life-course. Strategies to deliver this include: availability of a comprehensive package of preconception care for all women of childbearing age and their partners; addressing the specific reproductive health issues of women and their partners throughout



the life-course, including women with special needs; integrating relevant sexually transmitted infection and HIV/AIDS services into the maternal and child health programme; and strengthening partnership with health-care providers. The programme provides preconception care to improve the health of the woman before her first pregnancy or any subsequent pregnancy.

There is a preconception care package for newly married couples, which addresses the need to improve reproductive health outcomes by improving the health of the couple. The programme aims to increase reproductive health awareness and thereby change unhealthy behaviours; improve/protect the health status of women/men before the woman becomes pregnant; address risk conditions/issues of women/men before they attain parenthood; and reduce the probable adverse effects and complications of pregnancy and pregnancy-related outcomes.

A public health midwife identifies newly married couples and uses an invitation card to invite them for two sessions. The health worker uses a screening tool and has a guide to refer to, and the couple receive a booklet with relevant information. Specific interventions include: risk screening and physical assessment for both partners; immunization; awareness and counselling; and provision of services and referrals as required. The pilot project is now being scaled up, and plans are under way to monitor progress.

Discussion

It was clarified that there are already global, UN definitions for "adolescents", "youth" and "young people". These are: adolescents, 10–19 years; youth, 15–24 years; and young people, 10–24 years. The needs of adolescents differ, depending on age. Furthermore, there are categories of people within an age group whose needs must be addressed based on their intellectual capacities, and whether they are sexually active or not.

Attention was brought to the fact that nutrition is an important determinant of RMNCAH. The nutrition status of adolescent girls is especially important because of its intergenerational implications. Poor nutrition/malnutrition is a huge problem, and nutritional deficiencies need to be identified and addressed. It is important to establish good

nutritional status and develop healthy habits right from early adolescence in order to ensure future health. In addition, numbers on early initiation of breastfeeding and exclusive breastfeeding have to increase. There is a need to address complimentary feeding and micronutrients, and provide counselling for best practices during breastfeeding (including attention to nutritive diet).

Issues of consent and confidentiality related to legally minor adolescents were discussed. The need for parental or spousal consent is a barrier for adolescents to access sexual and reproductive health services such as contraception, safe abortion, HIV testing and treatment. Consensual sex with, and between, minor adolescents is criminalized; often it is difficult to rule out the element of coercion and, thus, the possibility of sexual abuse. Clear policies and guidelines can mitigate some such barriers of access to services until laws are changed.

It was highlighted that adolescents are a heterogeneous group of people with evolving cognitive capacities. Their needs are very different, so is their internal capacity to understand and take decisions. All this has to be taken into account, together with legal entitlements. It was acknowledged that RSK aims to provide holistic care and appears very ambitious; yet, it is important for a country such as India with a relatively young population.



Demand as a driver for RMNCAH services

Dr Anthony Costello, Director, Professor of International Child Health and Director of UCL institute for Global Health, London talked about global perspectives and evidence on developing community-based interventions for maternal and newborn health. In his presentation entitled Demand, inequality and other wicked problems, he explained that “wicked” problems are those which are difficult to solve and complex. The difficulty is that the effort to solve one aspect of a wicked problem may reveal or create other problems.

He said that demand in public health includes several components: environmental (sanitation, etc.); biomedical (drugs and biomedical interventions); technology (for diagnostics and treatment); techno-economic (low-cost technologies to treat diseases and improve health); socio-behavioural; and ecological. He explained how financial barriers have been addressed by cash transfer schemes. Such schemes have resulted in higher enrolment in schools, higher rates of institutional deliveries and uptake of immunization – thus reducing the impact of extreme poverty. Cash transfer schemes have faced problems in implementation, delays in payments, exclusion, corruption and mistrust of governments where these programmes were politicized.



Cash transfer schemes have been used in Bangladesh, India, Nepal, and many other countries. A review of these programmes suggests that

there is a need for more efficient management, clear guidelines, financial transparency, and clear plans for sustainability. Evaluation of such schemes must demonstrate evidence of equity, quality of care and above all, the desired impact on maternal mortality and morbidity.

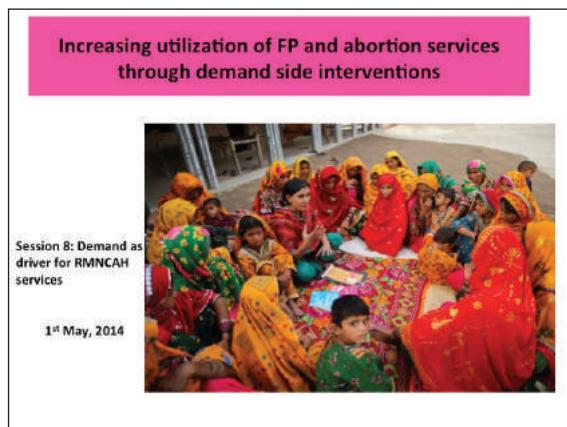
Regarding behaviour change, Dr Costello highlighted the exciting use of mobile phones – mHealth. This affordable technology has been used for client education and behaviour change. mHealth has the potential to extend point-of-care diagnostics for better treatment, and improve information systems through registries, vital events recording and electronic health records. Mobile phones are used for provider-to-provider communication, provider training and education, human resource management, and so on.

A number of community interventions are available, but it is necessary to understand which ones are effective and can be scaled up. The phases of the community action cycle were explained, which include: identifying and prioritizing problems; planning appropriate strategies and putting them into practice; and, finally, evaluating them together with the community. Findings were shared from different randomized control trials undertaken in developing countries that highlight community action and the impact of these programmes. Health-care services delivery is not only about the health of the mother and child, but should also include empowerment and community action. Health systems must address the social determinants of health through community action and men getting involved, as well as changing behaviours and thinking.

Mechanisms for community participation interventions include knowledge-sharing, social support, decision-making and political advocacy, ensuring that women are in control and that they question the existing situation. Women's groups are different from other health system interventions, because they can be geared to active decision-making rather than being passive recipients. Participation by women's groups has broader benefits than a reduction in maternal and newborn mortality. Such initiatives contribute to better mental health (reduction in maternal depression), gender equality and empowerment, which in turn lead to improvements in water, food, farm and environment conditions. Group and community action leads to sustained behaviour change and use of technology to improve overall health. Community participation and women's groups have demonstrated better results among the poorest, whose needs are the highest, but who are most likely to be left out during routine implementation of maternal and child health programmes.

Dr Anjali Sen, Regional Director, International Planned Parenthood Federation highlighted their work on increasing utilization of family planning and abortion services through demand-side interventions. IPPF Declaration of Sexual Rights emphasizes the fundamental concept of informed choice, which is the right to choose and the right to decide whether or not, how and when, to have children.

In the Region as a whole, the younger population are not adequately addressed and there is high unmet need for contraceptives in young women – Bangladesh 17%, India 27%, Maldives 36%, and Nepal 42% resulting in high adolescent fertility rates, for example: 118, 90 and 81 births per 1000 women aged 15–19 years in Bangladesh, India and Nepal, respectively.



There is an urgent need to ensure that different human rights dimensions, as highlighted in the 2014 WHO guidelines¹, are systematically integrated into the provision of contraceptive information and services. These rights-based recommendations such as nondiscrimination (based on individual choice, free from coercion or violence) and accessibility (particularly for poor, marginalized and young people) are critical for demand-side intervention. Men need to be addressed to clarify myths around the use of condoms and sterilization. The regional initiative on integrated counselling on sexual reproductive health rights is a manual designed as a resource on sexual reproductive health and rights, in the context of counselling. It helps to identify any unmet needs of clients.

Dr Sen shared the service delivery model of member associations in Bangladesh, Nepal and Pakistan. The different service delivery outlets are interconnected and linked with community structures relevant in each country, such as schools, *madrasas*, health posts, youth centres, family health centres, etc. The demand created through community-based campaigns, women's groups and peer educators contributes to

¹ Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations. Geneva, WHO, 2014.

The challenges in the Region

Younger population not adequately addressed

- High unmet need for contraceptives in young women – Nepal 42%, India 27%, Maldives 36% Bangladesh 17%
- Resulted into high level of adolescent fertility rate e.g. 118, 90, 81 per 1000 women aged 15-19 yr. in Bangladesh, India and Nepal respectively

Interventions:

Youth friendly services, Comprehensive Sexuality Education

Community mobilization (PEER educators, established youth network at district, national and regional level)

Meaningful participation of youth (ensured 20% YP in board)

an increase in services at different service delivery outlets. Besides information, education and communication/BCC materials (such as posters, pamphlets and games), mass media was also used to reach the community at large.

Summing up, she said that there has been meaningful participation

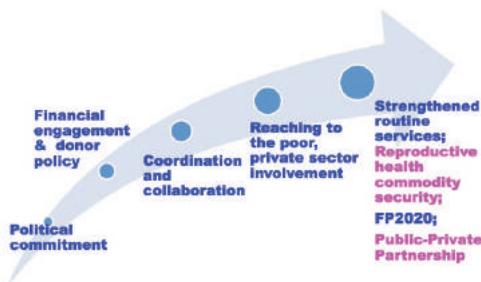
of young people at all levels – mobilization, programme design and policy formulation. Trained frontline workers (such as rural health practitioners in Bangladesh) serve as a vital link between health centres and poor and marginalized people seeking health services. These frontline workers mobilize the community, conduct group sessions, support campaigns and provide referrals. The IPPF experience shows that there should be strong linkages between health centres and the community in order to increase access to sexual and reproductive health services for poor, marginalized, socially excluded and underserved people.

Dr Theingi Myint, Deputy Director, Maternal and Child Health, Department of Health, Ministry of Health, shared experiences in Improving birth spacing in Myanmar. The MMR is still high in Myanmar at 200 maternal deaths per 100 000 live births. Data show that 24 600 newborns

die within the first week of life, and that there are 15 000 stillbirths.

The birth spacing programme was launched in 1991, and has been expanded to 142 townships in 20 years; the aim is to fulfil the unmet need for family planning by 2020. Reversible contraceptive methods are provided

Scaling-up family planning



through the public sector. Information is given to clients through pamphlets with more illustrations than text. The technical competence of providers is strengthened by continuing training to all health-care providers at all levels. Mechanisms are in place to encourage continuity of contraceptive use by involving well-informed users. Long-term contraceptive methods are also provided. The appropriateness of the constellation of services is taken into account, and clients are provided family planning services together with antenatal care, sexually transmitted infection services, prevention of mother-to-child transmission of HIV services, and other necessary needs. The main thrust areas of the programme are safe motherhood, birth spacing, scanning for cervical cancer, and adolescent reproductive health.

Scaling up of the family planning programme has been possible because of high political commitment, improved government expenditure, better coordination and cooperation mechanisms, reaching to the poor and strengthening routine services. Regarding future priorities, it is important to create broad-based support by the Government and increased financing in the national budget for scaling up family planning to the primary health care level. At the same time, geographic, social and economic barriers must be overcome. Improving the quality of services is another important issue.

Discussion

Myanmar and India have similar schemes, including door-to-door distribution and incentive-based schemes. In India, ASHA (village-level volunteers) get an incentive for ensuring birth spacing. There are pockets in India where although contraceptives are distributed, usage is poor. It is similar, however, in the case of iron supplements and folic acid tablets. Bhutan has had comparable experiences: where all health services are free including contraceptives, yet, while condom distribution is high, usage remains poor.

The necessity of working with adolescents and young people to instil healthy behaviours was highlighted. Although there are some studies, a lot more needs to be done in terms of working with adolescents in schools, and changing concepts of masculinity among youth, and so on.

The question of the sustainability of community groups beyond the project phase was discussed. The availability of joint funding by governments right from the inception stage could ensure that groups remain sustainable. The need for public-private and civil society partnership was emphasized.

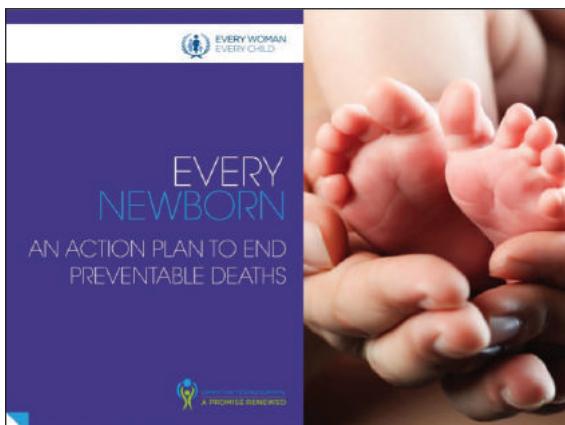


Global initiatives – regional implications: opportunities and challenges for RMNCAH

Dr Nabila Zaka, Maternal and Child Specialist, UNICEF, EAPRO presented on Promises made and in the making: MDG, a promise renewed and Every Newborn Action Plan, with a specific focus on MDG 4. Dr Zaka indicated that if the current trend continues, South Asia will be able to achieve MDG 4 by 2021 and the world could achieve it by 2028.

“A promise renewed” refers to renewed global commitment to child survival. There will be reduction in under-five mortality through existing and new interventions, such as new vaccines. To accelerate decline, however, there is a need to work across sectors with a focus on social and economic issues such as discriminatory practices, poverty, gender discrimination, and girls’ education.

New components in “A promise renewed” include stocktaking of successes and failures so far; assessing the significant gains in “post-neonatal mortality”, but acknowledging that reductions in neonatal mortality rate lag behind those for under-five mortality and maternal mortality. Understanding the underlying causes (malnutrition, inadequate sanitation, poverty, girls’ education, social norms) requires greater attention.



Newborn deaths were invisible in global estimates until 2005. There are proven interventions within the RMNCH continuum of care which can be used. It is clear that care around birth gives a triple return on investments by reducing maternal deaths, newborn deaths and stillbirths.

A Promise Renewed also recommends some actions at the national level, including: developing national plans; counting every newborn; adopting standards of quality and indicators for assessing quality; ensuring sufficient funding; and ensuring training, deployment and support of health workers, in particular midwifery personnel, nurses and CHW. It also suggests that innovation and research should be supported, and that communities, civil society representatives and other stakeholders should be engaged. Using parents' voices as champions is an innovative way to change social norms, so that newborn and child deaths are no longer acceptable.

Dr Ostergren informed that IMCI has been in place since 1995. The aim was to have an integrated approach to child health that focuses on the well-being of the child using three main components: improving case management skills of health-care staff, improving overall health systems, and improving family and community health practices. The purpose of the integrated GAPPD

is to provide a general framework and guidance to countries and partners for scaling up interventions in a coordinated way, propose action steps and programme activities to move forward efficiently, and build a broad coalition of global and national policy-makers, planners, donor agencies and civil society.

Goals for 2025



For children under 5 years of age

- reduce mortality from pneumonia to fewer than 3 per 1000 live births;
- reduce mortality from diarrhoea to fewer than 1 per 1000 live births;
- reduce the incidence of severe pneumonia by 75% compared to 2010 levels;
- reduce the incidence of severe diarrhoea by 75% compared to 2010 levels;
- reduce by 40% the global number who are stunted compared to 2010 levels.

GAPPD envisions ending preventable pneumonia and diarrhoea deaths through a healthy environment, and ensuring that every child has access to proven and appropriate preventive and treatment interventions through integrated approaches such as IMCI.

Dr Wame Baravilala's presentation focused on Family Planning 2020 and the UN Commission on Life-Saving Commodities. In the London Summit on Family Planning in 2012, more than 20 governments committed to addressing policy, financing, delivery and sociocultural barriers to women accessing contraceptive information, services and supplies. Family Planning

UN Commission on Life-Saving Commodities

- Build on the success of the Commission on Information and Accountability for Women's and Children's Health (CoIA)
- Provide broad policy guidance for the development of a set of strategic recommendations
- Board comprised of leaders of government, development, business and commerce
- UNFPA and UNICEF serve as vice-chairs of the Commission. Commissioners will be
- Supported by a working group composed of technical experts and a secretariat, hosted at UNICEF

2020 is a global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. The key is working with governments, civil society, multilaterals, donors, the private sector, and research and development agencies to allow 120 million more

women and girls to use modern contraceptives of their choice by 2020. The outcome of Family Planning 2020 is that – if this happens – more than 100 million unintended pregnancies will be avoided, 3 million fewer babies will die in their first year of life, and 200 000 fewer women and girls will die in pregnancy and childbirth. Countries from the Asia–Pacific region made country-specific commitments to expand and make available family planning services.

Dr Wame shared that the UN Commission on Life-Saving Commodities for Women's and Children's Health was formed in 2012, as part of the Every Woman Every Child movement (UN Secretary-General's Global Strategy for Women's and Children's Health), to increase access to and use of essential medicines, medical services and health supplies that effectively address causes of death during pregnancy, childbirth and childhood. The Commission on Life-Saving Commodities builds on CoIA and provides broad policy guidance and a set of strategic recommendations. Multiple stakeholders are involved including governments, development partners, and business and commerce entities. The Commission has identified 13 life-saving commodities essential for reproductive, maternal, newborn and child health. The Commission suggested that to increase access and use there is a need for improved markets and national delivery systems, and integration of the private sector and consumer needs.

Dr Arvind Mathur, Medical Officer, Making Pregnancy Safer, WHO South-East Asia Region elaborated on ending preventable maternal mortality (EPMM): targets for post-2015. A number of consultations have fed into the next (post-2015) development framework. A consultation convened in Bangkok, Thailand, on targets and strategies for EPMM affirmed that

EPMM is within reach, and that the necessary acceleration of progress can be achieved by positioning maternal survival in the context of every woman's right to health care and the highest attainable level of health across the lifespan. This goal must be supported by targets and strategies to ensure that maternal health – along with sexual and reproductive health, and newborn and child survival – continue to be development priorities post-2015. Revised rates for reduction of MMR were proposed: the global average MMR should be less than 70 by 2030; countries with a baseline MMR of less than 420 in 2010 should reduce MMR by more than two thirds from 2010 to 2030, and for high-mortality countries with a MMR more than 420 in 2010, the revised MMR should be less than 140 by 2030.

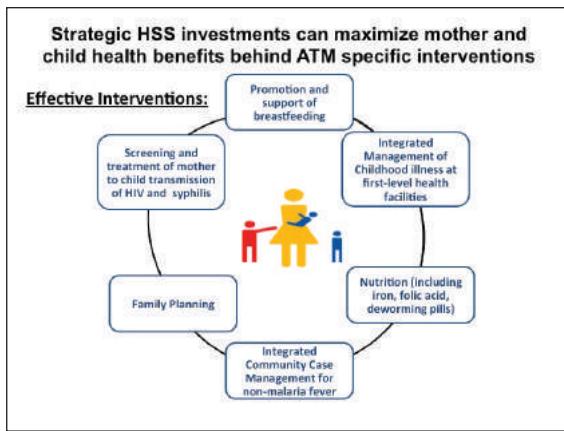
The guiding principles for the strategic framework towards EPMM are to empower women, girls and communities; and to ensure country ownership, leadership and supportive legal, regulatory and financial frameworks. It guarantees accessible, acceptable and quality reproductive, maternal and newborn health care within a human rights framework. It reiterates the need for cross-cutting actions for achieving this goal including improving metrics, measurement systems and data quality, and prioritizing adequate resources and effective health-care financing.

Strategic objectives toward meeting this goal

- Address inequities in access to and quality of reproductive, maternal, and newborn healthcare services
- Ensure universal health coverage for comprehensive reproductive, maternal and newborn healthcare
- Address all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities
- Strengthen health systems to respond to the needs and priorities of women and girls
- Ensure accountability to improve quality of care and equity

Strategic objectives include addressing inequities in access to and quality of reproductive, maternal, and newborn health-care services; ensuring UHC for comprehensive reproductive, maternal and newborn health care; and addressing all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities. On the systems side, it proposes to strengthen health systems to respond to the needs and priorities of women and girls; and ensures accountability to improve quality of care and equity.

Dr Viviana Mangiaterra, Senior Coordinator, GFATM, presented on Maximizing impact by addressing RMNCH. She talked about the Global Fund



to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and how it has been used in different components of RMNCH, including Every Woman Every Child and the Global Strategy for Women's and Children's Health. Between 2003 and 2010, the Global Fund has contributed approximately US\$ 3.12 billion to RMNCH, but

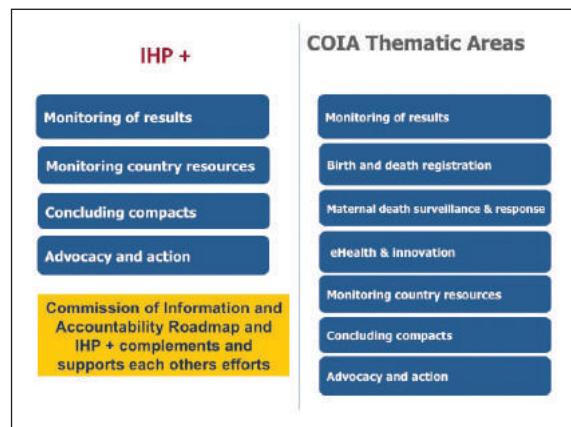
there is a need to ensure that these investments lead to optimal RMNCH outcomes. Dr Mangiaterra detailed the process of application for funds and said that countries can apply anytime in 2014–2016. The Global Fund's Technical Review Panel will evaluate the submissions based on evidence and gap analyses. Some key RMNCH questions to address during the country dialogue include: whether the country sufficiently supports RMNCH interventions that directly address HIV, tuberculosis and malaria; what the synergistic interventions highly relevant to HIV, tuberculosis and malaria are, and how these interventions are funded and implemented; is there any potential complementarity with governments and other donors; and, finally, is the health system strengthening funding supporting the key elements of effective RMNCH service integration. National strategic plans or investment cases are the basis for Global Fund support. National strategic plans should be costed, prioritized, and developed through inclusive, multi-stakeholder efforts involving key affected populations and people living with or affected by the diseases. They should be aligned with international normative guidance, national health sector strategies, and developed in coordination across the three diseases.

Finally, it was noted that intensive engagement at both global and country levels is needed over the coming months to meet the first New Funding Model submission deadlines in 2014.

Dr Padam Bahadur Chand, Chief Public Health Administrator, Ministry of Health and Population, Nepal talked about experiences in Coordination at country level and IHP+. Nepal finalized and signed a Country Compact in 2009, which was a joint memorandum of understanding between the

Government of Nepal and eight external development partners supporting Nepal's health sector. The seven focus areas of the Compact are to: strengthen alignment and management of official development assistance in accord with national policy, advance citizens' rights, improve financial planning and alignment, increase access and service delivery, advance equity and social inclusion, strengthen the sector-wide approach, governance and accountability.

Nepal formulated a single National Health Sector Plan with support through joint financial arrangements, pooled funding mechanisms and sectoral support from external development partners. Consultative meetings with partners on annual workplans, budgets and joint annual reviews have also contributed to the progress. There is increased accountability towards the aide-memoire at different levels of the Ministry of Health and Population, and increased transparency on funding from the Ministry of Finance. The participation of civil society organizations and nongovernmental organizations has also increased. The challenges include the need for timely follow-up on the aide-memoire and building mutual accountability between partners and the Government, to strengthen involvement of civil society and nongovernmental organizations in policy dialogue, and for better harmonization of technical assistance provided by external development partners.



Nepal focused on one commitment area of the Compact, namely to strengthen governance and accountability and develop a Country Accountability Roadmap-Nepal based on recommendations made by CoIA. The Roadmap recommended that while some indicators are on track, others need improvement including: eHealth; advocacy and outreach; and reporting on total and RMNCH health expenditure by financing source, per capita.

Some key factors that are likely to ensure the success of CoIA are good coordination between different stakeholders, formation of national

monitoring and evaluation, technical harmonization between partners to support the activities, commitment from the Government through funding, and the availability of CoIA catalytic fund.

There have been challenges in implementing CoIA, such as the need for better alignment and harmonization of multiple thematic areas and responsibilities; the need to further strengthen donor/partner support to translate plans into action; time taken for policy and system reforms; eHealth institutionalization; and engagement of political leaders and civil society. The way forward includes: long-term support, resource mobilization, including adolescents in all monitoring indicators, prioritizing quality of care to ensure equity and dignity, putting in place mechanisms for collecting better data; and holistic and integrated approaches in managing information systems, and linking that with planning.

Dr Preeti Kudesia, Senior Health Specialist, World Bank, South Asia Region, Kathmandu, Nepal presented on H4+: supporting countries for accelerating efforts to improve the health of women and children. She informed that the Joint UN Programme on HIV and AIDS (UNAIDS), UNFPA, UNICEF, UN Women, WHO, and the World Bank are partners in the “Health

4+” (H4+) grouping. In 2010, H4+ joined hands with nongovernmental organizations, governments, the private sector, foundations and other multilateral organizations and partnerships in their commitment to the Every Woman Every Child initiative and the Global Strategy. In 2012, they made a commitment to build on

the collective strengths and comparative advantages of the six agencies to jointly support countries with the highest rates of maternal, newborn and child mortality to accelerate progress towards achieving the health-related MDG.

Strategies used by the H4+ to support implementation of the Global Strategy include: mobilizing political support; building technical capacity at

the regional and country levels; focusing on the most vulnerable women and children; ensuring universal access to an integrated, essential package of health services; addressing root causes of morbidity and mortality, such as gender inequality; and engaging other sectors, such as education, nutrition, water and sanitation, culture and human rights.

The H4+ supported High Burden Countries Initiative (HBCI) is leading an in-depth assessment of the midwifery workforce in the eight countries that together represent nearly 60% of global maternal and newborn deaths: Afghanistan, Bangladesh, Democratic Republic of the Congo, Ethiopia, India, Mozambique, Nigeria and the United Republic of Tanzania.

World Bank supports all the initiatives, but specific mention must be made of the MDG Acceleration Framework (MAF). MAF is a process piloted by the UN Development Programme (UNDP) in 2010, which helps accelerate progress at the country level on the MDG that seem unlikely to be achieved. It has shown that acceleration is possible when governments take the lead, supported with effective assistance and cooperation from all partners. MAF provides national stakeholders with a systematic approach to identify and analyse bottlenecks in achieving the MDG, generate shared diagnostics, and recommend comprehensive, collaborative and focused actions, based on prioritized "acceleration" solutions. It does not aim to replace existing, nationally-owned planning processes and frameworks; rather, it draws upon them and complements national efforts. All the MDG are being monitored through MAF in the eight selected countries.

Some of the lessons learnt were highlighted. First, to find solutions that bring peace and security to individuals, communities, and countries – as without that there is no development, and without development the hopes for peace are diminished. Second, to focus on building government systems to deliver targeted and quality services. Third, not to underestimate the social aspects of change; for example, gender, rights, empowerment, and participation in civic affairs, which help people to take control of their own destinies and hold their governments accountable. Fourth, to ensure MDG action plans have clear indicators that can be monitored. Fifth, to build strong data and statistical systems. And, finally, that when a unified message from the World Bank and UN is sent out, it is a strong message.

There is still much more to do, especially in terms of coordination and the big challenge post-2015, particularly for health. Now is the time to start

a dialogue on UHC and involve countries in this process, as H4+ will be responsible for country-level finance and planning.

Following the set of presentations on new global initiatives and existing coordination mechanisms, a panel discussion on coordination and partnerships at the country level was convened. Panel members included representatives from UNFPA (Dr Wame Baravilala), UNICEF (Dr Robin Nandy), World Bank (Dr Preeti Kudesia), The Global Fund (Dr Viviana Mangiaterra), WHO (Dr Arvind Mathur and Dr Mikael Meyer Ostergren) and Nepal (Dr Padam Bahadur Chand). Dr Andrew Cassels moderated the discussion.

The moderator articulated issues for the panelists, as below.

- The presentations made it clear that the present global scene is characterized by a number of recent initiatives. Many of these have presented new goals, targets and indicators, several with different timelines. The initiatives have also given rise to their own separate reporting systems, meetings and publications. Moreover, they in turn have increased the need for better coordination and, indeed, the development of competing coordination mechanisms and accountability systems.
- A number of conclusions could be drawn from the analysis.
 - (1) The proliferation of global initiatives causes confusion at country level and risks duplication and fragmentation of efforts, and there is a tendency to create new programmes rather than adding additional and new inputs to existing successful programmes such as IMCI.
 - (2) On the other hand, the new initiatives could be seen as an opportunity to mobilize new resources to existing national efforts, and a reflection of successful advocacy.
 - (3) The recent focus on new specific initiatives could be seen as an inevitable consequence of the need for donors and their political backers to keep RMNCAH in the limelight in an environment of competition for increasingly scarce development funding.
 - (4) They could be seen as an important way of bringing in non-state stakeholders as equal partners to a common cause.

Panelists were asked to reflect on these conclusions. They responded, as below.

Dr Nandy (UNICEF) observed that in the past few years there have been a number of initiatives, movements, partnerships and frameworks, and that some of them have been forgotten. He cautioned that development programmes and indicators are not independent boxes. In Indonesia, an attempt was made to put the programmes in circles to see where the overlaps were, but it was very difficult. Governments complain about fragmentation at the ministry level, and we are also fragmented as an international development fraternity. At the country level, it is difficult to support, guide, and advise colleagues at the ministry to make these initiatives real. The issue is of duplication and confusion in planning, monitoring and accountability as we talk about multisectoral platforms and the pandemic of meetings in a crowded environment.

There are different initiatives at different levels, and at the global level it must be acknowledged that these initiatives need to be contextualized and adapted to local realities. For example, Indonesia has attempted to put A Promise Renewed within the existing coordination mechanisms including accountability, technical interventions, etc. Over time, however, there is a need to evaluate and review whether this works or not. Using existing platforms is great, but is there any way to make these links better at the global level and correct from the design phase.

Dr Mikael Meyer Ostergren said that there are three things the RMNCH community can be proud of. One, in the past five years there has been an unprecedented political will to promote reproductive, maternal, newborn and child health care. Two, the unprecedented influx of funding opportunities that have been pledged by different partners including World Bank, WHO, Global Fund, GAVI, and individual donors. Three, a number of partnerships have been created, such as H4+, working in different ways but at global, regional and country levels. Highlighting the challenges, Dr Ostergren said that there are no global policemen who could say, "no more initiatives". Initiatives will continue to come, and the challenge is at the country level where the initiatives have to materialize into results. These initiatives cannot be fragmented, but have to fit within the existing national RMNCH programmes.

Dr Viviana Mangiaterra said that donor funding is a complex issue. There are different sections of people and health-care delivery is a complex

process requiring functioning health systems at community, primary and tertiary levels. There are multiple plans in countries justified for newborn, maternal and child health and sometimes these have little money attached to them. Technical assistance is often needed to put these plans into action. The key element of success is to strengthen country-level capacities to lead the initiatives, and it has been seen that strong leadership results in better alignment of initiatives to existing country programmes.

Dr Arvind Mathur said that we are all working together for maternal and child health. He was optimistic about this; as the agencies work together and there is no one-upmanship or saying that an initiative is mine or someone else's. We move together and not in boxes. It is clear that country capacities should be built and all agencies work as catalysts to ensure that all these initiatives benefit women and children in the countries.

Dr Wame Baravilala talked about collaboration within the UN and suggested that although there is competition, we can all work together. Ministries of health may find it difficult to deal with all the different initiatives coming their way and with different reporting formats. The UN has done much good work, but they cannot do everything; therefore, alternative mechanisms and channels are needed to deliver services. We need to do things differently to achieve goals; for example, there is a lot of funding for family planning, yet the couple protection rate remains low and unmet needs remain high. We need to think of working with all partners. Although the private sector has good ideas, we say that we cannot work with them as we are not pro-private sector. We must acknowledge that what we need has mainly come from the private sector, and thus we need to involve them.

Dr Padam Bahadur Chand reiterated the three challenges: integration, monitoring and evaluation, and coordination. He emphasized the need for an integrated approach due to limited resources. Bringing partners together is difficult, as they come up with their own set of indicators. It is challenging to collect these different sets of information and report it back. Coordination is also a challenge, as partners have their own priorities (especially those for whom health is not a primary mandate).

Dr Preeti Kudesia agreed that there is demand for specific sets of data from specific initiatives, without taking into account national capacity to capture such data. The countries need funding; hence they are required to complete the reporting. Thus, it is imperative to address national-level

capacities to report along different indicators. On the donor side, there is a need for coordinated efforts and, although challenging, to undertake sector-wise funding. One can have an informal but improved mechanism of reporting by sitting together and coming up with reporting formats. One must look at country-level capacities, be aware of what is already happening, and assess what is needed. Dr Kudesia raised a concern about becoming focused on one initiative to the detriment of other important components (for example, nutrition). She advised keeping the bigger picture in mind.

In conclusion, Dr Cassels said that there are many new initiatives, which are now a part of our life. The 2005 Paris Declaration on Aid Effectiveness says that while taking on new initiatives please think twice. One must look at the difficulties faced by countries in managing these complicated tasks. It is necessary to think these through very carefully and creatively plan on how they will be implemented. With creativity and strong country leadership, new initiatives could be aligned to national priorities.

The key message from the session was to stress the importance of an overall comprehensive strategy in-country to which any initiative could be aligned. Mechanisms such as IHP+ were particularly helpful in this regard. Similarly, there was a need for development partners, notably the UN agencies, to work collaboratively rather than to compete for funds.

Plans for action at country level

The participants were asked to develop country action plans based on the framework provided. They were requested to identify priority actions relevant to their countries (based on the deliberations in the meeting), and draft an action plan with timelines. (See Annex 2).



The Kathmandu Meeting Declaration

Ending preventable maternal and child mortality towards achieving MDGs 4 and 5 in South-East Asia

We, the delegates from ministries of health representing countries of the WHO South-East Asia Region,² and partner development agencies³ met in Kathmandu from 29 April to 1 May 2014 for the regional meeting on "2015 and beyond: the unfinished agenda of MDGs 4 and 5".

We reviewed and appreciated the efforts being made by Member States and their development partners and we took stock of the unfinished agenda towards achieving the Millennium Development Goals (MDGs) 4 and 5 in the Region. Our main objective was to look forward, beyond 2015, to see how we can sustain and/or accelerate the reduction of maternal, newborn and child mortality in all of our countries in the Region.

We are proud of what we have achieved. Between 1990 and 2012 child mortality has declined by more than 50% in our Region and the maternal mortality ratio (MMR) has also declined by more than half.

We are keen to focus on the reduction of neonatal mortality, which remains a critical area of concern as it constitutes over 55% of child mortality – a higher rate than the global average of 44%. We also note with great concern that efforts for reduction of stillbirths and ensuring universal access to family planning remain major challenges.

While overall achievements in relation to MDG 4 and 5 have been positive, we noted that the achievements are not uniform and progress has been uneven both across the Region and within our individual countries.

² Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste (Democratic People's Republic of Korea could not attend).

³ Partner agencies in the meeting: WHO, UNICEF, UNFPA, World Bank, IPPF, GFATM, Save the Children, JICA, Plan International, DFID-Nepal

Economic, environmental and social factors including gender, poverty, early marriage, education level and age of mothers, and differences between rural and urban areas fuel the inequity observed in mortality and morbidity. Reducing such inequities alone would represent a major gain towards the achievement of MDG 4 and 5.

We also reaffirm that strengthening health systems is a precondition for more rapid progress. We know that evidence-based life-saving interventions are available across the life-course both at health facility and community level to prevent maternal, newborn and child deaths. The challenge that faces us all is to reach all people in need with effective services i.e. to ensure quality in service delivery going beyond the coverage numbers. It is a matter of concern to us that despite consensus and increased commitments at global, regional and country levels the progress in effective coverage is variable.

We warmly welcome the Joint UN Statement on Women and Children by the Regional Directors of WHO, UNICEF and UNFPA. This statement signals the continued commitment of all three agencies to work together in support of governments along with partners and other stakeholders to improve overall health and well-being of women and children in the Region.

As the outcome of the regional meeting, we declare our support to the following Declaration and Call for Action and seek sustained political commitment from the highest levels of our governments and from our colleagues and supporters in the international community. This has particularly urgency and relevance as UN Member States debate the next generation of development goals post-2015.

- Governments in the WHO South-East Asia Region must continue to give high priority to the achievement of MDG 4 and 5.
- Post-2015, governments need to support a health goal within which the reduction of preventable child and maternal mortality and provision of reproductive health services has a prominent place with even more ambitious goals compared to the MDGs.
- Such commitment by national governments must be expressed through enhanced investment for comprehensive reproductive, maternal, newborn, child and adolescent health (RMNCAH) interventions and ensure equitable and affordable health coverage with quality assurance.

- In line with the principles of UHC and the need to build stronger and more equitable health systems, we express commitment to:
 - work with governments' health financing strategy for reducing out-of-pocket expenditure to improve access to and affordability of RMNCAH services;
 - strengthen home-, community- and facility-based delivery of services, including a focus on improving health systems and use of local innovative approaches and available technology to improve access especially for the unreach people;
 - ensure access and specific targeting of maternal health, family planning and primary health care services to sexually active adolescents to reduce unwanted pregnancy;
 - empower communities with knowledge and skills for practicing optimum health care of girls and women, mothers, newborns, children and adolescents;
 - ensure availability of essential RMNCAH commodities and access to good quality family planning information, contraceptive products and services at all levels of care;
 - strengthen supportive supervision, morbidity and mortality surveillance, data triangulation and disaggregation including inequity analysis, effective monitoring and evaluation for timely tracking of results for RMNCAH and using the data for planning further improvements in services.
- For ensuring success we will strengthen efforts across the whole government to address the cross-cutting social determinants for RMNCAH and promote multisectoral actions to help achieve desired outcomes.
- Special attention will be given to reduction in early newborn mortality through interventions across the life-course that would ensure reduction in preterm births, stillbirths and maternal mortality, all at the same time.
- Specific and focused action will be given to prevention and control of pneumonia and diarrhoea in children, through coordinated approaches like Integrated Management of Childhood Illness (IMCI) and community case management.

- Recognizing that achieving MDG 4 and 5 (and also MDG 6) needs greater focus on adolescent sexual and reproductive health, increased priority will be given to strengthening adolescent health and nutrition services.
- We will strengthen national efforts towards achieving universal access to reproductive health (MDG 5b), especially family planning, and address reproductive morbidities as well as prioritize preconception health education and health-care services.
- We will work towards initiating/strengthening actions to prevent birth defects for further reduction in child mortality and associated life-long morbidity and disability, as well as to invest in interventions for early childhood development to improve quality of survival.

Annex 1

Address by Dr Poonam Khetrapal Singh, Regional Director, WHO Regional Office for South-East Asia

Distinguished participants, dear colleagues, ladies and gentlemen,

We have come together in this meeting because we share a common concern that many preventable deaths among mothers, newborns and children are still occurring in our Region. In an ideal world, not even a single mother, newborn or a child should die due to a preventable cause.

Of course, we must acknowledge the progress made in the South-East Asia Region in reducing maternal and child mortality since the inception of the global movement on the Millennium Development Goals (MDG) in 1990. As per the United Nations Inter-agency Group estimates (2013), under-five mortality has declined from 118 per 1000 live births in 1990 to 50 per 1000 live births in 2012. In the Region, an estimated 1.8 million deaths occurred in the under-five age group, and there were about 1 million newborn deaths in 2012.

Reduction in the maternal mortality ratio (MMR) from 590 per 100 000 live births in 1990 to 200 per 100 000 live births in 2010 is one of the most significant achievements over the past decade in the South-East Asia Region. While the progress is appreciable, still 76 000 mothers died as a result of pregnancy and childbirth in 2012. While appreciating these achievements for improving maternal health; universal access to reproductive health remains a big challenge as the contraceptive prevalence rate has remained stagnant over the years in countries of the Region.

The significant achievements of our Member States have also been acknowledged globally. Two countries of our Region received the UN Secretary-General's award in 2010: Bangladesh for progress towards achieving MDG 4, and Nepal for progress towards achieving MDG 5.

However, the overall progress towards MDGs 4 and 5 in the Region has been variable, and has been uneven among and within countries. Even in countries that have achieved the MDG targets, there are subpopulations or geographic areas that have higher mortality than the national average.

Significant inequities exist in maternal and child health on account of economic and social parameters such as gender, poverty, education level and rural–urban location.

Fortunately, Member States have included in their national health plans most of the evidence-based life-saving interventions in their service packages to address the main causes of maternal and child mortality. However, the population-based coverage of these interventions has been low and uneven among and within countries.

Progress along the trajectory of increase in coverage in the past two decades has not been fast enough. Efforts must be made to expeditiously scale up the coverage of interventions, with special emphasis on reaching out to the unreach ed people who need them the most. At the same time, enough attention must be given to ensure that the quality of care provided meets reasonable predetermined standards.

We understand that there are several health-systems-related challenges that have affected progress in maternal and child health. These include: low public investments in health, high out-of-pocket expenses, inadequate number and distribution of health workers with the necessary skill mix, poor availability and access to essential medicines and equipment, and poor health information systems. Investment in strengthening health systems has strong potential to benefit all health services – beyond maternal and child health services. In addition, there is a need to address the well-known underlying social, economic and cultural factors such as poverty, illiteracy, gender imbalance, early marriage and adolescent pregnancy, suboptimal birth spacing, and inadequate water and sanitation facilities that adversely affect maternal, newborn and child survival and health. Some countries have done good work to address these issues. We will hear some such experiences in this meeting.

National governments and the global community have expressed renewed commitments for MDGs 4 and 5 as reflected in the UN Secretary General's Global Strategy for Women's and Children's Health and the UN commissions on Information and Accountability, and Essential Life-Saving Commodities. There have been subsequent initiatives such as the Child Survival Call to Action, *Every Newborn Action Plan* and Family Planning 2020. These have raised the visibility of the maternal and child health agenda and provided common platforms for working together.

Recognizing the need, importance and possible impact of working together with common objectives, a number of global partnerships have been established during the past decade. By combining the strengths of public and non-state players and civil society, global partnerships with a common vision and one voice are indeed an answer to several challenges faced in global health today.

A coordinated approach among the national governments and partners within the health sector and other related sectors is the key to accelerate further progress. All of us must adopt the global movement towards accountability under the stewardship of national governments to collectively discharge the noble responsibility of improving the health of every woman and child. I am pleased to note that the crucial issue of progress in the implementation of the accountability framework will be discussed in this meeting.

Ladies and gentlemen,

Now is the time to act, since the realization is clear that "more of the same" may not work as we reach lower levels of maternal and child mortality. We urgently need to expand the coverage of evidence-based life-saving interventions with quality and equity. The recent polio-free certification of the WHO South-East Asia Region is a clear example that we can achieve apparently difficult goals by concerted action through broad-based partnerships. We should be ready to learn from successful experiences in neighbouring countries and beyond to ensure that what we do is appropriate, efficient and cost-effective. I believe this meeting provides the opportunity to share success stories and best practices for possible replication within local contexts.

I am pleased to share that the WHO Regional Office for South-East Asia has recently launched a Flagship to support expansion of effective interventions with quality services in an efficient manner to achieve a higher annual rate of reduction of maternal, newborn and child mortality. It is significant that we have the support and agreement of the Honourable Ministers of Health from Member States for the Flagship.

We also need to proactively engage – individually as countries and, more importantly, collectively as a Region – for defining the post-2015 agenda. Within Universal Health Coverage (UHC) we must be able to sustain the gains of MDGs 4 and 5 and look forward to progressing much

beyond the present targets. WHO is closely involved in the global process of developing goals and targets for the post-2015 development agenda. Under sub-Goal 1 – Achieve the health MDGs, the targets under proposal are: under-five mortality below 20 per 1000 live births, neonatal mortality below 10 per 1000 live births and maternal mortality ratio below 50 per 100 000 live births by 2035.

At the same time, it is important to look at issues beyond survival. We must prepare to rapidly expand contraception services, address morbidities among women related to abortion, cervical and breast cancers, reproductive tract infections, and gestational diabetes in order to ensure the overall health and well-being of women. Investing in early childhood development through age-appropriate care by the family will further foster improvement in nutrition and health outcomes of growing children, as well as contribute to improved quality of life in the long term.

WHO has recently led consultations to strengthen preconception care in the continuum of care across the life-course. Addressing maternal health risk factors before conception will contribute to better reproductive health outcomes including healthier babies as well as prevention of certain birth defects. At the same time, investment in promoting healthy behaviours among adolescents, such as healthy diets, physical activity and avoidance of tobacco use, will contribute to reduction in noncommunicable diseases in the long term. To achieve this, the WHO Regional Office for South-East Asia is now consulting Member States and partners to evolve an innovative package named “Healthy Transitions for Adolescents”.

Ladies and gentlemen,

I would like to thank the Government of Nepal for collaboration in hosting this important meeting and all of you for your participation. I acknowledge the presence of senior-level representatives from national governments and partners. I sincerely hope that the deliberations are able to help forge accelerated actions in countries to improve the health of women and children in our Region.

I particularly appreciate the collaboration of the Regional Directors of UNICEF and UNFPA, and wish to offer collective and unified support on behalf of all development partners to Member States to achieve the common goal of saving precious lives of women and children in our Region.

I wish you all the very best for successful deliberations in the meeting, and hope you have a pleasant stay in Kathmandu.

Annex 2

Country action plans

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Bangladesh			
Saving mothers' and children's lives: what worked, where and how?	Demand-side financing (DSF) at 53 upazilas (subdistricts) Establish SCANU at tertiary- and secondary-level hospitals Universalization of IMCI implementation	<ul style="list-style-type: none"> • Implementation of A Promise Renewed • Implementation of GAPPD • Development and implementation of QI framework 	
Reduction of newborn mortality	Introduce and promote provision of antenatal corticosteroid and kangaroo mother care Appropriate, better management of newborn infections with antibiotics Continue establishing neonatal stabilization units at primary-level hospitals and SCANU at secondary- and tertiary-level hospitals Strengthen essential newborn care at all levels, especially community level Implement Helping Babies Breathe initiative		
Beyond 2015: call for greater equity	DSF focusing on poor and marginalized women and children Special interventions such as MNCS, MNCH, MaMoni and MNHI in low-performing and hard-to-reach districts Local-level planning		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
	1. Continue establishment of QI system (5S-CQI-TQM) in facilities nationwide, in phases 2. Develop country strategic framework and comprehensive action plan on QI 3. Develop core sets of Indicators for maternal and child health service		
Monitoring and innovations	Establish civil registration and vital statistics system Implement MDSR Use of integrated/single system to collect health information including maternal and child health		
Investing in health of adolescent boys and girls	Strengthen adolescent-friendly health services and preconception care at facilities Enhance existing school health programme Introduce adolescent health clinics at tertiary-level facilities Revise and strengthen adolescent health strategy		
Social mobilization for RMNCAH services	Participation of mothers and communities in demand creation for RMNCAH services Rights-based approach for RMNCAH Media campaigns		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Global initiatives	A Promise Renewed – Bangladesh Call for Action – released on 21 July 2013		
	GAPPD		
	Every Newborn Action Plan		
Bhutan			
Saving mothers' and children's lives: what worked, where and how?	Strengthen and expand EmONC services	<ul style="list-style-type: none"> ● Institute a system of providing short-term training courses for MBBS doctors on EmONC skills to expand its services ● Improve the continuum of care through effective operationalization of tracking every mother and child initiative (Revised MCH Handbook) ● Update National Midwifery Standards and Newborn Care Standards ● Strengthening of postnatal care ● Integration of birth defects surveillance, antenatal corticosteroid, kangaroo mother care 	<ul style="list-style-type: none"> ● Revitalization of volunteer health worker programme: development of its long-term strategy ● Develop and implement RHCS strategy ● Revise and implement National Family Planning Standards
	Improve continuum of care through rigorous tracking of every mother and child		
Reduction of newborn mortality	Improve quality of maternal and newborn care services		
	Initiate prevention and surveillance mechanism for birth defects		
Beyond 2015: call for greater equity			
Quality of care			
Monitoring and innovations	Strengthen health information system		
Investing in health of adolescent boys and girls	Strengthen adolescent sexual and reproductive health services		
Social mobilization for RMNCAH	Enhance community participation in RMNCAH services		
	Development of Reproductive Health Commodity Security (RHCS) strategy		
	Provide quality family planning services		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
India			
Saving mothers' and children's lives: what worked, where and how?	Strengthening quality of care with focus on providing skilled birth attendants, especially for high-risk populations	<ul style="list-style-type: none"> • Strengthen quality of care with focus on providing SBA, especially for high-risk populations 	<ul style="list-style-type: none"> • Implement multisectoral plan for adolescent health
	Improve monitoring of surveillance of maternal, child and perinatal deaths through maternal death reviews and maternal near-miss reviews, child death reviews and stillbirth surveillance	<ul style="list-style-type: none"> • Improve monitoring of RMNCH+A strategy through scale-up of maternal and child death reviews and stillbirth surveillance 	<ul style="list-style-type: none"> • Prevent teenage pregnancies and provision of safe abortion services
	Increase access to comprehensive abortion care	<ul style="list-style-type: none"> • Develop and implement the Newborn Action Plan 	<ul style="list-style-type: none"> • Pilot UHC with a focus on equity and quality in RMNCH+A, including metrics for measurement
	Address infertility	<ul style="list-style-type: none"> • Develop and implement a comprehensive action plan for prevention and management of pneumonia and diarrhoea 	
	Implement various recent initiatives for maternal and women's health (screening for breast and cervical cancer, screening for syphilis and hepatitis B during pregnancy, etc.)	<ul style="list-style-type: none"> • Scale up and monitor home-based newborn care 	<ul style="list-style-type: none"> • Develop Maternal Health 2020 and Family Planning 2020 action plans
	Expand the basket of choices of contraceptives	<ul style="list-style-type: none"> • Consult with states and development partners. 	
Reduction of newborn mortality	Develop and implement a comprehensive action plan for prevention and management of pneumonia and diarrhoea		
	Scale up and monitor home-based newborn care		
Beyond 2015: call for greater equity impact	Strengthen and monitor facility-based care		
	Pilot UHC with a focus on equity and quality in RMNCH+A		
	Monitor impact of intervention and services with a focus on equity and quality		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Quality of care	Strengthen quality of care with focus on RMNCH+A services		
Monitoring and innovations	Promote accountability in RMNCAH/NHM		
Investing in health of Adolescents boys and girls	Implement multisectoral plan for adolescent health		
	Prevent teenage pregnancies and provision of safe abortion services		
	Ensure contraceptive availability for adolescents.		
Social mobilization for RMNCAH	Strengthen community-based interventions		
Global initiatives	Develop and implement Every Newborn Action Plan		
	Develop a country-level tracking system for Family Planning 2020		
	Develop a Maternal Health 2020 and Family Planning 2020 action plan		
Indonesia			
Saving mothers' and children's lives: what worked, where and how?	Increase the number of acceptors of family planning (contraceptive prevalence rate)	<ul style="list-style-type: none"> • Ensure implementation of maternal and neonatal action plan up to district level by monitoring, evaluation and assistance • Socialization accreditation system, SOP and algorithm as a legal aspect at whole health facility through provincial and district health offices • Develop birth defect programme • Strengthen health system information • Strengthen healthy life programme 	<ul style="list-style-type: none"> • Develop youth adolescent and pre-marital programme • Strengthen basic nutrition, include micro-nutrition • Strengthen health education programme, include field practices • Establish human resources system especially on recruitment, distribution system
	Increase standardized maternal health services (antenatal to postnatal care)		
	Ensure BEmONC and CEmONC function properly 24/7		
	Ensure referral system work effectively		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Reduction of newborn mortality	Implement C-IMCI in remote area		
	Improve Maternal and Child Health Handbook as a communication and monitoring tool between cadres and midwives		
	Ensure postnatal care (mother and newborn)		
	Develop birth defects and newborn screening programmes		
Beyond 2015: call for greater equity	National health insurance, going to UHC in 2019		
	Distribution of health personnel for remote area		
Quality of care	Ensure health personnel and health facilities implementing standards to deliver quality health services		
	Empower national and subnational governments		
	Promote and implement legal aspects		
Monitoring and innovations	Strengthen information system		
	Strengthen maternal and perinatal death audit		
Investing in health of adolescent boys and girls	Scale up/implement national standards for adolescent reproductive health		
	Improve access to young adolescent health services through school health programme		
	Develop premarital programme		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Social mobilization for RMNCAH	Strengthen CHW as frontline cadre		
	Collaboration between health programme and women 's organizations (PKK, Persit, Bayangkari, IWAPI etc) and women's group associations (AIMI, Asyiah, NU, etc.)		
Global initiatives	Develop Indonesia Maternal and Newborn Action Plan (IMNAP)		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Maldives			
Saving mothers' and children's lives: what worked, where and how?	Increase contraceptive prevalence rate and prevent unwanted pregnancy Maintain and improve coverage and quality of antenatal and postnatal care	<ul style="list-style-type: none"> Strengthen family planning programme to improve acceptance and utilization 	<ul style="list-style-type: none"> Ensure that health centres, atoll and regional hospitals function well to provide comprehensive maternal and newborn health services, with special attention to childbirth
Reduction of newborn mortality	Implement newborn care standards in health facilities at all levels Prevent and screen birth defects	<ul style="list-style-type: none"> Conduct research on family planning acceptance, knowledge and quality Strengthen linkages between family planning services and other reproductive health services in health facilities 	<ul style="list-style-type: none"> Provide quality and timely childbirth and newborn care as a continuum of care in all hospitals
Beyond 2015: call for greater equity	Strengthen services for reproductive health morbidities especially among groups with special needs, for gender-based violence and during crisis situations	<ul style="list-style-type: none"> Strengthen maternal death reviews – develop and implement near-misses review 	<ul style="list-style-type: none"> Provide quality and timely childbirth and newborn care as a continuum of care in all hospitals
Quality of care	Improve quality of antenatal and postnatal care Prevent unsafe abortion and delivery of abortion care	<ul style="list-style-type: none"> Conduct research on stillbirths and early neonatal deaths in hospitals 	<ul style="list-style-type: none"> Ensure availability of essential medicines, supplies and equipment in all health-care facilities
Investing in health of adolescent boys and girls	Address sexual and reproductive health of adolescents and young people	<ul style="list-style-type: none"> Development/ endorsement of adolescent-friendly sexual and reproductive health services protocols 	<ul style="list-style-type: none"> Ensure quality of care by monitoring performance of health providers
Social mobilization for RMNCAH	Advocate for political commitment; needs assessment	<ul style="list-style-type: none"> Roll-out of adolescent friendly sexual and reproductive health services at regional and higher levels Establish effective referral mechanism for premature and sick newborns 	<ul style="list-style-type: none"> Initiate regular monitoring Establish maternal-perinatal network among regional and atoll hospitals and health centres

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Myanmar			
Saving mothers' and children's lives: what worked, where and how?	<p>Create demand for SBA</p> <p>Expand quality and quantity of skilled midwives – hard-to-reach areas</p> <p>Expand evidence-based interventions that meet adolescent sexual and reproductive health needs</p>	<ul style="list-style-type: none"> Build health system strengthening for UHC (especially financial management and procurement capacity) Build reproductive health LMIS for equal distribution of life-saving commodities nationwide Improve quality skilled birth attendants with a focus on intrapartum and postpartum care, from 70% to 80% 	<ul style="list-style-type: none"> Improve RMNCAH continuum of care Prioritize roll-out of TQM system Refurbish and expand health infrastructure and emergency referral
Reduction of newborn mortality	<p>Improve services across RMNCAH continuum of care</p> <p>Identify gaps in comprehensive obstetric care</p> <p>Scale up intrapartum and immediate postpartum interventions</p>		
Beyond 2015: call for greater equity	<p>Increase routine data disaggregation and use</p> <p>Ensure universal availability of essential quality supplies/commodities</p> <p>Define and cost Essential Package of Health Services (poorest first)</p>		
Quality of care	<p>Prioritize roll-out of a TQM system</p> <p>Understand causes and determinants of maternal and child deaths</p> <p>Refurbishment of health facilities (with equipment and supplies)</p>		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Monitoring and innovations	Integrate community-based programmes Nepal (CBNC, CIMCI, CIYCF) combined to improve effectiveness and reduce overlap		
	Review reproductive health policy to include MNCAH and develop related user-friendly comprehensive standards		
	5X5 interventions (India), RMNCH+A high-impact interventions		
Investing in health of adolescent boys and girls	Generate data		
	Short programme review (situation analysis and actions)		
	Build capacity of BHS to address adolescent health		
Social mobilization for RMNCAH	Reduce opportunity costs among poor		
	Strengthen referral		
	Explore mHealth possibilities for RMNCAH demand creation		
Global initiatives	National leadership and accountability		
	Build health system strengthening for universal health coverage		
	Explore new financing opportunities (e.g . Global Fund for health system strengthening and RMNCAH)		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Nepal			
Saving mothers' and children's lives: what worked, where and how?	<p>Female CHW programme (initiated 1988)</p> <p>Safe delivery incentive programme (initiated 2005); later Aama programme (2012)</p> <p>Abortion legalized (2002), services available from 2004</p> <p>Preventing mother-to-child transmission of HIV in selected sites</p> <p>Increasing access to family planning services</p>	<ul style="list-style-type: none"> • Increase coverage and quality of maternal and newborn care at all levels (community to facility level) (antenatal care coverage, improve referral of high-risk pregnancies, establish emergency transportation) 	<ul style="list-style-type: none"> • Establishment of professional midwives (long-term goal) to strengthen human resources for maternity care • Strengthen quality of care through infrastructure improvement and human resources and monitoring and evaluation mechanisms • Network for newborn perinatal database needs to be strengthened and expanded
Reduction of newborn mortality	<p>Expanded programme on immunization (initiated 1997)</p> <p>Community-based newborn care package 2009 (39 districts)</p> <p>Community-based IMCI (1997 to >2009 national coverage)</p>	<ul style="list-style-type: none"> • Surveillance and prevention of birth defects • Strengthen existing birthing centres and expand 	<ul style="list-style-type: none"> • Strengthen the health system • Birth preparedness package • Mobilization of women's groups • Improve equity and work towards universal health coverage
Beyond 2015: call for greater equity	<p>Safe delivery Incentive programme for poor people</p> <p>Increased number of birthing centres in rural areas</p>		
Quality of Care	<p>Establish and upgrade hospitals to comprehensive EmOC</p> <p>Establishment of national quality of care mechanisms and systems</p> <p>In-depth newborn care service needs assessment</p>		<ul style="list-style-type: none"> • Strengthen and scale up comprehensive RMNHC • Strengthen accountability *RMNCH as a human right

Thematic area	Action	Priority actions: short term	Priority actions: medium term
	Develop national-level implementation plan for POP and cervical cancer. Development of competency-based training manuals on POP and OF care		
	Establish community-based birth centres (1800), aiming at national coverage, staffed by SBA		
Monitoring	MDSR guidelines developed		
	Strengthen civil registration and vital statistics		
	Establish neonatal and perinatal data network		
Investing in health of adolescent boys and girls	Strengthen adolescent sexual and reproductive health strategy		
	Scale up adolescent-friendly services/sites (1100 in 67 districts)		
	Scale up youth information centres		
Social mobilization for RMNCAH	Social marketing of zinc, oral rehydration salts and other essential commodities		
	Provide clean delivery kits in case women are unable to reach health facility		
	Social marketing of family planning		
Global initiatives	Further progress in MDG 4 and 5		
	Develop Every Newborn Action Plan		
	Strengthen SWAP		
	Strengthen IMCI implementation		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Sri Lanka			
Saving mothers' and children's lives: what worked, where and how?	<p>Review existing antenatal/postnatal/newborn interventions/strategies, with a view to finding gaps in producing expected outcomes</p> <p>Introduce new innovative approaches for further reduction of maternal and child mortality and morbidity</p> <p>Develop management guidelines/SOPs in maternal and child care, and innovative mechanisms</p> <p>Ensure adherence to case management guidelines</p> <p>Increase utilization of findings of programme reviews</p> <p>Streamline planning and programme reviews with area-specific plans</p> <p>Establish highly specialized maternal/newborn care centres for patients with severe maternal/newborn morbidity at provincial level</p>	<ul style="list-style-type: none"> Review existing antenatal/postnatal/newborn interventions/strategies with a view to finding gaps in producing expected outcomes Develop management guidelines/SOPs in maternal and child care, and innovative mechanisms Increase utilization of findings of review processes In-depth analysis of deficiencies in service delivery using confidential enquiries into maternal deaths approach Introduce near-miss enquiry Streamline perinatal death audit system and introduce a newborn morbidity and mortality database 	<ul style="list-style-type: none"> Establish highly specialized maternal/newborn care centres at provincial level for patients with severe maternal/newborn morbidity Develop highly specialized centres/advocate intrauterine transfer and expansion of neonatal retrieval system
Reduction of newborn mortality	<p>Develop standard guidelines at field and hospital levels (sick newborn guidelines)</p> <p>Develop highly specialized centres/advocate intrauterine transfer and expansion of neonatal retrieval system</p> <p>Introduce quality of care to newborn care programme, improve the availability of newborn life-saving equipment</p>		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
	Scale-up of kangaroo mother care		
	Streamline perinatal death audit system and Introduce a newborn morbidity and mortality database		
Beyond 2015: call for greater equity	Identify equity-related data and equity disaggregate existing data (RH MIS and DHS)		
	Identify service package for UHC		
Quality of care	Redefine role of National Secretariat in improving quality of care for maternal and child health		
	Strengthen case management at first-contact level and referral level by improving quality		
Monitoring and innovations	Introduce near-miss enquiry		
	In-depth analysis of deficiencies in service delivery using confidential enquiries into maternal deaths approach		
Investing in health of adolescent boys and girls	Advocate for a high-level national committee for adolescent care		
	Conduct an external programme review on adolescent health		
	Introduce innovative strategies in approaching adolescents		
Social mobilization for RMNCAH	Reorient the existing family planning programme to address the present challenges		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Global initiatives	Quality of care and inter-district disparities are the key challenges in pneumonia/diarrhoea prevention and control		
	Establish acute respiratory infection/control of diarrhoeal disease surveillance system		
Thailand			
Saving mothers' and children's lives: what worked, where and how?	Safe Motherhood Project Women's health Cervix and breast cancer screening	<ul style="list-style-type: none"> • Expand youth-friendly health services into all hospitals and health centres • Safe Motherhood Project • Cervix and breast cancer screening • Birth defect surveillance programme • Reduction in teenage pregnancy programme • Strengthen quality of newborn care 	
Reduction of newborn mortality	Birth defect surveillance programme Reduction in teenage pregnancy programme Strengthen quality of newborn care	<ul style="list-style-type: none"> • Birth defect surveillance programme • Reduction in teenage pregnancy programme • Strengthen quality of newborn care 	
Beyond 2015: call for greater equity	Strengthen national universal health coverage scheme focusing on woman, newborn, child and adolescent	<ul style="list-style-type: none"> • Strengthen quality of newborn care • Strengthen national universal health coverage scheme • Strengthen on accessibility and quality assurance 	
Quality of Care	Strengthen on accessibility and quality assurance		
Monitoring and innovations	Family planning skills training programme for health providers	<ul style="list-style-type: none"> • Family planning skills training programme for health providers 	
Investing in health of adolescent boys and girls	Expand youth-friendly health services into all hospitals and health centres	<ul style="list-style-type: none"> • Expand youth-friendly health services into all hospitals and health centres 	

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Timor-Leste			
Saving mothers' and children's lives: what worked, where and how?	<p>Increase access to high quality family planning, prenatal, delivery, postnatal and newborn care at primary care level</p> <p>Improve EmONC through early detection and management at primary care and referral levels</p> <p>Prevent and manage of teenage pregnancy</p> <p>Improve adolescent and maternal nutrition</p> <p>Prevent mother-to-child transmission of HIV and elimination of congenital syphilis</p> <p>Empower individuals/ couples, families and communities for RMNCAH</p> <p>Strengthen health management information system at all levels through data collection, analysis and use for decision-making</p>		
Reduction of newborn mortality	<p>Ensure essential newborn care is implemented properly at childbirth</p> <p>Ensure quality of postnatal visit at first and second visit</p> <p>Ensure sick newborns are treated according to standards</p>		

Thematic area	Action	Priority actions: short term	Priority actions: medium term
Beyond 2015: call for greater equity	Universal access to quality and integrated basic maternal and newborn health services, including antenatal care, safe delivery, postpartum care, essential newborn care		
	Strengthen referral system for maternal and newborn health, e.g. adequate first aid/stabilization of cases before referral		

Annex 3

Agenda

Setting the Scene: MDG 4 &5: So close, yet so far

- Global monitoring progress and challenges in MDG 4 and 5
- SEAR achievements and gaps including COIA progress

Saving mothers and children lives: What worked, where and how?

- Global and regional evidence and investment framework for women and children health
- Country Experience in accelerating reduction in maternal mortality
 - Bangladesh
 - India

Unresolved Challenge: Newborn Mortality

- Challenges of newborn mortality: Current reality, evidence of what works and what more?
- Successes and lessons from countries:
 - Community based Newborn Care
 - Facility based Newborn Care

Beyond 2015: Call for greater Equity

- Equity in Reproductive, Maternal, Newborn, Child and Adolescent Health
- Post-2015 development agenda
- Ensuring equity through UHC
- Primary health care as basis for equity

The missing link: Quality of Care

- Quality of care across continuum of care
 - First Step assessment of quality of maternal care
- Total quality management for MNCH

Market Place/Poster Session:

- Innovations to accelerate achievements for MDG4 and MDG5
- Country progress on COIA implementation
- Emerging areas such as birth defect surveillance, preconception, maternal morbidities, early childhood development

Investing in health of adolescents boys and girls

- It pays to invest in adolescents
- Unfinished business: SRH for adolescents and young people
- Strengthening AH strategy within RMNCH+A Strategy
- Preconception Care – Programme for newlyweds

Demand as driver for RMNCAH services

- Global perspective and evidences on developing community-based interventions for maternal and newborn health
- Increasing utilization of Family Planning and abortion services through demand side interventions
- Improving birth spacing in Myanmar

Global initiatives-regional implications: Opportunities and Challenges for RMNCAH

- A Promised Renewed and Every Newborn Action Plan
- Integrated Management of Childhood Illness and Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea

- Family Planning 2020 + Commodities Commission
- Ending preventable maternal mortality : Global and country targets
- Integrating RMNCAH in Global Fund
- Coordination at country level – IHP+
- H4+ mechanism for supporting countries
- Panel discussion: Coordination and partnerships at country level

Plans for action at country level

Conclusion and Recommendations

Annex 4

List of participants

Bangladesh

Dr Md. Altaf Hossain
Programme Manager
IMCI, DGHS
Dhaka

Mr Sukhendu Shekhor Roy
System Analyst
MIS, DGHS
Dhaka

Dr Ishita Hossain Chowdhury
DPM (CSBA and Midwifery)
MNH, DGHS
Dhaka

Bhutan

Mr Nima Wangdi
Secretary
Ministry of Health
Thimphu

Mr Sonam Wangdi
Assistant Programme Officer
Reproductive Programme
Ministry of Health
Thimphu

Mr Jayendra Sharma
Planning Officer
Planning and Policy Division
Ministry of Health
Thimphu

India

Dr Rakesh Kumar
Joint Secretary – Reproductive and Child
Health
Ministry of Health and Family Welfare
New Delhi

Dr Dinesh Baswal
Deputy Commissioner –
Maternal Health III
Ministry of Health and Family Welfare
New Delhi

Dr Ajay Khera
Deputy Commissioner and In-charge
Child Health and Immunization
Ministry of Health and Family Welfare
New Delhi

Dr Ravinder Kaur
Senior Consultant
Maternal Health Division
Ministry of Health and Family Welfare
New Delhi

Dr Arun K Singh
National Advisor
Rashtriya Bal Swasthya Karyakram
National Institute of Health and
Family Welfare
New Delhi

Indonesia

Dr Anung Sugihantono
Director General
Nutrition and Maternal and Child Health
Ministry of Health
Jakarta

Dr Eni Gustina
Head
Subdivision of Toddlers and
Pre-School Survival
Directorate of Child Health
Directorate General of Nutrition and
Child Health
Ministry of Health
Jakarta

Dr Rusmiyati
Head
Subdivision of Maternal with
Complication Prevention
Directorate of Maternal Health
Directorate General of Nutrition and
Child Health
Ministry of Health
Jakarta

Dr Wahyuni Khaulah
Head
Section of Standardization
Subdirectorate of Reproduction Health Protection
Directorate of Maternal Health
Directorate General of Nutrition and Child Health
Ministry of Health
Jakarta

Dr Sulistya Widada
Head
Section of Guidance and Evaluation
Directorate of Surveillance
Immunization, Quarantine and Matra Health
Directorate General of Diseases Control and Environmental Health
Ministry of Health
Jakarta

Maldives

Ms Maimoona Aboobakuru
Director
Health Protection Agency
Malé

Ms Mariyam Raufa
Senior Project Officer
Policy Planning Division
Ministry of Health and Gender
Malé

Myanmar

Dr Min Than Nyunt (Mr)
Director General
Department of Health
Ministry of Health
Nay Pyi Taw

Dr Theingi Myint (Mrs)
Deputy Director (Maternal and Child Health)
Department of Health
Ministry of Health
Nay Pyi Taw

Dr Myint Myint Than (Mrs)
Deputy Director (Women and Child Health)
Department of Health
Ministry of Health
Nay Pyi Taw

Dr Hla Mya Thway Einda (Mrs)
Deputy Director (HEB)
Department of Health
Ministry of Health
Nay Pyi Taw

Nepal

Dr Praveen Mishra
Secretary
Ministry of Health and Population
Kathmandu

Dr Lakhan Lal Sah
Director General
Department of Health Services
Ministry of Health and Population
Kathmandu

Dr Padam Bahadur Chand
Chief Public Health Administrator
Ministry of Health and Population
Kathmandu

Dr Kiran Regmi
Director
Family Health Division
Department of Health Services
Ministry of Health and Population
Kathmandu

Dr Shyam Raj Upreti
Director
Child Health Division
Department of Health Services
Ministry of Health and Population
Kathmandu

Sri Lanka

Dr Y D Nihal Jayathilake
Secretary
Ministry of Health
Colombo

Dr (Mrs) L H M N Lansakara
Consultant Community Physician
Family Health Bureau
Colombo

Dr I L K Jayarathne
Consultant Community Physician
Family Health Bureau
Colombo

Thailand

Dr Nuttaporn Wongsuttipakorn
Deputy Director-General
Department of Health
Ministry of Public Health
Nonthaburi

Dr Kittipong Sae-Jeng
Director
Bureau of Reproductive Health
Department of Health
Ministry of Public Health
Nonthaburi

Dr Sawaiwan Paiprasert
Medical Officer
Senior Professional Level
Health Promotion Region 8
Nakornsawan
Nonthaburi

Timor-Leste

Ms Isabel Maria Gomes
Lic.SP
Director of Community Health
Services
Dili

Experts

Professor Anthony Costello
Professor of International Child Health
and
Director
UCL Institute for Global Health
London
United Kingdom

Dr Andrew Kennedy Cassels
Consultant
Geneva
Switzerland

Dr Rita Thapa
Senior Policy Advisor
Ministry of Health and Population
Kathmandu
Nepal

Professional associations

Regional level

Professor Ashma Rana
The President Elect of SAFOG
South Asian Federation of Obstetrics and
Gynaecology (SAFOG)
Kathmandu
Nepal
Dr C P Bansal
President
South Asia Paediatrics Association
Indore
India
Dr P K Shah
Member of Safe Motherhood Committee
International Federation of Gynaecology
and Obstetrics
Mumbai, India

Country level

Prof Mohammed Shahidullah
Chairman
Department of Neonatalogy and Pro-Vice
Chancellor
Bangabandhu Sheikh Mujib Medical
University
Secretary-General-Bangladesh Paediatric
Association
Dhaka
Bangladesh
Dr Abha Singh
Head of Department - Obstetrics and
Gynaecology
Lady Hardinge Medical College
New Delhi
India
Dr Nurdadi Saleh
Chairman of PB Indonesian Society of
Obstetrics and Gynaecology (POGI)
Jakarta
Indonesia
Dr Badrul Hegar
Chairman
Indonesian Association of Paediatricians
(IDAI)
Jakart
Indonesia

Dr Moe Nwe (Ms) Senior Consultant (OG) General Hospital Nay Pyi Taw Myanmar	Associate Professor Dr Prasobsri Ungthavorn Senior Adviser Royal College of Pediatricians of Thailand Nonthaburi Thailand
Dr Kyaw Myo (Mr) Lecturer Department of Child Health University of Medicine Magwe Myanmar	Clinical Professor Dr Wiboolphan Thitadilok President Royal College of Obstetricians and Gynaecologists of Thailand Nonthaburi Thailand
Dr Jyoti Ratna Dhakhwa Chairman Nepal Paediatric Society Kathmandu, Nepal	WHO collaborating centres
Dr Pushpa Chaudhary Chairman Nepal Obstetric/Gynaecological Association Kathmandu Nepal	Dr Vinod K Paul Head, Department of Paediatrics WHO Collaborating Centre for Training and Research in Newborn Health All India Institute of Medical Sciences New Delhi India
Dr Laxman Shrestha President Nepal Paediatric Society Associate Professor of Paediatrics Institute of Medicine Kathmandu Nepal	Dr Unnop Jaisamrarn Associate Professor in Ob/Gyn Head of Family Planning and Reproductive Health Unit Secretary-General Department of Obstetrics and Gynaecology Associate Dean for International Affairs Faculty of Medicine Chulalongkorn University Bangkok Thailand
Dr Sheela Verma President Perinatal Society of Nepal Kathmandu Nepal	Dr Sanjay Chauhan Sr. Grade Dep. Director (Scientist F) and Head, Dept. of Operational Research and Dept. of Clinical Research National Institute for Research in Reproductive Health Mumbai India
Dr J R S De Silva Consultant Paediatrician Lady Ridgeway Hospital for Children Colombo Sri Lanka	Dr Shams El Arifeen Director, Child and Adolescent Health International Centre for Diarrhoeal Disease Research Dhaka Bangladesh
Dr Sardha Hemapriya Chairman/Regional Activities and Development Sri Lanka College of Obstetricians and Gynaecologists Colombo Sri Lanka	

Dr Lakhbir Dhaliwal
Professor and Head
Department of Obstetrics and
Gynaecology
Post Graduate Institute of Medical
Education and Research
Chandigarh
India

Partners

Dr Anjali Sen
Regional Director
International Planned Parenthood
Federation (IPPF)
South Asia Region, IPPF House
New Delhi
India

Mr Michel Anglade
Campaigns and Advocacy Director
Save the Children
Geneva
Switzerland

Dr Viviana Mangiaterra
Senior Coordinator of HSS and
RMNCH teams
The Global Fund to Fight AIDS,
Tuberculosis and Malaria
Geneva
Switzerland

Dr Helenlouise Taylor
Plan International Asia Region
Maternal Newborn Child Health and
Nutrition Adviser
Hanoi
Viet Nam

Ms Keiko Osaki
Senior Adviser
Japan International Cooperation Agency
(JICA)
Human Development Department
Health Group 2, Health Division 3
Tokyo
Japan

Ms Aya Kagota
Japan International Cooperation Agency
(JICA)
Human Development Department
Health Group 2, Health Division 3
Tokyo
Japan

Dr Yukie Yoshimura
Chief Adviser
Safe Motherhood Promotion Project
Phase 2
Japan International Cooperation Agency
Dhaka
Bangladesh

Ms Natasha Mesko
Health Adviser
Department for International
Development (DFID)
Kathmandu
Nepal

UN agencies

UNICEF

Ms Karin Hulshof
Regional Director
United Nations Children's Fund
Regional Office for South Asia
Kathmandu
Nepal

Dr Mickey Chopra
Chief of Health Section
United Nations Children's Fund
New York
United States of America

Dr Isabel Vashti Simbeye
Health and Nutrition Specialist
United Nations Children's Fund
Thimphu
Bhutan

Dr Robin Nandy
Chief, Child Survival and Development
Cluster
United Nations Children's Fund
Jakarta
Indonesia

Dr Penelope Campbell
Chief, Young Child Survival and
Development
United Nations Children's Fund
Yangon
Myanmar

Dr Douglas Noble
Regional Health Adviser
United Nations Children's Fund
Regional Office for South Asia
Kathmandu
Nepal

Dr Nuzhat Rafique Regional Maternal Newborn Health Specialist United Nations Children's Fund Regional Office for South Asia Kathmandu Nepal	Dr Hla Hla Aye Assistant Representative United Nations Population Fund Yangon Myanmar
Dr Hendrikus Raaijmakers Chief of Health United Nations Children's Fund Regional Office for South Asia Kathmandu Nepal	Ms Latika Maskey Pradhan Assistant Representative United Nations Population Fund Kathmandu, Nepal
Dr Nabila Zaka Maternal and Child Health Specialist Young Survival and Development Section UNICEF East Asia Pacific Regional Office Bangkok Thailand	Dr Shilu Adhikari SRH Specialist United Nations Population Fund Kathmandu Nepal
UNFPA	Mr Jayan Abeywickrama National Programme Analyst United Nations Population Fund Colombo Sri Lanka
Ms. Lubna Baqi Deputy Regional Director Asia and Pacific Regional Office United Nations Population Fund Bangkok Thailand	Dr Wame Baravilala Technical Adviser Reproductive Health/Maternal Health United Nations Population Fund Asia and the Pacific Regional Office Bangkok Thailand
Dr Prasanna Gunasekera Chief- Reproductive Health and Coordinator- MNHI United Nations Population Fund Dhaka Bangladesh	World Bank
Ms Frederika Meijer The Representative United Nations Population Fund New Delhi India	Ms Preeti Kudesia Senior Health Specialist Health, Nutrition and Population South Asia Region The World Bank Kathmandu Nepal
Dr Anchita Patil National Programme Officer (Reproductive Health) United Nations Population Fund New Delhi, India	WHO headquarters, Geneva, Switzerland
Dr Elvira Liyanto Maternal Health Officer United Nations Population Fund Jakarta Indonesia	Dr Mikael Meyer Ostergren Programme Manager Department of Maternal, Newborn, Child and Adolescent Health
	Dr Venkatraman Chandramouli Department of Reproductive Health and Research

WHO Regional Office for South-East Asia, New Delhi, India

Dr Neena Raina
Regional Adviser
Child and Adolescent Health

Dr Martin Weber
Regional Adviser
Maternal and Reproductive Health

Dr Kunal Bagchi
Regional Adviser
Nutrition and Food Safety

Ms Jyotsna Chikarsal
Regional Adviser
Health Situation and Trend Assessment

Ms Vismita Gupta-Smith
Information Officer
Public Information and Advocacy

Dr Arvind Mathur
Medical Officer
Making Pregnancy Safer

Dr Rajesh Mehta
Medical Officer
Child and Adolescent Health

Ms Shveta Kalyanwala
Freelance Consultant
New Delhi
India

WHO country offices

Dr Mamadou Hady Diallo
Medical Officer – MCH
WCO Bangladesh
Dhaka

Dr Rabeya Khatoon
Temporary National Professional- MNCAH
WCO Bangladesh
Dhaka

Ms Om Rinzi
AAP/UN Focal
WCO Bhutan
Thimphu

Dr Paul Francis
Technical Officer
Maternal and Child Health
WCO India
New Delhi

Dr Kiran Sharma
National Professional Officer
WCO India
New Delhi

Dr Edwin Salvador
Technical Officer EHA/Ag.PHA
WCO Nepal
Kathmandu

Dr Meera Thapa Upadhyay
National Professional Officer - MNCAH
and Gender
WCO Nepal
Kathmandu

Dr Zainab Naimy
Technical Officer (JPO), MNCAH
WCO Nepal
Kathmandu

Mr Susheel Lekhak
National Professional Officer -
COIA coordination
WCO Nepal
Kathmandu

Dr Atul Dahal
National Professional Officer
WCO Nepal
Kathmandu

Ms Charlotte Christiansen
Technical Officer - RMNCAH
WCO Myanmar
Yangon

Dr Salma Burton
Public Health Administrator
WCO Myanmar
Yangon

Dr (Mrs) Anoma Jayathilake
National Professional Officer for
MPS, CAH, RH and GWH
WCO Sri Lanka
Colombo

Dr Jorge Mario Luna
WHO Representative to Timor-Leste
WCO Timor-Leste
Dili



A regional meeting on “2015 and beyond: the unfinished agenda of MDGs 4 and 5 in South-East Asia” was organized by the World Health Organization (WHO) Regional Office for South-East Asia, from 29 April to 1 May 2014 in Kathmandu, Nepal, with the aim to enhance commitment and accountability in the Member States of the Region towards achieving MDGs 4 and 5, and progressing beyond 2015. Countries reviewed the progress on the United Nations (UN) Secretary-General's *Global Strategy for Women's and Children's Health* and the Commission on Information and Accountability for Women's and Children's Health (CoIA) framework.

Country participants and partners shared experiences to reach a common understanding on approaches that are likely to improve coordination and make a large impact on country efforts for accelerating progress. A Joint UN Statement on Women's and Children's Health was released by the Regional Directors of WHO, United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) to call upon countries and partner organizations for recommitting their efforts to address the unfinished agenda of MDGs 4 and 5.

This report provides a summary of the proceedings of the regional meeting, the Joint UN Statement in support of MDG 4 and 5, country action plans, and the meeting declaration.



World Health Organization
Regional Office for South-East Asia
World Health House
Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi-110002, India
www.searo.who.int



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