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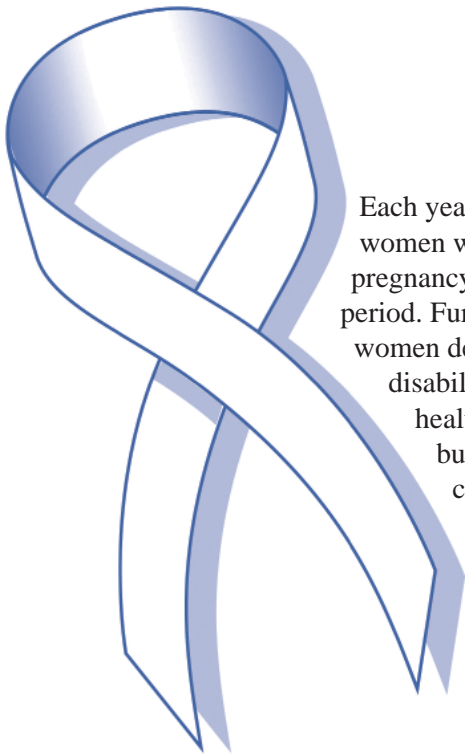
**HEALTH POLICY
INITIATIVE**

TIME TO DELIVER ON MATERNAL HEALTH AND FAMILY PLANNING BEST PRACTICES:

White Ribbon Alliances in Asia and the Middle East Make It Happen



*A woman and children wait for health services in rural India.
Photo by Suneeta Sharma.*



Each year, more than half a million women worldwide die during pregnancy, delivery, or in the postpartum period. Further, another 10 million women develop short- or long-term disabilities.¹ Improving maternal health benefits not only women, but also their families and communities. Children who lose their mothers are at an increased risk for malnutrition or even death. Moreover, the world loses an estimated \$15 billion in productivity each year due to maternal and neonatal mortality.² The tragedy, and opportunity, is that most maternal deaths and disabilities can be prevented through known, evidence-based best practices (Box 1). A fundamental challenge is to marshal the political commitment, public support, and resources (human, financial, and material) to implement best practices to save the lives of mothers and children.

White Ribbon Alliances (WRAs) across Asia and the Middle East have become strong advocates for evidence-based strategies to reduce maternal mortality. The USAID | Health Policy Initiative, Task Order 1—a consortium that includes the

WRA Global Secretariat as an implementing partner—has helped to form alliances and support their efforts to scale up family planning (FP) and maternal, neonatal, and child health (MNCH) best practices in the region. This assistance includes technical updates, training, and support for organizational development, networking, policy advocacy, and strategic planning.

In September 2007, the Extending Service Delivery Project organized a meeting in Bangkok, Thailand, on “Scaling Up High-impact FP/MNCH Best Practices in the Asia/Near East Region.”³ Participants included WRA members from 14 countries. At the meeting, teams identified priorities and designed strategic action plans to scale up best practices. The Health Policy Initiative worked closely with the Extending Service Delivery Project and other partners to organize the meeting, provide technical assistance to draft country plans, and support roll-out of the plans following the meeting. In February 2008, the Health Policy Initiative awarded small grants of \$10,000 each to alliances in Bangladesh, Indonesia, Pakistan, Yemen, and Orissa State (India) to help support implementation of the scale-up plans. (Table 1 presents the maternal health situation in the five countries.)

TABLE 1. MATERNAL HEALTH SITUATION IN SELECTED COUNTRIES IN ASIA AND THE MIDDLE EAST

Country	Maternal Mortality Ratio (maternal deaths per 100,000 live births) [low - high estimates]	Number of maternal deaths	Lifetime risk of maternal death 1 in:
Bangladesh*	570 [380 - 760]	21,000	51
India*	459 [300 - 600]	117,000	70
Indonesia*	420 [240 - 600]	19,000	97
Pakistan**	276 [175 - 785]***	N/A	89
Yemen*	430 [150 - 900]	3,600	39

*WHO, UNICEF, UNFPA, and The World Bank. 2007. *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and The World Bank*. Geneva: WHO.

**National Institute of Population Studies (NIPS) [Pakistan] and Macro International, Inc. 2008. *Pakistan Demographic and Health Survey 2006-07*. Islamabad, Pakistan: NIPS and Macro International, Inc.

***Note: For Pakistan, the numbers in the brackets present the range in the maternal mortality ratios across provinces.

The Millennium Development Goals (MDGs) identify women's and children's health as priorities.

MDG #4:
Reduce the under five mortality rate by two-thirds from 1990 to 2015

MDG #5:
Reduce the maternal mortality ratio by three-quarters from 1990 to 2015

BOX I. ILLUSTRATIVE FP/MNCH BEST PRACTICES

- Promoting healthy timing and spacing of pregnancies through use of family planning
- Integrating family planning counseling and services into postpartum care
- Expanding access to long acting and permanent methods (LAPM) to limit or space births
- Encouraging institutional deliveries and expanding access to emergency obstetric care
- Providing active management of the third stage of labor (AMTSL) to facilitate delivery of the placenta and reduce postpartum hemorrhage
- Providing magnesium sulfate (MgSO₄) to prevent pre-eclampsia and eclampsia
- Promoting “Kangaroo Mother Care” for newborns—in particular, premature babies—that involves skin-to-skin contact, exclusive breastfeeding, and medical and psychosocial support to the mother and newborn without separating them to help prevent hypothermia and infection
- Reducing vitamin A deficiency in women and children, including integrating vitamin A provision into postpartum care

The WRA action plans supported by the Health Policy Initiative focus on policy dialogue, advocacy, and networking. These activities are essential for ensuring that the results of small, effective pilot initiatives are shared and taken to scale, and that the necessary leadership, multisectoral engagement, and resources are mobilized to support the effort.

As the five stories presented in this brief demonstrate, safe motherhood champions from all levels of society are playing a crucial role in the scale up of FP/MNCH best practices in Asia and the Middle East. Over the past year and a half, alliances have galvanized support

for maternal and child health, from national decisionmakers to the districts and communities. The alliances have learned about, disseminated, and designed country-specific action plans to scale up evidenced-based FP/MNCH best practices for improving women's and children's health. Along the way, they have piloted innovative approaches that are being replicated by in-country and international partners. Importantly, the alliances have “widened the tent” of people who are committed to and active in promoting maternal health. These efforts lay the groundwork to take the best practices to scale and make a difference in the lives of women, children, and their families.



WRA Bangladesh Promotes Action from the District to National Levels

Bangladesh must dramatically step up efforts to improve maternal health if it is to achieve its Millennium Development Goal (MDG) target of reducing the maternal mortality ratio from 570 in 2005 to 143 by 2015. While the government has expanded access to emergency obstetric care, trained community-based skilled birth attendants, and initiated a maternal health voucher scheme in selected areas, much more is needed—especially in rural areas—to prevent maternal deaths. In response, WRA Bangladesh has partnered with the government, donors, and NGOs to mobilize communities and districts to scale up maternal health best practices.

The Bangladesh country team for the 2007 Bangkok best practices meeting identified a range of best practices to improve maternal, neonatal, and child health, as well as family planning. Key strategies include registering midwives and providing training to upgrade their skills, expanding essential immunization packages, delaying first pregnancy for adolescents, and promoting healthy timing and spacing of pregnancies.

To translate these practices into action, the team organized eight regional workshops with participants from the country's 64 districts. WRA Bangladesh and MotherNewborNet successfully mobilized funding and support from the Health Policy Initiative, Japan International Cooperation Agency, UNFPA, the International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B), Plan/Bangladesh, and others to organize the workshops in Barishal, Bogra, Chittagong, Dhaka, Faridpur, Khulna, Rajshahi, and Sylhet divisions/districts in April and May 2008. The Director General of Health Services and Director General for Family Planning were also co-organizers, demonstrating the ownership and commitment of the government.

About 675 district health authorities and service providers from the public health system, private sector, NGOs, and community level attended the workshops. The sessions focused on three objectives: (1) exploring the current situation and service delivery in the districts; (2) providing training on FP/MNCH best practices; and (3) devising strategic action plans to roll out the best practices in the districts. As part of the process, participants met in teams to set district-specific priority interventions, assess feasibility of each approach, and outline next steps. Among the key challenges teams identified are the shortage of human resources and the need to improve coordination among the health, family planning, and nutrition sub-sectors of the Ministry of Health.

The workshops for district stakeholders were coupled with extensive media outreach, resulting in 42 newspaper articles published on family planning and maternal health in national and local newspapers. Moreover, through the district planning process, WRA Bangladesh gained 350 new members, bringing its total membership to 799. Expanding the membership of the alliance into the districts and widening its scope to include faith-based groups, professional associations, community organizations, and the media will contribute to a broadening of its advocacy and policy development efforts. Increasing support for family planning and safe motherhood—particularly outside of Dhaka and outside of the health sector—is an integral component of efforts to reduce maternal mortality in Bangladesh.

Plans are underway to share the recommendations from the districts at an upcoming national workshop.

Bangladesh



A district-level public hearing on maternal and child health issues in Orissa. Photo courtesy of WRA Orissa.



WRA Orissa Uses Innovative Approaches to Improve Awareness and Understanding

Lack of accurate data has been a constant challenge for safe motherhood advocates in developing countries. Maternal deaths and disabilities are typically underreported, difficult to define, and easy to misclassify. National registration systems and hospital records may be inadequate or incomplete. This situation is compounded by the fact that many women deliver at home, in communities where recordkeeping and knowledge of the specific causes of maternal death and disability are particularly limited. Much of the information on the conditions leading to maternal deaths and disabilities is simply lost. Yet, such data are vital for inspiring political commitment and action and designing appropriate maternal health strategies.

WRA Orissa recognized that addressing this lack of evidence would be essential to its ability to promote adoption of maternal health best practices. With a grant from the Health Policy Initiative, WRA Orissa set out to conduct “verbal autopsies” in the state’s 30 districts. Verbal autopsy is an approach approved by the World Health Organization (WHO) that involves using qualitative research techniques to compile case studies on the causes of and events surrounding maternal deaths. In Orissa, the investigation teams included representatives from WRA Orissa, a gynecologist, members of the *panchayati raj* institutions, local media,

and others. To foster sustainability, the alliance trained district coordinators and block-level partners in each district to build their skills and conduct the autopsies. District-level media representatives involved in the process had the opportunity to prepare stories on maternal health and increase their own knowledge of safe motherhood issues.

The verbal autopsies were compiled from January–August 2008. WRA Orissa began by identifying maternal deaths that occurred over the previous three months and randomly selected a case to investigate in each of the 30 districts. For each case, the team obtained permission from the woman’s family and finalized a date to meet. The teams then visited the communities of the women, gathering information from families and any community members who were present during her pregnancy, delivery, and/or postpartum complications. Next, the team interviewed community-based health workers, such as accredited social health activists (ASHAs), anganwadi workers, and auxiliary nurse-midwives (ANMs). Where relevant, the teams also gathered information from service providers and health facilities. The case studies were prepared with the agreement and observation of all the team members, and then immediately shared with the families, health workers and service providers, district health authorities, and local media.

orissa, india

The case studies provide rich data on which to base evidence-driven advocacy, policy dialogue, and program planning (see below). Importantly, the findings point to changes needed at the facility, provider, and community levels. Common challenges include:

- Lack of transportation (to and between health facilities)
- Failure of service providers or community-based health workers to identify and/or treat potential risk factors (e.g., anemia, pain)
- Failure of families to seek and/or follow medical advice
- Limited access to antenatal care
- Shortages in staffing
- Shortages of supplies (e.g., iron and folic acid tablets, blood for transfusions)
- High parity, short intervals between pregnancies, and childbearing at young or older ages

The government of Orissa has shown keen interest in replicating the verbal autopsy approach within the state. WRA Orissa, through its district counterparts, is an implementing partner to UNICEF and the state Department of Health and Family Welfare for the MaPeDIR project (Maternal and Perinatal Death, Inquiry, and Response). Through this project, 800 verbal autopsies have been conducted in eight districts with significant tribal populations. CARE-India has also replicated the approach in its focus district of Keonjhar.

WRA Orissa is also working to ensure that the findings revealed by the verbal autopsies have an impact on policymaking and service delivery. As part of the nationwide “Deliver Now for Women + Children”⁷⁴ campaign, the alliance has helped to organize public hearings on women’s and children’s health issues in 12 districts (eventually, all 30 districts in Orissa will organize hearings). These hearings are groundbreaking in that they have provided women with a forum to publicly present their grievances and ask questions to local government and health authorities. WRA Orissa has presented the findings of the verbal autopsies at the public hearings.

The hearings, which are covered by the local media, have generated excitement and lively debates in communities, with anywhere from 500 to 1,300 women taking part in each event. That district officials have come forward for such public scrutiny and interaction is in itself a sign of increased political commitment. However, the hearings have led to additional changes. For example, Balangir district officials have agreed to establish a grievance unit, including an anonymous complaint box, at the district hospital. The Chief Medical Officer will also track and present data on MNCH services at the monthly meetings of the local government council. In Koraput, district authorities pledged to take action against doctors who demand bribes for institutional deliveries; committed to ensuring proper implementation of the *Janani Suraksha Yojna* scheme; and issued a circular to all service providers, including ANMs, calling for health facilities to remain open 24 hours a day.

In Cuttack District, Delays and Frustration Turn Fatal

Case Study Excerpt: The mother belonged to the scheduled caste community. The family is extremely poor and her husband works as a daily laborer. She had two female children prior to this pregnancy. However, during this pregnancy, she had only two antenatal checkups, but she took two tetanus toxoid injections with 100 iron and folic acid tablets. Her level of rest and household activities was as usual. The labor pain started around 6:00pm on August 2nd. There was a ruptured membrane and she was taken to the nearest community health center (CHC), which is five kilometers from her home, by the family members. However, upon reaching the CHC, she was severely anemic with generalized edema. Looking at her condition, the CHC referred her to the subdivisional hospital, yet it took them four hours to arrange the vehicle. The patient reached the subdivisional hospital around midnight. The Ob/Gyn specialist was there, but without physical examination or provision of medication, motivated the family to go to the medical college/hospital (tertiary facility). The patient, with her labor pain, waited there for two hours and she was neither admitted nor provided any service. Hopelessly, the family brought her back home. On reaching the home, she delivered a male baby with placenta. Soon after the delivery, she became restless and died at about 4:00am on August 3rd.



Members of WRA Indonesia carry out awareness-raising activities in alert villages in Bandung, West Java. Photo by Betsy McCallon.

WRA Indonesia Establishes “Alert Villages” to Enhance Birth Preparedness in Communities



In Indonesia, about six in 10 births are delivered at home. While the proportion of births attended by skilled birth attendants has increased, the country’s maternal mortality ratio (420 maternal deaths per 100,000 live births) remains high, with about two women dying every hour due to pregnancy- and delivery-related complications. Too often, women lack adequate emergency obstetric care and face delays in seeking hospital services. In response, WRA Indonesia has promoted the creation of “alert villages” (*desa siaga*) and other best practices to improve birth preparedness and complication readiness at the community level.

The idea for alert villages originally came from national government efforts to encourage village readiness for development challenges, including national disasters. WRA Indonesia decided to adapt the concept for maternal and child health, and began to establish alert villages in the early 2000s. With funding from the Health Policy Initiative, and building on the 2007 Bangkok best practices meeting, WRA Indonesia and in-country partners worked with the Ministry of Health to finalize the country’s scale-up action plan. In March 2008, WRA Indonesia conducted a workshop to orient participants on selected best practices in the plan, including alert

villages, Kangaroo Mother Care, prevention of postpartum hemorrhage, and contraceptive technologies using the guide, *Family Planning: A Global Handbook for Providers (2008 update)*, prepared by WHO, USAID, and Johns Hopkins University.⁵ About 60 participants from 22 provinces attended the workshop. Each province prepared a draft action plan, outlining their role in scaling up best practices. The alliance’s national strategy incorporates these provincial plans.

As a next step, WRA Indonesia, with the Indonesia Midwives Association and funding from the Health Policy Initiative, focused on the community component of the country action plan. The effort included training 30 facilitators on the formation of alert villages with a focus on birth preparedness, community savings plans, transport plans, tracking of pregnant women, and setting up blood donor systems in partnership with the Red Cross. As a result, six new alert villages were formed in Banten and West Java Provinces. In addition, 30 midwives in these villages participated in a three-day training to increase their knowledge and skills in selected best practices, including Kangaroo Mother Care and care for low birthweight babies, AMTSL, and the standard days method.

indonesia

In alert villages, WRA Indonesia supports midwives to identify pregnant women, provide antenatal care, encourage savings for maternal and child healthcare, and map and advocate for local resources. For example, some communities have established savings plans, such as the

Additional Activities of WRA Indonesia

- Expansion of youth chapters
- Training on reproductive health
- Weekly national radio program

Social Delivery Fund (*dasolin*) maintained by the midwives; the pregnant women's savings plan (*tabulin*) kept by the alert village coordinator; and a non-cash savings plan (e.g., rice, traditional herbs) to benefit pregnant women. Some community members in the villages have offered

material support in cases of emergency, including offering access to vehicles and telephones. In addition, people have come forward as potential blood donors, and relationships have been established with district hospitals to accept referrals.

Keys to success in alert villages have included: capacity building and an active role for midwives; support from village leaders; and strong motivation and coordination among families, community members, district authorities, transportation owners, blood donors,

and other stakeholders. Challenges have been to ensure the availability of midwives right at the moment of need and to encourage healthcare providers to adapt to the local culture and conditions.

The six new alert villages established in mid-2008 serve as models for continued replication within their districts. WRA Indonesia has already garnered support from other communities, resulting in replication of the model in 12 additional villages in West Java. Moreover, this work has attracted the attention of national leaders. Indonesia's First Lady, Hj Ani Bambang Yudhoyono, is a patron of WRA Indonesia. In December 2008, she hosted a competition for the Best Alert Village as part of a national program of the Ministry of Women Empowerment called *Gerakan Sayang Ibu* or "Mother-friendly Movement." Representatives from the winning village participated in a national event for Indonesia's Mothers' Day Celebration on December 22, 2008. Further, the Ministry of Health has expanded its strategy for National Alert Villages by integrating maternal and child health issues. Such commitment from national and community leaders will hasten scale-up of the alert villages and help promote safe motherhood for women and families across Indonesia.

Medical students from Atmajaya University are members of RAPPI, the Youth WRA of Indonesia. They volunteer their time to offer health services in alert villages, including antenatal care, immunizations, family planning counseling, and support for the hand-washing program for children under five. Photo by Betsy McCallon.



WRA Pakistan Targets Advocacy to Reach National Policymakers in a Changing Political Environment



Groups working on maternal health in Pakistan had long been informally connected through a listserv and occasional meetings to share lessons learned and discuss strategies. However, a cohesive group, particularly one engaged in policy dialogue, was lacking. On August 23, 2007, with technical assistance from the Health Policy Initiative, representatives from various groups and sectors came together to form a national alliance. WRA Pakistan currently has more than 300 members and an 11-person executive committee. Through establishing an alliance, the groups involved in maternal health advocacy expanded from professional societies to include a wide range of international and local NGOs, donor agencies, the private sector, religious leaders, government agencies and officials, and members of the National Assembly. The Health Policy Initiative has assisted the alliance with network formation and organizational development by sharing key tools and lessons learned from other alliances and guiding the establishment of efficient and transparent organizational policies and decisionmaking mechanisms.

The Pakistan delegation to the 2007 Bangkok best practices meeting included members of the WRA, high-level government officials—such as the Director General of the Ministry of Population Welfare and Special Secretary for Health of Sindh Province—and other key partners. The team prepared an action plan comprising recommended interventions for MNCH, family planning, integration of services, and crosscutting issues, such as involvement of Islamic leaders. The proposed maternal health best practices include AMTSL, provision of MgSO₄, and postabortion care. These interventions can help reduce the risk of postpartum hemorrhage, eclampsia, and other leading causes of maternal deaths. The action plan also calls for family planning counseling and services, which can reduce maternal and infant mortality by preventing unintended

pregnancies and promoting healthy timing and spacing of pregnancies.

With its small grant from the Health Policy Initiative, WRA Pakistan convened two planning meetings in 2008 to finalize the scale-up action plan. The alliance then organized a special session to present the plan of action to the Ministry of Health and Ministry of Population Welfare and to determine next steps. To help disseminate the best practices and encourage policy dialogue, the alliance developed an advocacy toolkit that contains user-friendly policy briefs on each proposed best practice.

In working to garner and sustain high-level political support for maternal health issues, WRA Pakistan has encountered a common challenge in developing countries—that of frequent transfers of key government leaders. The recent transfer of the Federal Secretary has delayed the planned national and provincial stakeholder best practices dissemination meetings. Nevertheless, WRA Pakistan has been able to widely disseminate the best practices and begin to gain consensus on priorities for the removal of policy barriers. The alliance has also established a critical mass of champions for best practices who are moving forward with implementation and dissemination of high-impact best practices.

Additionally, WRA Pakistan provided technical assistance to the Health Ministry's Advisory Group to design the first five-year Mother and Neonatal Child Health Program and has been commissioned by the Packard Foundation to undertake an analysis of the 2006/07 Pakistan Demographic and Health Survey. The analysis will help to identify the subpopulations most in need and further inform the alliance's advocacy efforts. A crucial next step will be to ensure that the alliance's proposed best practices and provisions in the Mother and Neonatal Child Health Program are disseminated and put into practice in Pakistan's provinces and districts.

pakistan



New National Alliance Launches and Partners with Leading Hospital to Pilot Best Practices

Yemen's National Safe Motherhood Alliance (NSMA) is one of the newest national WRA chapters formed with assistance from the Health Policy Initiative. After a year of work by stakeholders, the alliance was registered with the Ministry of Social Affairs in October 2007. The alliance had its official launch at a high-visibility event to commemorate International Women's Day on March 8, 2008, that was attended by more than 400 people, including members of Parliament and the Ministers of Social Affairs and Education. At the ceremony, Dr. Rashad Al Aleemy, the Deputy Prime Minister and Minister of Interior, attending on behalf of the Prime Minister's Office, pledged government support for the alliance and committed approximately US\$10,000 to fund alliance activities.

The alliance currently has 180 voting members—comprising a range of government ministries, NGOs, and professional associations. The executive board includes 21 representatives from government and NGOs, as well as professional individuals elected during the General Assembly meeting. NSMA's major priorities for 2008 involved (1) strengthening the capacity of the alliance and (2) implementing the action plan to scale up maternal health best practices in Yemen. In March 2008, the Health Policy Initiative facilitated an advocacy workshop for NSMA executive committee members and key partners (25 participants). The participants included religious leaders, healthcare providers, government representatives, NGO leaders, and media representatives. The country team finalized an advocacy action plan with a focus on encouraging Parliament to adopt the national safe motherhood policy currently under review,

which includes the provision of free services for facility-based deliveries.

Members of the emerging national alliance had participated in the 2007 Bangkok best practices meeting and assisted in the preparation of a draft action plan. In March 2008, the Basic Health Services Project convened a meeting with members of NSMA and the country team from Bangkok to follow up on the plan. The group drafted recommendations for the Ministry of Health to remove policy barriers hindering the scale up of selected best practices, such as the automatic discharge of women two hours after delivery, which significantly reduces the opportunity to provide care and counsel mothers on postpartum family planning and breastfeeding practices.

Country team members also prepared a detailed action and training plan for the roll-out of five selected best practices: Kangaroo Mother Care, postpartum family planning, early and immediate breastfeeding, neonatal infection prevention, and postpartum vitamin A supplementation. To disseminate and pilot the selected best practices, the NSMA received a grant from the Health Policy Initiative and additional technical and financial support from the Basic Health Services and Extending Service Delivery projects. The grant from the Health Policy Initiative supported NSMA's dissemination efforts, advocacy for adoption of the best practices, and training on best practices. Once adopted, the Basic Health Services Project supported the implementation of best practices at the national pilot site, Al Sabeen Hospital, the specialist maternal and child hospital in Sana'a.

yemen



Dr. Amat Al Kareem Al Hori (left), member of the Executive Board of NSMA and Director of Al Sabeen Hospital, and Jamila Ghalib Al Sharie (right), Secretary General of NSMA and community mobilization adviser for the Basic Health Services Project. Photo by Betsy McCallon.

“The goal of safe motherhood is to enable women to be pregnant and give birth in healthy conditions, free from any preventable health problems that could lead to the death of either mother or child.”

**Jamila Ghalib Al Sharie,
NSMA Secretary General**

As part of the dissemination activities, the national alliance conducted a three-day workshop on best practices for its executive committee members and a member of Parliament from the Health Committee. The executive committee members have an extensive reach within the government and NGO programs to encourage adoption of these best practices. In turn, the executive committee held three trainings in August, each with 30 participants from the general membership, to educate them on the best practices and to expand the promotion of best practices into the members' organizations. In addition, in 2008, NSMA expanded its activities to five governorates by holding orientation meetings on best practices with stakeholders in Aden, Amran, Ibb, Lahj, and Taiz. The Basic Health Services Project is also now expanding implementation to one hospital serving mothers and children in each of these governorates and NSMA will be cooperating in these efforts.

NSMA Institutional Training

With financial support from the Health Policy Initiative, NSMA organized the following trainings for its Executive Committee and General Assembly members:

- Communication skills
- MNCH best practices
- Networking and advocacy
- Resource mobilization and management
- Negotiation skills

Conclusion

International commitments, such as the Millennium Development Goals, recognize the importance of reducing maternal and child mortality. Increasingly, countries will be held accountable for achieving these goals. Research has documented numerous best practices in family planning and maternal, neonatal, and child health that can save lives and empower women to make informed reproductive health

decisions. Champions for safe motherhood are essential for ensuring that these best practices are adopted, have adequate resources and high-level support, and are taken to scale. As shown in this brief, WRA alliances in Asia and the Middle East are leading the necessary advocacy, networking, and policy dialogue efforts to help make it happen.

ENDNOTES

¹ World Health Organization (WHO). 2005. *World Health Report 2005: Make Every Mother and Child Count*. Geneva: WHO.

² United States Agency for International Development (USAID). 2001. *USAID Congressional Budget Justification FY2002: Program, Performance, and Prospects—The Global Health Pillar*. Washington, DC: USAID.

³ To learn more about the meeting, please visit http://www.esdproj.org/site/PageNavigator/Conf_ANE_Meeting and http://www.esdproj.org/site/PageServer?pagename=ANE_Technical_Activity_Homepage.

⁴ WRA Orissa's work contributes to a larger advocacy initiative being implemented by the national WRA India, called "Deliver Now for Women + Children." This initiative is supported by the Partnership for Maternal, Newborn, and Child Health—a global partnership brought together under the auspices of WHO.

⁵ WHO Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), INFO Project. 2008. *Family Planning: A Global Handbook for Providers (2008 Update)*. Baltimore and Geneva: CCP and WHO.

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