World Progress in Maternal and Child Health, and the Future Role for the U.S.
Kaiser Family Foundation
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DIANE ROWLAND: I'm Diane Rowland, the Executive Vice President of the Foundation, and we're very pleased to be able to welcome you here today and to host this important discussion about world progress in maternal, newborn, and child health and the future role of the U.S.

This is part of an endeavor that the Kaiser Family Foundation is engaged in to try and take a longer term look at the investment of the United States in global health and to develop more materials and information about global health policy and the U.S.'s role so that we can help stimulate a broader debate about these investments and how these should bear out.

This forum really is part of our work on trying to pull together policy analysis, public opinion research, journalism, and communications to provide that information and to give broader

views on key issues to the U.S. and other stakeholders.

We are pleased to be able to track and analyze the Global Health Initiative that the Administration has put forward to be able to look at some of the challenges facing us as we decide in these days of limited resources how to best invest in the future for not only our own country, but for the world.

And one of the key issues in this is obviously the world's children and how we raise them and how we help to develop them in the most healthy and meaningful ways so that they can live full and productive lives.

So today we are really going to focus on maternal, newborn, and child health to try and look at the way in which this endeavor is being undertaken by the U.S., as well as to look at how some of the future changes could be made with

different investments and different challenges. This is really a very critical moment to look at these issues as the world is engaging through the G8 and the Millennium Development Goals to try and improve maternal and child health so what progress can we see and how will we be able to go forward.

The goal of today then is for our forum to explore those issues and we are very grateful for the panelists and their organizations who are part of today's meeting. In fact, we have such a distinguished panel that I am not going to spend a lot of time talking; I am going to let you get to the panel.

We're going to start with a very short overview from Jen Kates, who is our Vice President for our Global Health and HIV Policy and she is going to set a little bit of the tone for how we are going to proceed today with a little

background on the GHI and maternal and child issues.

We also obviously always put together as Kaiser, we like to do fact sheets, we like to do background documents, so you will have both a very exhaustive document on the U.S. role in maternal, newborn, and child health, as well as two new fact sheets in your packets. So I hope you will refer to those and find those useful.

After Jen presents, we are going to turn to Jennifer Klein, the Senior Advisor on Global Women's Issues in the Office of Global Women's Issues as the U.S. Department of State and ask Jen to give us a perspective on the Administration's endeavors with regard to improving our way of dealing with maternal and child health.

And then we are going to turn to Dr. Flavia Bustreo, the Director of the Partnership for Maternal, Newborn, and Child Health at the

World Health Organization, who's been instrumental in developing and monitoring the Millennium Goals and Dr. Chris Murray, the Director of the Institute for Health Metrics and Evaluation, IHME as you will hear frequently today is a Professor of Global Health at the University of Washington School of Medicine and he's going to start following Jen by telling about some of the challenges in monitoring and in evaluating health outcomes.

And finally, our other panelist is Dr. Ana Langer, the President of EngenderHealth, a not-for-profit international reproductive health organization and she's going to focus on the work she's been doing through her organization on helping some of the most vulnerable and some of our poorest nations and communities.

So I think it will be a very round discussion and then as soon as we have our

panelists presentations, we are of course, going to turn to you to be able to ask our panelists questions. So without further adieu, I am going to turn to Jen and ask her to kick off our discussion. Thank you, Jen.

JEN KATES: Good morning everyone and I want to echo Diane's welcome and thanks to our panelists for being here with us today and I also want to thank two members of my team in particular, Kellie Moss and Allison Valentine, who were really the co-authors and brains behind a lot of the materials that you have in your packets, so thanks to them.

So, I'm going to provide some brief framing remarks that are largely drawn from our report and the analysis we've done that I hope will give some food for thought for the conversation. One of the things that I think all of us are in this room and beyond are thinking

about, is this the key moment for addressing maternal, newborn, and child health and MDGs 4 and 5.

There's a long history, longer than on here, on different efforts to do so, but there are a lot of things more recently that are drawing more attention and new opportunities, including of course the G-8 Summit that's about to occur, the September MDG review, and the Women Deliver Conference that is going to happen before those, so there's a lot of momentum at this time and one of the things that has helped to drive that momentum is the U.S. focus on this as well.

Here's again, a timeline of U.S. involvement, which is long, but more recently with the Global Health Initiative, which was announced last year and most of you know this and we have this information in our reports as well, $63 billion over six years with $12 billion going to

"other global health priorities" that includes maternal and child health.

Also, as part of the GHI, the President really put maternal and child's health on the map as a critical issue that the GHI would explore in saying we would do more, specifically calling on it "to improve health systems around the world and focus our efforts on child and maternal health".

There were targets that were recently released that generally align with the MDGs. There are targets on maternal and child health; there are targets on reproductive health and family planning. And there are several other targets that relate directly and indirectly to improving health for women, children, and newborns.

This is very broad overview of the GHI proposal and our analysis of the GHI budget - what's already been enacted, proposed, and looking

forward for other global health priorities that, again, includes funding for maternal and child health. It includes funding for reproductive health and family planning. That bucket of funding would need to increase at a faster rate to reach the goals that were laid out by the initiative.

Here's a historical look at funding for global maternal and child health and nutrition, which are funded together - this is the funding that is designated for these programs. There's other funding in the other U.S. government programs that obviously goes to these areas, but this is the designated funding. And you can see that it grew relatively slowly until recently. This is the budget request at the end here, which is a pretty steep increase.

This shows over time what share have these programs represented of what we now call the GHI,

the set of activities that are part of the GHI. In the fiscal year 2001, it was 17 percent. Over time, it has decreased. The funding amount has increased, but it has decreased as disease specific and other big initiatives emerged. It's starting to go up again slightly and in the budget request would be 9 percent.

So some key questions and issues to think about and I hope our panel will discuss them and you all will ask them and lend your thoughts. First for the U.S. specifically, how will the GHI of the U.S. balance the funding for maternal, newborn, and child's health with all the other global health issues, given the budget constraints, given the challenges of making those decisions?

How will these programs be integrated with disease specific programs? Well you know that they're funded separately, and they are sometimes

managed separately, but they obviously all intersect with each other in the daily lives of people that we are trying to help around the world.

Clearly there's a lot of issues related to family planning and reproductive health and how those relate the maternal, newborn, and child health programs and integration there.

The role of non-health interventions, obviously education initiatives, anti-poverty initiatives that help women and children, , how do those connect with these other U.S. efforts?

And then a big part of the GHI and many other initiatives that the U.S. has put forward under the Obama Administration has focused on a women and girls-centered approach. How does this approach, this principle get put into practice?

And then finally, what will be the U.S. role in the international arena given that there

are so many opportunities coming up. And, just to highlight a couple of those, the G-8 Summit. Will this summit and as those of you who have been following it, know the Canadians have made their signature initiative a maternal and child health initiative. What will that look like? What components will it include? What will the language be? And the U.S. clearly has a role to play in that.

What will happen at the UN MDG review? That is another key moment in September when the world will be focused on where we are on the MDGs.

And there's a lot of discussion going on around whether there should there be a new financing vehicle specific to maternal and child health or should existing ones be ramped up to focus on this

And, given the global economic crisis and the challenges for all donor budgets - this is a

really challenging issue and then other new efforts, will other new things be put out on the table that could augment the focus? So with that, I am going to stop and let our panelists start to tell us what they think on these issues. Thank you.

JENNIFER KLEIN: Thank you very much Jen and thank you to Kaiser for hosting this event and for your commitment to educating all of us about global health. I don't think I would survive without my daily e-mail update. In particular, I would like to thank Diane, who is my long-time, not old, long-time friend and colleague from moderating and to Jen. And in particular to this unbelievable group of panelists for your invaluable work in this area.

As Jen has said, maternal, newborn, and child health is an area that's very high priority for the Obama Administration - in particular for

the Secretary of State - and it's an area in desperate need of greater resources and attention. So that's why you have seen the Administration and the State Department and USAID really refocusing our efforts in that area.

I'm going to skip over the part where I tell you about the problem, first of all because you all know what the problem is. I'm looking out here and seeing people who I've worked intricately with on this issue for many, many months. And second of all because everybody else on the panel is much more qualified than I am to talk about that, so I'm going to try to address Jen's questions. I'm happy to get back to them. I will do I think a brief overview and then we can delve into some of them more deeply, but I think I do touch on most of them.

As I said, we are very committed to doing more, most recently the U.S. sponsored a

resolution at the UN Commission on the Status of Women, specifically on maternal mortality. We're intricately involved in the G-8 negotiations with the Canadians and others on their maternal, newborn, and child health initiative.

We're working very closely with Flavia and others and the UN Secretary General on the joint effort on MDGs 4 and 5 leading up to the September summit at the UN General Assembly and all of these, Women Deliver, all of these provide wonderful opportunities for us to continue our work together.

I think many people know a lot about the Global Health Initiative, but let me take a few minutes to talk about what it is and the basic principles that guided it. As Jen said, it is a six-year, $63 billion proposal to help partner countries, improve health outcomes through

strengthened health systems and a particular focus on women, newborns, and children.

As you know, this country and the world made significant progress in global health. The Bush Administration through its championing of the PEPFAR initiative and USAID's long work in this area really have developed a platform which we need to build on and really appreciate.

So, that's where we started our thinking about the Global Health Initiative is global health is an area where there has been a tremendous amount of progress, and Dr. Murray will, of course, talk about some of that progress, but what do we need to do next, what are the next frontiers?

So we really thought about a set of five core principles to think about as we began our work on the Global Health Initiative. And I'm happy to say that the first principle was, this,

what we've already heard referred to as the women and girls-centered approach.

And as the representative on the Global Health Initiative's work from the Women's Office, we thought that it was our job to raise the importance of women and girls to global health and to, more generally, to development and in fact, we didn't have to.

And that was the first piece of good news. I came to the State Department a year ago thinking that this was going to be a challenge, thinking that the Secretary was coming in with a drastically new view of the role of women and girls, and while she is certainly a champion and has pushed the envelope at every opportunity, there is real receptivity throughout the Department and throughout USAID.

So somebody else raised the importance of making women and girls-centered. And really

there's consensus that the need to focus on women and girls is two-fold. One is women and girls have disproportionately experienced health problems and faced disparities, but also women are really at the center of the health of their families and communities.

So there is a multiplier effect - not only are you helping women, which is the right thing to do, the good thing to do, but there's also a greater benefit.

The second principle that we're really focused on is coordination, collaboration, and integration at all levels. So that means at the point of contact with individual patients on the ground to integration and collaboration among and between U.S. government agencies and other partners to really increase efficiency and meet people's health needs better than we've done in the past.

The third principle is strengthening and leveraging multilateral partner country, NGO, and private sector efforts. In recognition of the fact that improving global health outcomes is a shared responsibility and I think you can see the commitment to that in all of the different places that we're doing our work, as I said, through the UN, through the G-8, and so many other opportunities.

The fourth is country ownership and investment in country-led plans, to ensure that our investments are really aligned with national priorities and maintained in the future. And the fifth principle is learning and accountability through increased monitoring, evaluation, research, and innovation so that our approach is really results-oriented. And actually, I think I'm going to stop ther,e and then we can delve into these questions as people want to hear more.

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CHRIS MURRAY: Good morning, and what I'd like to do in this next 10 minutes or so is touch on some of the new evidence that we have on MDG 4 and MDG 5. And I'm going to take advantage of two studies, one in The Lancet in April and one in The Lancet today that tries to provide the world with science-based documentation as to the trends of countries both in maternal mortality and child mortality.

These studies were the collaborative effort of a team of researchers at the Institute for Health Metrics and Evaluation and the University of Queensland, and many of the members of the research teams are actually here today and involved in the technical symposium that follows this with panels on child and maternal mortality.

So I'm going to try to do the impossible, which is summarize quite long papers in a very short period of time. So the high-level message

here is lots of progress, progress that's less than the extraordinarily ambitious, aspirational goals established in the MDGs. And I think that's a separate policy conversation, which is how do we set those aspirational goals.

Is it getting people to perform at the 5-percentile level, bring everybody up from the bottom to fifth or tenth percentile, or should goals in the future be grounded in some stronger sense of empirical reality, but that's a separate discussion.

What we do see here on the left side is the summary results on maternal deaths. If we looked at the maternal mortality ratio, it looks about the same, because interestingly, global births in the world are relatively constant in the last 20 years with less than 5 percent variation over that period of time. So these are numbers, but the rates diagrams look about the same. We

have the maternal death count dropping from around about 450,000 in 1990, reducing it about 1.3 percent per year, down to 340,000 deaths, the red line, in around about 2008.

And part of this study also looked at the number of maternal deaths that are related to HIV, and if you hadn't had a large HIV epidemic, maternal mortality would have dropped much more down to about 280,000 deaths. And so that emphasizes one the messages I think that will come out during this discussion, which is the intimate link between maternal mortality and HIV care.

On the right panel is a series of different estimates including our own study from three years ago, the UN Population Division figures in the triangles and UNICEF's figures from last year and then the study published today which shows that with a larger data set and new methods, we see that there's more progress than people had

thought on reducing child mortality. So, at the largest level, reasons to see considerable progress, more certainly than expected, not reaching MDG goals either for mothers or for children.

The concentration of both child deaths and maternal deaths in certain countries and regions is quite strong. These pie charts show our analysis by 21 regions. We divide the world based on epidemiological criteria into 21 regions that are used as part of the global burden of disease study, and what these studies show are that four regions account for more than 80 percent of child deaths and more than 80 percent of maternal deaths.

And in fact, that regional distribution looks quite similar. It doesn't look as similar at the country level as we will see in a moment, but the regional distribution says that four regions -

South Asia, the very large segment there; West Africa; East Africa; and Central Sub-Saharan Africa - account for 80 percent.

There are important contributions in Southeast Asia next, even though they have generally lower rates but due to large population size. So high concentration of the remaining burden in four of 21 regions in the world.

Now what's fascinating for us as researchers and I think incredibly relevant to the policy debate is the enormous variation that we've seen in progress around the world within regions. So you see that regional view, but within any region, there is marked variation in progress.

So this slide shows the annualized rate of decline from 1990 to 2010 for child mortality. And so, the MDG target, just to put it in context, would be 4.4 percent per year. And that would be the sort of medium blue color there.

In some countries - a number of them in the Middle East, countries in Latin America, countries in East Asia - the rate of decline is considerably higher, but in Sub-Saharan Africa - often the focus of where most of the burden of child death is - you see enormous variation.

Countries like Liberia, Ethiopia, Niger - incredibly poor, Malawi, and Madagascar, have quite high rates of decline: over 4 percent per year, and you have other countries, neighboring countries in some cases (Malawi, quite close to Botswana or Zimbabwe or Southern Africa) with rates of decline close to 1 percent per year. So huge variation within region, and of course we would like to understand, as we'll end on, why.

What is the link between that enormous variation within regions. Consider Pakistan and India as another example in policy. Now part of this study which I think is interesting and again

a part of the hint that we are entering a phase, a critical phase for MDG 4, is that we see signs of accelerated decline.

So what we looked at is the rate of progress from 1990 to 2000 and from 2000 to 2010. So on the x-axis is the rate of decline from 1990 to 2000 and on the y-axis on this diagram is the rate of decline in the last decade. The line is the equivalence line.

So if the pace of progress was the same, everybody would be on the same line, but what we see is a cluster of regions where progress is slowing down, those are actually mostly the higher-income or middle-income regions. And then you see many regions above the line, with one or two percentage point accelerations - that includes all of Sub-Saharan Africa and a cluster of East Asia, Central Asia, and actually Eastern Europe

with marked acceleration in the last decade where the pace of progress has more than doubled.

So, substantial evidence, 13 regions with accelerated progress and most notably 34 countries in Sub-Saharan Africa with evidence of accelerated progress. So, again, suggestions, and we might come back to why, that things are speeding up.

Now here's the slightly contrasting story or more varied story for mothers. So the same type of analysis - this was back in April in the paper, which is the annualized rate of decline for maternal mortality. You see some spectacular success stories: countries like Egypt and, in fact, most of that region of the Middle East and North Africa with substantial progress.

Countries like Bolivia, other - not as spectacular but nevertheless substantial - progress in India, in China, in Rwanda, as examples of major declines in maternal mortality,

and yet, you see countries with increases. All of the high HIV concentration parts of southern Africa, as well as Nigeria and some other countries in West Africa showing actually increases in the maternal mortality ratio during that period.

So the story for mothers is more heterogeneity, more variation against the backdrop of global progress of about 1.3 percent per year. Now your first instinct might be the same drivers that reduce child mortality are also going to be operating on mothers or vice versa, and yet, then you go into the policy debate that addressing maternal mortality takes more of a health systems, a more horizontal approach, and that there are more vertical or targeted programs that may have a direct impact on survival.

And so you might suspect that there is a considerable difference by country and how well

countries manage to reduce child mortality versus maternal mortality. And this diagram brings the two papers together - it's not in either of the papers actually - and compares the annualized rate of decline on the x-axis for mothers and the annualized rate of decline for children on the y-axis over the period from 1990 to 2008.

And the green line is countries or regions in this case where the rate of progress is the same, and South Asia, notably, is on that line, and there's a cluster of regions at the top right, which are the star-performing regions that have pretty much the same rate of decline for mothers and children, about 5 percent per year, pretty dramatically sustained declines.

These regions include a number of countries in Central Asia, East Asia, as well as North Africa and the Middle East. Perhaps of interest, of course, is that we see a cluster of

regions in the middle with much greater progress for children than for mothers.

And I think that may speak a little bit to this different types of strategies that address child mortality versus maternal mortality, and then we have two regions that stand out from the diagram with zero progress for children and negative progress for mothers; that's Southern Africa over in the far bottom left, and then just an editorial footnote, the U.S. and Canada, that brown diamond with intermediate progress on children and no progress or actually negative progress on maternal mortality.

Well, what's driving these patterns? And our studies don't actually test these hypotheses, but having looked at the data quite substantially and looked at plausible explanations and we actually do have types of causal studies underway, we see five factors that might be explanations.

And certainly don't have proof of these, but nevertheless, you can't ignore the massive expansion of educational attainment of mothers through the post-colonial expansion of primary school in Africa, particularly.

So for example, average years of schooling have gone from one and one half years in Sub-Saharan Africa in 1980 to 4.4 in 2008 and we know the strong links to child mortality and maternal mortality. That's a big long-term driver in the background. By the way, a long-term driver of fertility decline, so we expect to see accelerated fertility decline coming in Africa quite soon.

Second factor, of course, outside of Sub-Saharan Africa is rising levels of income. Third factor is the decline in fertility, particularly marked outside of Africa, just starting in many parts of Africa.

The fourth factor, which I think we see in those curves, the bump due to HIV, large in mothers and smaller in children, is that we're through the period of largest impact of HIV on children and mothers and we're actually now into a phase where the impact is large but less than it was five years ago.

And last, and of course, the one that we care about the most in this context is it's hard to explain declines in countries like Niger and progress in countries like Malawi without viewing that policy and intervention delivery is a key component of it.

There's no other plausible story that we can see. So that to us means really good news that what we are spending on health interventions is likely having an impact. So, what does this mean for this discussion this morning and for the U.S. government policy formulation?

And five suggestions as food for thought. First, I think now would be the wrong time and certainly everything suggests that the political process is moving in the correct direction. That is thatwe need to sustain, nurture, and help these evidence of accelerated progress and not in the setting of a global financial crisis, see decreases in development assistance for health.

Second, we really need in a much more in-depth way to understand success, because embedded in this huge variability in progress within regions are clearly some lessons that we should draw about why the same technical strategies most countries have adopted seem to work in some places and not in others. Is it just money or is it leadership or is it some combination of the two? Places like Malawi, Madagascar, Niger and Ethiopia should be studied, studied in detail and contrasted with countries with much less progress.

Third, of course, coming from a measurement group this sounds a little bit like self-promoting, but I actually think it's true, that we actually need to continue intensifying what the U.S. has been the world leader in, which is investing in the measurement of health outcomes through things like the Demographic and Health Surveys.

This has been one of the world's greatest public goods for global health and should be intensified and what we have learnt as a sort of a methodological nuance here is the quality of the measurement, through sibling histories and maternal mortality, the more data you collect in each country, gets better and that's for those interested in that, I'm sure we will be discussing that in the technical symposium later today.

Fourth, I think the evidence of the linkage particularly for mothers between HIV and

maternal mortality and a little bit less I think child mortality, does speak to the importance of building synergies between those types of investments. There are some synergies already, but I think those could be intensified.

And lastly, this perennial debate as we have sort of watched a little bit, which is who should be priority? And there's a trick here, which is you want to sort of nurture and reward those that are showing accelerated progress, but on the other hand you also don't want to ignore those in greatest need.

And I think it's the balancing act between those and quite how you establish those types of incentives and priorities that is perhaps the most challenging task given the good news in general that there's variation out there to observe and try to react to. So, thank you.

FLAVIA BUSTREO: Thank you very much, Diane and Jennifer, for inviting us, and thanks Chris for setting up the parameters so clearly, that makes my job of commenting much, much easier. I think many in the audience are aware that in this afternoon and today later, you will have a lot of discussion on the presentations that Chris has highlighted.

What we have from recent estimates on maternal and child health, have really a really similar and consistent message that the rates of maternal and child deaths are decreasing. And these are consistent very much with what Chris has already highlighted, but also with other publications that appear in The Lancet from Professor Black and his team working with what is called a child health epidemiology reference group supported by WHO and UNICEF, which in fact, is a very interesting and complementary paper that

looks at the causes of child deaths that can shed additional lights in terms of how and which causes of death are apparently decreasing.

And it's also very consistent with data that will appear later during the year with estimates from the UN and estimates from the group that we call Countdown to 2015, tracking progress in maternal, newborn, and child survival, that includes a number of academics, experts and UN agencies that in fact, will release its report in two weeks here in Washington, DC, at the time of the Women Deliver Conference. We really hope this entire room will be there and many, many more I am sure will be there.

So, my information is exploring two main questions. As Chris put it, what explains this decline and what do we know that is compatible with this decline? And as you will see in the Countdown report that I mentioned, what we have is

that we see that the coverage of life-saving interventions in many of the countries that are driving these reductions is increasing.

It's increasing across the continuum of care as we call it, that is the care that is necessary for mothers, in fact before they become pregnant, for adolescent girls. Mothers during the pregnancy, at the time of delivery, at the immediate postpartum, both for the mothers and for the newborn baby and for the child until he is five years and older.

But what we see in that analysis is that the interventions that can be delivered through outreach, all scheduled in advance, for example, vaccination, vitamin A supplementations, have achieved sustained high coverage.

And this is clearly, I completely agree with Chris, that more studies are needed to ascertain whether this is a causal link, but that

clearly during the last decade there have been intensive investments from many partners, including the U.S. government, but many multilateral partners, for example, the Global Alliance for Vaccine and Immunisation, that have been able to drive up that sustained coverage of immunization.

In contrast, interventions that must be provided in response to acute needs, for example, the treatment of a childhood illness, of pneumonia that the child contracts or the response to a complicated delivery and obstructed labor, those interventions impact otherwise where we have seen the least coverage, the least increasing coverage and hence, I think the argument that I am proposing and I'm trying to make here is that we really need to look at what are the elements of the system that can help us respond to these

demands that we see from both mothers and children at times of need.

Now, one other intervention where I like to drive the information where we haven't seen significant increase is family planning. And here is where I think the U.S. government, especially the Global Health Initiative, has a significant role to play, because during the last decade, we have in fact seen that the funding for family planning has been reduced, and we are very, very hopeful that with a new Global Health Initiative, this pattern will change.

One other aspect that I think is important to highlight from the presentations and that is today's question is so what remains to be done? Where should the world drive towards? And here I'd like to offer a couple of thoughts for consideration by the audience and by the other

panelists. I think much more needs to be done in support of the national priorities.

We have seen a number of global estimates, a number of global reports that are highlighting the progress. Where the focus needs to move now and I think Chris' presentation really highlights that is at the country level, analyzing countries that are making progress, why that is and working with countries that are not making progress and trying to support that so they will be able to make that progress.

And here, the reflection for the U.S. government and the new Administration, the signals are really positive because we have heard from Jennifer that in fact, this is one of the principles that the Global Health Initiative has adopted - to support national driving of the processes of reducing maternal and child mortality.

And here is also where I think at this point in time as Diane has mentioned, is a very, very critical and special year because there are a number of initiatives that have accepted this progress and are driving to rally support to national processes and national plans and national funding priorities.

We have already heard about the G-8, this is unprecedented, this is a first year since I've worked in this topic as I'm sure many of you have worked in this topic that the fact, the chair of the G-8, the Prime Minister of Canada is announcing an initiative on this topic.

I have had the opportunity and pleasure to discuss with the health experts of the G-8, while we were in Geneva, trying to shape what would this initiative mean and I think from the U.S. government there is a clear signal as Jennifer said that they would be supportive of the chair

initiative and they are discussing these other G-8 countries what does it mean for the other G-8 countries?

And our hope is that there will be complete financial commitments that will be additional to the resources that are already invested in this area, which by the way, we have been seeing increasing over the years since the year 2003. But still there is a significant financial gap and then, the final point I need to make in this opening remark is that this year is extremely unprecedented because not only do we have the G-8 leadership that has taken this step, but we also have the African Union Leadership.

As many of you may have heard, this year in July, the African Union heads of state summit, in fact, its theme is maternal and child health and I had the pleasure and the opportunity to meet and speak with many of the Minister of Heads from

the African continent last week in Geneva and because it's so encouraging to hear the level of political commitment that they express and that's clearly, must be one of the reasons we are seeing this progress that we have seen.

Because when you have the leadership at the top, that can really drive progress and then the final point which is very, very encouraging this year is what was mentioned. The initiative and drive that the UN Secretary General has started has kicked off in the spring.

This is a process that we currently call a joint action plan for the heads of women and child and the process that was intended to leverage additional commitments, policy commitments, financial commitments, and service delivery commitments from the countries that have the burden of maternal and child deaths from the countries and other stakeholders, including

private sector, foundations, NGOs, and other partners that are willing to invest in these very, very important developing cause.

And in fact, it has been positioned as the edge of the MDG movements, so I am quite hopeful that this year not only will we see additional progress as we have seen from the paper presented, but also that many of you and many of the partners, especially the U.S. government, will be key in making that change happen. Thanks.

ANA LANGER: Thank you Diane for inviting me to share with you my perspectives as well as one of the many advocates and health professionals who have spent many years working on the improvement of a women and children's health. In my case, I would like to talk from the perspective of someone who has lived and worked all her life in developing countries, particularly in Latin

America, but I have now a global perspective that I would like to bring to this table.

I share with the previous speakers the excitement about the evidence that we now have about progress made in maternal and child health and I also share the excitement about the Global Health Initiative and other very, very important events that are going to happen in the next few months and have happened already.

But, I want to make three points that also highlight the challenges that we have ahead of us. And to some extent, that builds on some skepticism that may exist among my colleagues in developing countries. And I would like to know for instance, what does the Global Health Initiative really mean for a developing country? How are we going to translate that rhetoric into action and I am trying to be provocative here.

So, I wonder for instance, what will the Global Health Initiative mean for a Nigerian women who is bleeding and has to walk three miles to get to a health service to find that there is no health provider available. Or to the surgeon in the Congo that he needs to perform an emergency caesarean section or repair a traumatic fistula and doesn't have the most basic supplies or to the family planning clinic in Guatemala with a very conservative government, where there are no commodities to keep serving the communities, those services are supposed to.

So what we really hope is that the Global Health Initiative will help translate, as you said Jen, into strengthened health systems that offer integrated services on a large scale and the health care providers will have the support and the help and the resources they need to provide quality maternal and reproductive and child care.

So how do we get there? Unfortunately I don't have the answers, but maybe you or many others, we have them, but the one point I want to make is that we won't get anywhere if we don't take into consideration the perspectives and the experience of the people working and living in developing countries, the countries that have the most adverse outcomes as Chris showed us.

So, developing country perspectives must inform the discussions that are taking place around the Global Health Initiative and around these other four that Flavia talked about. So I wonder how they are being taken into account, what are the mechanisms that currently exist and to take that perspective into the decisions that will be made about the location of funding, and also how are we going to ensure the developing country partners have a meaningful role in these discussions.

In talking now for a minute about the EngenderHealth approach to advocacy, that I think reflects exactly the needs I have been talking about, the needs of developing countries. In fact, we take a holistic approach. We don't see advocacy as an isolated action, but as something that needs to be accompanied by efforts to strengthen the supply side and to strengthen health systems and also to strengthen the demand side.

In other words, to raise the awareness among communities about their right to get good quality, in this case, maternal and reproductive and child health care, and how to improve their utilization of available health services. In other words, how to improve health seeking behaviors.

We also think of advocacy as happening at three levels, at the global, at the domestic here

in the U.S., and at the national level. And all three levels need to be connected.

We are seeing now great progress, particularly at the global level with Women Deliver, with Global Health Initiative, and we see some progress, well a lot of progress here in the U.S. too, with some outstanding organizations like Population Action International, CHANGE, and many, many others, but we don't see necessarily so much going on in developing countries, in the countries where maternal death and child death, in fact, occur.

So, why is that so and let me talk again from the perspective of someone who has worked as a professional in advocating those countries. First of all, you have to deal with governments that are not well-prepared to respond to your demands and that are sometimes reluctant to hear what you have to say. Also, there aren't always

the people with the right training or with the right tools or with the right evidence, or the evidence packaged in a way that they would really be able to understand it and be able to use it in those countries.

So, I think that that's one role that we as the international global community should play is support our colleagues in developing countries so they become empowered and better advocates.

We also need to work with donors and make sure that they recognize these and that they start investing more on advocacy and that they consider the way they are going to measure the progress we make with advocacy projects. Because they would have to be measured in a different way than a project that had much more concrete deliverables than what advocacy has.

So, I think that we are at an incredibly important moment; a moment that we won't see again

probably in many, many years and that we need to seize it now. It would be such a missed opportunity if we didn't.

The solutions exist, the technical solutions, the knowledge exists, we know what to do, we even know what it costs. Now with the new numbers, we know where the priority countries are both to make progress faster or to bring them to the same level as the other countries, but we need to do much more as a cohesive community, a community working at those three levels that I referred to.

And we also need to make sure that we get the funding, not only those billions of dollars we are talking about, but the billions of dollars focused or invested in the things that make sense and the things that are most required, that are more urgent. So, I will leave it there, and

Diane, would be happy to entertain any questions. Thank you.

DIANE ROWLAND: Well, thank you all. I think we've heard a lot of conversation and challenges in this discussion and I thought that we'd turn first to Jen Klein to get back to how to answer some of the issues that Ana and others have put on the table in terms of the U.S. government's role.

JENNIFER KLEIN: Okay, so Ana has put on the table all of the important issues. So let me start with and also getting back to the key issues and questions that were in your packet. I think first of all we are going to talk about funding. Point one was balancing funding for MNCH with other global health areas and actually I am going to involve point three, which is the role of family planning.

I think in some sense it's the wrong question, it's the right question. I think part of our concern has been that MNCH has been the left-behind area and if you look at the bar charts, the pictures speak for themselves. So I think rather than thinking about these as competing areas, the better way to look at it in our mind is to look at where we need to build up funding to support all of these areas.

And I think that again, all of the evidence that shows if you invest in maternal and child health, you are also investing in and you integrate better disease-specific programs, which is bullet two here, such as malaria and HIV, then everybody is benefitting because you really can't separate these things out, and that means funding for them all, but it also means how you are actually delivering the programs on the ground in a way that makes sense.

To get back to Ana's Nigerian woman who I have in my head every day, she walks to that clinic and she gets there and she gets the HIV service that she needs, but they don't have family planning and then she has to walk back. And that is first and foremost in our minds is how do you actually build a system?

Because we know what technology makes a difference, we know how to deliver those interventions, and what we have maybe not done as well as we can in the past, is integrating all of those, educating the patient, and really building the comprehensive health system, and that is obviously a long-term proposition, but it is also a short-term proposition as well. You start somewhere.

So you start by integrating small pieces of programs and having people in the U.S. government talk to each other and talk to the

other donors, and then over time, you work towards a long-term goal, which may be a 5, 10, 15 year goal of building a healthy health system.

And to your other point about working with the developing country, you can only do that if you're working with them and being sure that you are taking into account their priorities and what they're bringing to the table, so that's why one of our key principles is working on those national health plans and building a system within a country that is a joint effort. It can't be imposed by the U.S. government or any other government or any other multilateral organization.

I also wanted to get, and I'm not sure if this was part of the question, but to get a little back to what does it mean to put a women and girls-centered approach into practice. Because as you all know, it's very easy to sing it and it's very hard to imagine what that actually means.

And I think it means a lot of things, but I think that first and foremost, it means scaling up evidence-based, proven interventions that we know are crucial to reducing maternal, newborn, and child mortality. But it also means more than that and it means this sort of new model of business.

So, again, I've touched on some of this, but it means integrating infant and maternal health services with HIV/AIDs, with malaria, with our other infectious disease programs. It means strengthening health systems and addressing all of the environmental and structural determinants that affect women's access to care.

So, as again, the point was made, you can't address these issues without addressing education, without addressing poverty, without addressing water, nutrition, and this is obviously

a big task, but it is something we need to start doing a little bit or a lot better a job on.

So, to take just a few examples of what that means. It means integrating gender based violence, screening and referrals into health service delivery. It means placing additional emphasis on a long-neglected area, which is adolescent girls by linking to programs that address social determinants of their health status like early or forced marriage, their educational levels.

It means promoting women as leaders, service providers, and full partners in the planning and implementation of maternal and child health, and other health services, down to training female health service providers and all health service providers on gender issues.

There's a huge component of this that is improving monitoring, evaluation, and research on

the health of women, adolescents, and young girls, and collecting and disseminating sex disaggregated data.

And importantly, it also involves involving men and boys in advancing gender equality and improving health for women and girls. And to get back to Ana's point, I think a big piece of this is engaging civil society and partner countries.

On all of it, but in particular in the women and girls- centered approach because to get to her other example, the family planning clinic in Guatemala, that raises a whole host of other issues, which can only be dealt with if you see that as a sort of holistic way.

DIANE ROWLAND: I'm going to pose one question to all the panelists and then open it up to the audience to ask their questions. But I first would like to, we've talked a little bit

about this being such a critical moment and all of the G-8 and the other activities that are going on, so from each of you, given where we are in the progress or lack thereof, on maternal and child health, what would your main message be to world leaders about this issue and how to address it at the upcoming meetings? And we are going to start with you, Chris.

CHRIS MURRAY: Well, I guess the main message would be to try to learn from why things are working in some places and not in others, and often those countries have the same professed policy statements and, in some cases, even the same amount of money and so there's an element there.

Is it program leadership? I don't think we know, but if we don't unlock that part of the puzzle, I think we may still see hugely varied progress even if we scale up resources, which

hopefully this series of political events will achieve.

JEN KATES: To pick up on something that Ana said about not being able to see this kind of moment again. I agree with that, and therefore, what my message would be is to make the initiatives and the discussions concrete and specific. We have aspirational goals, we have the MDGs, we have a lot of the things that the world understands, that are out there, but be specific about this moment so that it can actually lead to some real outcomes.

ANA LANGER: So, consistently with what I just said, I think that I would tell them that developing countries need to be at the table, they need to have a strong voice, not to be there just for the sake of being there.

And that also very consistently with what Jen just said, that we need to find mechanisms to

make changes soon, as soon as we can and try to be as less convoluted as we can and streamline the support to the countries or the studies we need to do to better understand the differences between countries or whatever our agenda is, either in research, in programming, or in advocacy in trying to move forward as quickly as we can.

FLAVIA BUSTREO: I'll say seize the opportunity, the time is now. You have the challenge and an opportunity to make a historical contribution. Speak about the problem yourself, being the president and the leader of the countries, both from the South, I totally agree with Ana, and from the North, and invest in the health of women and children because that investment will pay off in the development of a country, in the economic growth of your country, and be prepared to be measured and your commitments to be accounted for.

Because that's one of the aspects that I didn't mention before, which is this joint action plan that the Secretary General is launching is really looking at how do we account for these commitments? How do we measure whether these leaders in fact deliver what they promised to the health of women and children?

JENNIFER KLEIN: Okay, so I guess I would say two things. I would say really do what everybody seems to be talking about doing, which is work together in a new way, because it's easy for various governments to commit to do things individually - it's a lot harder for them to do it together.

And I think one missing piece is if you listen, Flavia and I were at the same meeting listening to someone from Rwanda, and this is just one example, about the 800 indicators, 880 indicators that they report on. And that's only

one piece of the problem, but work together to make this much more of a seamless whole and that includes both the donor countries and the developing countries.

And my other piece of advice for the U.S. government as well as others is to be patient. Because I think that some of the things that we are talking about here are a lot harder to measure and they are a lot harder to see results and that doesn't mean they are less important.

And in fact, I think it means, as I started, it's the next important thing we need to do, but building a health system, that Congress may see a result of decreasing maternal deaths by a certain number by the date that they expect, but they might not and that doesn't mean that building that health system in the long run is not exactly the right step.

DIANE ROWLAND: And I would like to add that from the discussion today it is clear that there's a problem, but there's also been progress and to always remind the leaders that you can make more progress and that this is not an area where the solutions are not there; they just need to be pursued.

And with that, we're going to open up the questions from the audience. I would ask you to raise your hand so that the mikes can be delivered to you and to please identify yourself when you pose your question and if you want to direct it to a specific panelist, please do that, otherwise, just to the panel generally. So start here.

OSCAR CORDON: Good morning. My name is Oscar Cordon from Chemonics International. I have two questions for Chris. The first one is you mentioned that there are some changes in mortality

rates reduction of having possible to document in using different methods available.

Could you describe what those methods are? Could you show the red line going down? And the second one would be you mentioned that changes in infant mortality are more related to health system strengthening and changes with infant mortality are more related to vertical problems. So I was just thinking that there was a little bit of contradiction between those two changes. How can we address that contradiction of trying to reduce both mortality rates?

CHRIS MURRAY: So, I think on the methods, I won't answer, I will encourage you to come to the entire rest of the day is about the methods, so I would commend you to that and also direct you to the lengthy web appendices for the two Lancet papers with plenty of math. But, hopefully we will have a robust discussion in the technical

symposium on alternatives and the future way to improve the methods even more.

In terms of the sort of how do you do both and I'm sure the rest of the panel might actually have views on that, I think that's of course, one of the fundamental challenges here for maternal and child health, where many of the focused strategies on child health, whether it's bednet scale-up or vaccination, don't necessarily depend on health system strengthening.

In fact, we have found clever ways to deliver those technologies without doing much about the general district health system infrastructure, and that's, I think, exactly where some of the sort of innovation needs to come in the coming five years, and this issue about short-term versus long- term payoff, it takes a long time to strengthen health systems.

And of course, there will always be legitimate doubts that those types of investments, if they don't start to pay off, are they actually working? And so that's also the space where we really need to have ways to track progress in that arena that are going to give us some encouragement as you go along, that actually something is getting achieved.

FLAVIA BUSTREO: Yes, I would like to comment on the question on whether or not the effort are synergistic, and I would like to argue that they are very synergistic, and in fact, they can't be divorced, because in fact, if you look at the reduction in child mortality over the last 20 years, you see that progressively we have a concentration of deaths in the early part of life, in fact in the first months of life, and for those deaths that occur with a newborn, you really need to have a health system that delivers.

For example, in the paper by Bob Black, you will see that there is almost a million deaths in newborn for asphyxia. A child is born, it can be just eliminated very, very simple, and very, very easy, but there isn't a person there with the skill and the ability to do so.

And that is very, very similar strategy you need to deploy in order to assist a mother that has an obstructed labor, you need to have the person with the skill and the ability to assist both of them. So, in other words, the convergence and the synergy of the programs that are looking at maternal and newborn and the child deaths is a matter that needs to be pursued.

ANN STARRS: Thanks very much. I'm Ann Starrs from Family Care International, and I wanted to start out by thanking the panelists for a very rich and engaging set of presentations. I

would like to hone in on particular on the question around funding.

We have seen I think, from the history of the Global Health Initiatives of GAVI and Global Fund that progress has been strongly correlated on health issues that have been within the mandates of some of these global health partnership, Roll Back Malaria, etcetera, Stop TB, that we have seen tremendous progress in these areas where there is a specific local funding mechanism that is channeling funds to that issue.

I mean I won't say that that is the only reason that they've seen progress, but I think it is a striking correlation and it is also I think quite striking that there is no global funding mechanism right now that has maternal and child health and reproductive health at large within its mandate.

So, I'd like to hear some thoughts from the panelists on that issue and I think in particular, if we look at the Global Health Initiative, I think it is quite striking that that pie chart, that very simple pie chart at the beginning that of the $63 billion that is projected for Global Health Initiative, 12 percent is for all health issues other than HIV, TB, and malaria, so that includes MCH, reproductive health, but presumably a range of other global health issues as well.

So the progress is impressive, the increases in projected funding, but to be blunt, it doesn't look like it's enough and I think Jen mentioned that might be, the other Jen, I would be interested to hear more about Kaiser's analysis on that issue.

I also would be interested in hearing more about this issue which I'm glad to hear has come

up in a number of the presentations around integration across health issues. There's a coalition of advocacy groups across the range of MCH, reproductive health, family planning, HIV/AIDS, TB, neglected tropical diseases, that has been working together here in the U.S. to analyze and comment on the Global Health Initiative and had in fact, recommended a 50 percent increase in the total budgetary allocation for the Global Health Initiative if those targets are really going to be met.

I know that's obviously a tremendous increase in the current economic climate, but it is striking that policymakers and politicians, the rhetorical attention to MCH has been so dramatic over the last couple of years, but again, it hasn't been met by significant funding increases.

And then I just wanted to end by saying by disagreeing with one thing that was said by one of

the panelists, which is that and I hope we will have a chance to hear from her, but I think we have in fact seen tremendous increases in strong advocacy at the country level for both maternal health through White Ribbon Alliance and a range of other partners, as well as a number of child health groups.

So I think the statement that we haven't seen that the advocacy isn't happening at the national level, I think, is not completely correct. Certainly it could be stronger and the capacity could be built, but I think there has been a tremendous improvement in that area over the last few years.

JENNIFER KLEIN: I'm afraid that one's for me. Not the last part, the first part. I guess the answer or an answer is if you look at the graph, which I know you have done, you see the difference between even 2010 and 2011 is dramatic

in MNCH and you're working, that pie chart is a little bit unfair because you are working off of a base which includes a huge amount for HIV/AIDS to start with and nobody is walking away from that. So that's sort of your given pie chart and how much are you going to make the pie bigger I guess is the answer.

That said, I couldn't agree with you more. I wish there were more money, and I am proud of the increase over the last year and I hope that it gets enacted and we go from there, but I think that anybody who cares about this issue knows that this is the tip of the iceberg.

And we are at a moment, and I hope through the G-8, I think obviously there is a huge amount of responsibility on the U.S. government part, but I also think we shouldn't lose sight of the responsibility of other countries and multilateral organizations, and I think the G-8 provides a

great opportunity, UN effort provides a great opportunity, and I really hope that those will galvanize efforts.

And I also think this is certainly not a backtrack on funding, but I also think we need to, in the words of somebody at the UN Meeting that we were at, more money for health, but more health for the money, and I think that there's an equally important track where we need to focus on innovation and other ways to increase our efficiency, and the integration effort is a huge piece of that as well.

CHRIS MURRAY: I think that you've raised a really important issue that we need to keep in mind in the means that the opportunity right now on the current cycle of events, for example G-8, is so critical, that is what nobody seems to really want to talk about, which is that we're entering a phase where fiscal pressure on

development assistance is going to be intense. We had a couple of studies in the last year in The Lancet: one documenting the scale-up in global health spending; the second, how do developing country ministries of finance respond?

But behind that is the analysis that we've started to do with the IMF, that says what happens to development assistance as public sector debt in high-income countries grows.

And if you look historically, it is pretty grim news, which is that historically that empirical relationship is reduces ODA dramatically. So, we would expect maximum pressure on development systems budgets to start in fiscal year 13 and 14, looking at the historical record. And so that's going to be the critical period.

If anything, sustaining funding in this cycle will require incredibly effective messaging

and advocacy and I think what this set of events now will lay the ground as to whether there will actually be less money or more for maternal and child health.

Because the reality is, I mean, sure the government can't say that, but it seems highly implausible that there will be $63 billion spent in the next three years given the empirical record on development assistance. So, we really need to work hard to make that happen and so, I think that's the reality coming.

ANA LANGER: Yes, I wanted to answer Ann's comment about my comment on a country-level advocacy. Now probably I didn't make myself clear. Of course, there is so much going on in developing countries and in fact, again, I come from one of the regions where civil societies are really most organized and more active. I just think that in developing countries, our advocacy

developing countries, still needs a more support and more technical cooporation, because their work is probably more challenging.

They work in many, many different contexts and strategies and messages are different. They need to adjust to specific conditions and realities. Sometimes they don't have easy access to evidence, or it's difficult to translate the evidence that we hear about here into very compelling straight forward messages that policymakers will pay attention to.

So I was just trying to make a very rough comparison about advocacy at the global, a domestic level, and developing country level, and I think that advocacy in developing country level is the most challenging.

JEN KATES: Very quickly, we do have some analysis in a report that just looks if the proposal of $63 billion, the way it is allocated

is to be met, there will need to be a scale-up in these other areas and I just pose back a question. I think one of the challenges is interventions cost different things, so it's hard to also assess it from that perspective.

And the last thing is that we're also looking at some analysis of the relationship between ODA and financial crises, and one idea I'll throw out there that is preliminary is that it also seems to be very highly correlated with political incentives. So, regardless of the impact of the financial downturns, politics plays an important role.

RACHEL WILSON: Hi. Rachel Wilson from PATH. I had a question about the GHI Plus countries. A lot of us have been waiting to see what they're going to be and I'm curious if you can say a little bit about both what the - I suspect that a lot of what we're talking about

will be put into practice once that is moving forward, and I'm curious if you can say a little bit more concretely about what that will mean for maternal, newborn, and child health in those countries.

I'm also wondering not just in funding and programming, but also for integration. Also, when do you think we might know what those countries are? And then not just for Jen Klein, but for the others, thinking that this is coming down the road, what would you like to see in those GHI Plus countries and how this actually gets carried out?

JENNIFER KLEIN: Well, I'll start. Thank you, Rachel. The answer is no, I'm not going to say no. The countries are going to be announced soon. I apologize because I know they were supposed to have been already, but part of it is a process of working very closely with the countries and we want to be sure that they want to be GHI

Plus countries. And just for anybody who doesn't know, there's a small group - somewhere around 10 countries - will be designated as GHI Plus countries now and then another group will be designated as GHI Plus countries in the next year or so.

But what that means is a lot and a little. It means that they're laboratories that they are sort of going to receive an intensive focus and an intensive amount of technical assistance and dialogue with the United States. What it doesn't mean is that they get a lot more money and what it doesn't mean is that any of the countries who are not designated as GHI Plus countries are not also going to be part of the Global Health Initiative.

So really what is an opportunity to do is answer all those questions that you just raised, not to not answer what you're asking, but it's what does it really look like to integrate these

programs? What does it really look like to have a women and girls-centered approach? And it's really an ongoing conversation, for lack of a better way to explain it. And it’s already started.

As I said, part of the reason they haven't been announced yet is that the process of talking to the countries about what they're prepared to do and whether they actually want to be GHI Plus countries has taken longer than we expected.

So it's very much of a country driven choice. There's a huge number of factors involved which are not very tangible, does the country or some of them are tangible, does the country have a person, does the U.S. Embassy have a person who's willing to take this on? Because as I said, they don't get a lot other than a lot of attention and a lot of work in the next couple of years to see

if what we're talking about here can actually be put into practice in an effective way.

PORTER MCCONNELL: Hi, I'm Porter McConnell from Oxfam America. I have a question for all of the panelists. How would you respond to Ana's point - and Ann also echoed this point - about citizen advocacy in country.

And I think one of the ideas being tossed around with the GHI that I think would be wonderful is if you sort of pair support to ministries with support to civil society to do the advocacy, to do the measuring that I know Chris's passion is the measuring, but thinking about doing that measurement, citizens in country doing the measurement themselves and donors supporting that effort. Thanks.

FLAVIA BUSTREO: Well, just to agree completely with the comment that you made, in terms of stressing the importance that these

investments in fact, enable social and civil society organizations then the citizens of the country to understand how the progress is happening, what kind of investment is being made and to be really the ones that keep the leaders accountable. So, I do hope that the Global Health Initiative will look at this. I do know that other partners in global health are increasingly looking at these aspects.

One element that I would like to inject to qualify the comment you made is that the fact the investments needs to be made also in the way that we measure. Chris made a quite compelling argument for increased investment from U.S. government and others on the matters to estimates.

I would also like to make an argument that we do need an investment on countries themselves measuring the vital events, because we have to

remember and the rest of the day we will be discussing these very, very clearly.

These are estimates, but more than 40 percent of births go unnoticed. For example, less than half of the countries that have the birth and maternal deaths have enabled maternal notification of deaths, so we do not know where that vital event happened.

And one of the things that is has been very, very important, for example in the Latin America regions, has been totally certification of maternal deaths, but also inquire and audits of why that death happened and in that space, I think civil society organizations have an incredible role to play because they can be the ones that can drive the discussion and can drive really progress, further progress.

JUDY THIERRY: Good morning, I'm Judy Thierry with Indian Health Service, U.S. Public

Health Service. I have a question about the Millennium Villages Project and how that may afford maternal care improvements.

DIANE ROWLAND: I'm not sure anyone can answer your question. So, we'll move on to the next question.

DOYIN OLUWOLE: I'm Doyin Oluwole from AED. Thanks to all the presenters. I have just two quick points to make. The first one if you permit me to add my voice to the message to the leaders. I would say predictable, sustained investment in maternal, newborn, and child health is critical for progress. Because if we have these 10 countries, GHI Plus, not receiving additional resources that are sustained and predictable over the next x years - not just two years, not three years, but 10, 15 years. That will enable them to truly strengthen health systems.

And I'm not saying that the U.S. or any donor should be fully responsible for this strengthening of the health systems. The countries themselves must put in their own national resources, but all of this put together must be predictable, must be sustained in order to make progress. That is the key message that I would like to give to the leaders.

My second point is with respect to why do we see changes in child mortality reduction, and we do not see corresponding maternal mortality reduction in the same countries. I think it's obvious to me. Mabye I'm being very simplistic, but all the services that require 24-hour attention are critical for improving maternal mortality.

Because labor starts off any moment, nobody can predict it, even the clinicians say okay, this is the EDD, but they cannot say the

EDT, that is the time. So there's need for somebody to be available at that time when the need arises. And this is where we are failing.

So I'm basically saying that if we do not invest in services that provide emergency care and indeed link the continuum of care, we still will be missing out. Thank you.

JENNIFER KLEIN: Yes, both points are great points. Just on your first point to clarify. I'm sorry I think I was not clear when I said the GHI Plus countries are not receiving additional funding, I mean the GHI increases funding for maternal, newborn, and child health and family planning across the board, across all of the countries where the U.S. government has funding. The GHI Plus countries don't receive, they receive a small additional amount beyond the already increase, but not beyond what the entire

program will receive. I'm sorry to not be clear about that.

JEFF MEER: Thank you, my name is Jeff Meer. I'm with the Public Health Institute and again I'd like to thank all of the presenters for their presentations this morning. I wanted to bring up something that Jennifer, Flavia, and Ana all touched on, but nobody mentioned explicitly, which is the recent introduction by the World Bank of its reproductive health action plan.

This is something that's been several years in formation, and it takes into account the critical role that reproductive health plays in maternal health particularly. And there are advocacy initiatives underway that have to do with activating at the grassroots level and the national level as well as the global level.

There's also a role for the U.S. government to play as. one hopes. get our

executive director at the World Bank in place pretty soon, we hope. There will be opportunities also at the global level for the United Nations and the World Health Organization. I wonder if any of the panelists care to say anything about the new World Bank reproductive health action plan. Thank you.

ANA LANGER: I can say a few words, although I don't know it as I should probably. I think that it's great that the World Bank is taking this very, very clear and brave position. I think that the World Bank was a player that was somehow missing in that they have an incredibly important potential. I would like to see the mechanisms in place that will allow them to do or to support what they say they will, and in fact, the issue of mechanisms concerns me in general.

Also with the Global Health Initiative. Maybe it's my ignorance, and I should read those

documents more carefully, but I wonder how the Bank, for instance, just to use them as an example, and I hope they have a great idea to contradict me, the Bank usually works with governments and works through loans. It's not easy for them to give grants; it is not easy for them to work with civil society organizations.

So, how are they going to do that next? To make sure that commitment to advocacy and those resources that they will hopefully allocate to that it would truly get to the people who are able to do it.

FLAVIA BUSTREO: Thank you very much for raising the question. I think as Ana said, I was part of a group that actually reviewed the World Bank's plan, and I'm very, very much welcoming that it finally was approved by the board of the bank.

One aspect that I think is very important is the relation that this will have is what they called the MDG 4 and 5 Trust Fund, which is, in fact, is a trust fund that is looking at promoting very much innovation and results based financing associated to improvement of maternal and child health.

So these are very forthcoming development, and now I have very similar comment on the fact we very much hope to hear from the colleague from the Bank how these really in fact translate into the investment at the country level.

Because that's a part where the rubber meets the road because the additional investment, the governments, donor governments that are wheeling the Bank to make need to translate, and hopefully they will be synergistic with the ones that other governments are doing this year will be

making. So it's a good development, and we need to watch how we come forward.

KAREN LEBAN: Hi, my name's Karen LeBanwith the CORE Group. Thank you all for a very heartening policy discussion based on a growing evidence base. I think that's very exciting development. My question has to do with equity and equity within countries.

We know from World Bank data about 10 years ago that there was incredibly wide inequities within countries and that it was possible to achieve MDGs 4 and 5 by continuing along that track line. So I'm wondering what does the evidence tell us. Have we made improvements over the past decade, and are there any policy messages that should go to the G8 about how we go about achieving MDGs 4 and 5?

CHRIS MURRAY: That's a great question. I think it's interesting that there hasn't been as

much on the health outcome front of looking at within country distribution as there was a few, 5, 10 years ago. I think it's basically - we've started to look at this for children, so I think that's possible to get an answer to that. We don't have one yet.

I think there's enough rich information in the DHS and the mix, not so much in the vital registration data. There's exceptions to that. You can look at India, you can look at Indonesia, you can look at some of the large countries and look at geographic equity quite well.

For maternal, it's proving to be almost impossible We have a hard enough time getting robust assessments at the national level, because if you think about it for every maternal death, there's 20 child deaths.

So it's just easier to measure child mortality for both the event counts as well as

some other technical reasons as I'm sure you know. So I doubt we will have much in the way of inequality information on maternal except for large states, large countries where there's very detailed data. But I think it's reinvigorating that effort to track what's happening to within country inequality is important, and it would be good if more of that was done.

FLAVIA BUSTREO: Thank you very much, Karen, for raising that. We haven't really talked about in our discussion so far. I think the equity analysis is very much a central part of the report that I explained Countdown to 2015, tracking progress in maternal, newborn, and child survival, and this very much, you will see an analysis there of what are the inequities in coverage of different interventions and also an analysis of which countries have in fact managed to reduce some of those inequities.

And one example that I bring to your attention is the example of Brazil, where in fact, the reduction in maternal and child mortality rates in the country was a significantly faster in the lower income quintile of the population and that there is a lot of analysis that is being done and will be published soon in the American Journal of Public Health.

But what is very, very interesting is that that was in an intended policy that the government had for the last 20 years through the tax-based unified health system with no user fees that allowed basically the coverage of skilled attendants to basically become universal.

And this is a very interesting case to study and look because it's unprecedented that in fact, you have a faster decline in the under five mortality in the low income quintiles than in their other quintiles, but these are very, very

crucial question that has a lot of policy implications.

D**IANE ROWLAND:** Our time is drawing near, so we're going to take one last question and then have to close it down.

CHRIS HAFNER-EATON: Thank you panelists, Chris Hafner-Eatonwith the National Institutes of Health at NINR, which is the National Institute of Nursing Research. And I'd like someone, if they could possibly address the issue of nursing capacity, especially in developing countries; we know we have a severe disparity with regard to position ratios and nursing ratios.

And we know from nurse scientists and nurse scientist research that there is a direct correlation between outcomes and the ratio of trained nurses as well as other skilled attendants. Thank you.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

FLAVIA BUSTREO: Thank you very much. I think you've touched upon a point that is a fact that I had on my speaking points, but that I had in the interest of time not really addressed, which is the health workforce alliance.

So you specifically spoke about the nurses but in fact, in the countries where we see the numbers of maternal and child deaths there is a clear correlation with the density of overall health workers, physicians, midwives, very critically, and nurses.

And not only the absolute number, but the distribution because what we see is that there is a concentration of those skilled providers within the urban setting and clearly a major challenge is how do country enable the presence of skilled providers in rural areas. How do they train, retain and motivate that health workforce - that

is a very, very critical element of the health systems.

These are the investments, when we talk about investment in a health system, these are the concrete investments in the systems that need to happen and those investment in the human resources need to be sustained because they cannot be a program that starts for two years and then is withdrew because it needs to be a long-term investment that develop a capable workforce that remains within the country and provide those services that, as we have discussed, is so critical for saving their lives so women and children.

JENNIFER KLEIN: And that's a key piece when we talk about health system strengthening with the Global Health Initiative, that's a key piece of what we're talking about.

DIANE ROWLAND: Well, I would like to thank you all for being here this morning and to remind you that if you want to repeat the experience of hearing our wonderful panelists, this has been webcast and will be available on kff.org later this afternoon or tomorrow.

And I also want to encourage those who want to continue talking about measuring the progress on maternal and child mortality to join The Lancet and the Institute for Health Metrics and Evaluation here as soon as we close this down to continue the conversation with technical panels this afternoon.

Anyone who is leaving or is staying and wants to refreshen the spot is encouraged to remove any of the items you brought in here that you don't want to have for the afternoon since we don't have time to come in and do a thorough housekeeping job.

And I want to really thank all of the panelists that have been with us for their insights, but especially for their dedication to working on this issue, to trying to help improve the healthcare that women and children around the world so desperately need, and to look at all of the interventions that surround healthcare since we know healthcare alone is not the way to achieve everything we need to achieve. So thank you all very much, and we look forward to continuing our global discussions with you -

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