

Strategic Framework 2012 to 2015



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Executive Summary

This document sets out the Strategic Framework for the operations of the Partnership for Maternal, Newborn & Child Health (the Partnership) over the course of 2012 to 2015. It draws on discussions and conclusions from a number of Board meetings, as well as extensive consultations with the Partnership's members. It also reflects the Board's decision to recognize the entire reproductive, maternal, newborn and child health (RMNCH) Continuum of Care as the operational context for the Partnership.

The context for this Strategy is the success of the Partners in delivering the objectives in the Strategy and Workplan 2009 to 2011, which has contributed to major achievements in women's and children's health during this period. However, many opportunities and challenges are left for the global health community in terms of reducing child mortality (Millennium Development Goal 4) and improving maternal health (MDG 5), as well as in working towards achieving all the other MDGs. Key opportunities arise from the important political and financial commitments (e.g. the United Nations Secretary-General's Global Strategy for Women's and Children's Health, and the Campaign for the Accelerated Reduction of Maternal Mortality in Africa). Challenges include pressures on the global economy, other health priorities, an increasing tendency to focus on single health issues, and the challenges of the current global health aid architecture.

The Partnership's value proposition arises from its being the only platform that brings together all of the many Partners in the global health community focused on improving the health of women and children and promoting the Continuum of Care.

The Partnership's activities are guided by its Vision and Mission:

- Vision: The achievement of the MDGs, with women and children enabled to realize their right to the highest attainable standard of health in the years to 2015 and beyond.
- Mission: Supporting Partners to align their strategic directions and catalyse collective action to achieve universal access to comprehensive, high-quality reproductive, maternal, newborn and child health care.

The Partnership's work will be focused through three Strategic Objectives (SOs), which reflect the Partnership's value proposition and provide the framework for developing individual outputs and activities:

- SO 1: Broker knowledge and innovation for action, leading to increased access to, and use of, knowledge and innovations to enhance policy, service delivery and financing mechanisms.
- SO 2: Advocate for mobilizing and aligning resources and for greater engagement, leading to additional resource commitments for RMNCH, visibility of women's and children's health issues in relevant forums, and consensus on evidence-based policy development and implementation.
- SO 3: Promote accountability for resources and results, leading to better information to monitor RMNCH results, as well as better and more systematic tracking of how resource commitments are actually allocated.

In achieving these objectives, the Partnership will structure its activities around four operational principles:

- 1. Being **partner-centric**, by supporting Partners to deliver the Partnership's objectives, without replacing or replicating Partners' work or their internal governance / accountability processes.
- 2. Focusing on **convening** (i.e. providing a platform for Partners to discuss and agree on ways to align their existing and new activities) and **brokering** (i.e. actively brokering knowledge, innovations, collaborations, etc. among the Partners).
- 3. Being driven by country demand and regional priorities.
- 4. Promoting the Continuum of Care approach to improve women's and children's health.

The success of the Partnership will be measured in its ability to achieve the identified outcomes for each of its three Strategic Objectives, as summarized in Table 1 below, and ultimately by supporting the Partners to deliver their respective mandates, and achieve better RMNCH outcomes in high-burden countries than would otherwise have been possible.

Table 1: Summary of the Partnership's Strategic Framework

OVERVIEW

Vision

The achievement of the Millennium Development Goals, with women and children enabled to realize their right to the highest attainable standard of health in the years to 2015 and beyond.

Mission

Supporting Partners to align their strategic directions and catalyze collective action to achieve universal access to comprehensive, high-quality reproductive, maternal, newborn and child health care.

Added Value

To be an institutional platform bringing together and enhancing the interaction of Partners focused on improving the health of women and children, working across the reproductive, maternal, newborn and child health Continuum of Care. In essence, enabling Partners to share strategies, align objectives and resources, and agree on interventions to achieve more together than they would have been able to achieve individually.

Continuum of Care. In essence, enabling Partners to share strategies, align objectives and resources, and agree on interventions to achieve more together than they would have been able to achieve individually.				
STRATEGIC OBJECTIVES				
Broker knowledge and innovation for action Observably increase access to and use of knowledge and innovations to enhance policy, service delivery and financing mechanisms, so as to address key constraints to achieving universal access to comprehensive, high-quality reproductive, maternal, newborn and child health care in high-burden countries.	Advocate for mobilizing and aligning resources and for greater engagement Identify and mobilize additional resource commitments for RMNCH through Partner engagement and by maintaining clear visibility of women's and children's health issues in international and national policy and development forums. Promote consensus on evidence-based policy development and implementation (including strategic priorities and alignment of resources).	Promote accountability for resources and results Promote accountability for resources and results, leading to better information to monitor RMNCH results, as well as better and more systematic tracking of how resource commitments are actually allocated.		
DELIVERABLES				
To be developed as part of the detailed Workplan.				
ACTIVITIES				
To be developed as part of the detailed Workplan.				
CROSS-CUTTING PRINCIPLES				
Partner-centric				
Convening and Brokering				
Country demand and regional priorities				
Continuum of Care				

1. Introduction

This document sets out the Strategic Framework for the operations of the Partnership for Maternal, Newborn & Child Health (the Partnership) over the course of 2012 to 2015. It presents the context in which the Partnership operates and sets out the Partnership's Vision, Mission and Value added. It proposes Strategic Objectives for delivering these aims and outlines the operational principles by which the Partnership guides its work. It builds on the successful implementation of the Partnership's Strategy and Workplan 2009 to 2011, which will be completed in 2011. More information on the Partnership's history and activities, and its Partners, can be found at www.pmnch.org.

The Strategic Framework for 2012 to 2015 draws on the discussions and conclusions from the Partnership's Board Retreat held on 9 and 10 March 2011 and its supporting discussion papers. It also reflects the lessons learned from the previous Strategy and Workplan 2009 to 2011 and the ongoing global efforts to improve the health of women and children and achieve the Millennium Development Goals (MDGs). The development of the Strategic Framework took place between March and October 2011 under the guidance of the Board and Executive Committee of the Partnership. It included consultations with the wider membership, particularly at the early stages of the development. A short version of the document was made available in April 2011 as part of consultations with the whole membership. Comments received from Partners and other collaborators during the consultation period have been considered and integrated.¹ The paper also reflects discussions and decisions made at the Partnership's Board meeting in June 2011.

From a framework to a plan of work

The Strategic Framework is the basis for further and more detailed work translating this framework into specific, identifiable and costed outputs and activities, which will make up the dynamic, four-year rolling Strategy and Workplan 2012 to 2015 (the Workplan) for the Partnership. The full Workplan will guide the Partnership's activities in 2012 and beyond. Its "dynamic" nature reflects the shared and pragmatic view that the Partnership must retain a degree of responsiveness to a fast-moving global health environment. The Board agreed that the Workplan should reassess and adapt the focus of its outputs and activities on an annual basis in the years to 2015, as appropriate and relevant.

This document has been developed by the Partnership's Secretariat with the support of Cambridge Economic Policy Associates (CEPA).²

The Strategic Framework is structured as follows:

- Section 2 provides a brief overview of the progress, challenges, opportunities and risks in the current reproductive, maternal, newborn and child health (RMNCH) landscape.
- Section 3 sets out the Partnership's overall value proposition.
- Section 4 proposes the Vision and the Mission for the Partnership.
- Section 5 discusses the Partnership's Strategic Objectives for the period 2012-2015.
- Section 6 details the cross-cutting principles that underpin the Partnership's Strategy.

Progress, challenges, opportunities and risks in the current landscape

2.1 Progress and the challenges ahead

As the current Strategy and Workplan 2009 to 2011 comes to a close, the Partnership, through its Partners and the global health community at large, can claim to have achieved much for women's and children's health. But much more still remains to be done. The last decade has seen insufficient progress towards achieving the Millennium Development Goals (MDGs), particularly with regard to the health goals. MDG 4 (reduce the mortality rate among children under-five years, by two thirds) and MDG 5 (reduce maternal mortality ratio by three quarters) are two of the MDGs furthest from being achieved. Slow progress towards the MDGs, or a lack of progress, is seen particularly in countries where the burden of ill-health and poverty is greatest. The most vulnerable populations and communities in these countries are the worst hit.

Progress

Maternal mortality rates have declined globally and in most high-burden countries.^{3,4} But, as maternal mortality is declining at an average rate of 2.3% (as it has between 1990 and 2008), instead of the required 5.5%, this progress is insufficient to achieve MDG 5. In low- and middle-income countries, pregnancy and childbirth continue to claim the lives of over 1000 women each day, amounting to over 350 000 deaths a year. Contraception uptake has also slowed down since the year 2000, and in several places the gap between need for and coverage of contraception has widened.⁵ Correspondingly, teenage pregnancy rates continue to be high, and progress in this area has slowed down since 2000. Many more women and children suffer from long-term disabilities developed during pregnancy and childbirth. Most of these deaths and long-term disabilities are preventable.

Similarly, although mortality rates among children under five years dropped by 28% between 1990 and 2008, only 19 of the 68 Countdown to 2015 (high-burden) countries are currently on track to achieve MDG 4.5 More than 22 000 children under five die every day, amounting to 8 million deaths a year. Nearly 40% of these deaths occur in the first month of life. In addition, there are 7300 stillbirths every day, amounting to 2.6 million a year, and 45% of these occur during labour.6 Substantial evidence points to several gaps that sustain such unacceptable levels of mortality and morbidity - gaps in the coverage and quality of various services across the RMNCH Continuum of Care, and equitable access to them; and gaps in the funding of such services. Also, data gaps affect decisions on service improvements. For example:

- Despite the well-known clustering of maternal and newborn deaths around childbirth and the immediate postnatal period, about 40% of women in developing countries still do not have a skilled birth attendant during childbirth, and less than 40% women receive a postnatal visit.^{5,7}
- Pneumonia and diarrhoea are the largest killers of children after the newborn period but very few receive the correct treatment. For example, antibiotics for pneumonia reach just over 25% of affected children in high-burden countries, and diarrhoea treatment only 42%.^{5,7}
- Lack of access to family planning contributes to 76 million unintended pregnancies every year, and accounts for 13% of the maternal deaths caused by unsafe abortions.⁸ But in nearly a third of high-burden countries, the gap between need for and access to contraception either increased between 2000 and 2008 or remained the same.^{5,7}

- Poor-quality care, which affects demand for and use of health services, contributes to high mortality and morbidity rates. However, resources are severely constrained in many countries. For example, less than half of high-burden countries have the complete equipment and skills needed for emergency obstetric care.⁵
- Inequities among the affected are stark.⁹ The poorest households and those with little education have the least coverage across the RMNCH interventions; and this gap between the rich and poor is widest in sub-Saharan Africa and South Asia.^{5,10}
- Young girls (aged 15 to 19), with low levels of education and from the poorest rural households, are the most vulnerable group. They face the greatest barriers in accessing reproductive and maternal health services, as well as a higher risk of maternal mortality and disability, and of low birth weight and mortality among newborns.⁵
- There are large gaps not only in the data for mortality and morbidity, but also in the data related to coverage of services. Vital registration systems and management-information systems are weak in several low-income countries.¹¹

Needs and Challenges

The proven interventions that can improve rates of mortality and morbidity are well known. However, coverage, quality, inequity and data issues have to be addressed (ANNEX I: Needs and Challenges). It is difficult to make progress on these in the face of constraints in skills and infrastructure, and more importantly in funding (both the volume of funding, and its efficient use). All of this combined results in poorly functioning health systems. A strong and well-functioning health system implies that, across the policy-to-practice spectrum, "the right people are available at the right place, with the right resources and doing the right activities, so as to achieve the right results".⁷

- **Right people:** A significant change is possible only when skilled and motivated people are advancing the agenda in terms of right policies, implementing the proven interventions appropriately and supporting the uptake of available services. Also needed are political leadership, the required numbers of adequately skilled health workers, and supportive households and local communities.
- Right place: Measures are necessary to ensure the right people are present and can work effectively, when and where they are needed most. These will require investments within the health sector for better geographical outreach of services, and cross-sectoral linkages to improve access and uptake of services. To achieve better RMNCH outcomes, it is important to have coordinated systems, such as those for birth planning and referrals to, and across, the various levels of facility-based care. Other important factors include incentivising skilled workers to work in rural areas, improving transportation, enabling women to achieve more in education and establishing gender-sensitive policies.
- **Right resources:** Quicker gains of course depend on higher public investments, but also on newer ways of raising and distributing funds, which can help reinforce the various components of the system. This must be complemented by medical and technological advances that are more effective and cost-efficient, and by stronger planning, coordination and management of the health and information systems. In short, a reliable health service can accelerate progress.
- Right activities: The effectiveness of proven RMNCH interventions can be thwarted by barriers that
 are systemic or community-based. Both supply- and demand-side activities to promote women's and
 children's health are equally important, because service quality and health illiteracy can affect

service uptake equally. Education, economic ability and residential factors can all affect both supply of and demand for services, thus reinforcing the need for cross-sectoral efforts.

• Right results: The aim in the short-term is to achieve the MDGs 4 and 5, but ultimately it is to ensure that women and children claim their basic right to live healthy lives. All women and children deserve to have access to clinically effective and safe health care, which is a good experience for them. Political leaders, governments, donors, international agencies, health-sector staff and all other stakeholders are accountable for all actions that can help or hinder the achievement of this right.

The MDGs and integration

The MDGs, while encouraging specific targets for each individual goal, also have synergies that can offer opportunities for linking across MDGs and sectors. RMNCH has long-established links with hunger, poverty and under-nutrition (MDG 1), education (MDG 2), gender (MDG 3), safe drinking water and sanitation (MDG 7). Cross-sectoral coordination brings cost-efficiencies and better outreach - thereby raising the likelihood of quicker progress.

Similarly, there are many opportunities for integration of services that attempt to reach out to the same group of women and children. The RMNCH Continuum of Care framework has facilitated the integration of services and packages, which have proved more cost-efficient and improved maternal and newborn outcomes.^{13,14} Communicable diseases such as HIV/AIDS or malaria (MDG 6) and family planning and maternal health are both elements of reproductive health care and can therefore easily be linked. For example, the needs of all can be addressed at referrals or visits, and health messages relating to them can be synchronized. There is also scope for improving detection of HIV/AIDS in women who have the disease but do not display symptoms, and for providing counselling.¹⁵ Similar opportunities exist to exploit synergies between noncommunicable diseases such as diabetes, cervical cancer and RMNCH, and need to be seized because they are important to prevent mortality and morbidity. For example, high-blood pressure and diabetes in pregnant women have been associated with a higher risk of stillbirths.¹⁶

Mothers and children worldwide benefit when partners who focus efforts on the relevant MDGs work hand in hand with other stakeholders.

Good-quality health care for women and children is possible. However, to achieve it the global health community needs to work with countries to:

- advocate for increased funding for RMNCH;
- advocate for evidence-based and efficient spending (funding the proven and effective interventions in the most efficient way);
- support country efforts to improve data collection and analysis;
- invest in implementation research;
- maximize financial and technical support for large-scale implementation of priority strategies and interventions;
- encourage accountability of key actors to ensure they keep their promise

These are considerable challenges. They do, however, constitute tangible targets for the global community to focus its attention on.

2.2 Capitalizing on the opportunities

A recognition of the lack of progress to date, and a universal determination to increase the opportunities for improving women's and children's health in high-burden countries, has resulted in important political and financial commitments over the last few years.

A number of global developments built on the opportunities that this positive political will presented. The United Nations Secretary-General's 2010 Global Strategy for Women's and Children's Health¹⁷ (the Global Strategy) was the culmination of many coordinated global efforts. These included the launch of the Partnership's Strategy and Workplan 2009 to 2011, the High Level Task Force on Innovative Financing for Health Systems, the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA), the 2010 African Union Summit of Heads of States on Maternal, Infant and Child Health and Development, the Washington Women Deliver Conference and many others. The Global Strategy, and its associated Every Woman Every Child campaign, was an important watershed in the field of women's and children's health and the key context in which to determine the role that the Partnership will play in the years ahead.

As part of the above efforts to achieve the MDGs, and in the context of the Global Strategy, there have been increased interest and significant commitments from a large number of high-burden countries, from civil society, donor partners and foundations, and from the private sector. In particular, in 2010, US\$40 billion in new financial, policy and service-delivery commitments were announced. This was achieved despite the pressure on donor and national budgets. This interest has also expanded from maternal, newborn and child health to encompass the sexual and reproductive health of women. In addition, significant donor commitments continue to be made to strengthen child health, through immunization programmes. For example, in June 2011 the Global Alliance for Vaccines and Immunisation (GAVI) was successful in raising US\$4.3 billion in donor commitments, exceeding its US\$3.7 billion target.

As facilitator of the Global Strategy, and the platform that supported the participation of all key stakeholders in these processes, the Partnership has played an important role. It now has a chance to continue being an active member in the processes of creating and implementing mechanisms over the next four years, to capitalize on these opportunities.

The details of the Partnership's activities within the context of the Global Strategy, and associated efforts such as the Every Woman Every Child campaign (ANNEX II: Every Woman Every Child), will be presented in the more detailed Strategy and Workplan for 2012 to 2015. The Partnership's contribution will focus on adding value through better knowledge for policy, advocacy for mobilization and engagement and accountability for results. These reflect the Partnership's Strategic Objectives for 2012 to 2015, as discussed in Section 5 below. Some examples of the Partnership's interactions in these areas with existing initiatives include:

- Contributing technical knowledge, through its network of Partners, to support the development of a strategic framework to guide the development of private-public projects and partnerships. This would build on the work already underway as part of the Innovation Working Group of the Global Strategy. Such partnerships have the potential to deliver significant impact in areas with a high potential return on investment, in relation to implementing the Global Strategy.
- Advocacy activities related to mobilizing additional commitments (in terms of resources but also on engagement and policies) to the Global Strategy.
- Development of a 2011 report on the Global Strategy commitments, aimed at complementing the work of the Commission on Information and Accountability for Women's and Children's Health (ANNEX III: Recommendations of the Commission on Information and Accountability for Women's and Children's Health, and the 11 indicators) and boosting momentum for the Global Strategy and Every Woman Every Child.

2.3 The risks

A clear and powerful momentum has been achieved by the Global Strategy and other related work to date. It is now critical that this momentum builds, and that commitments are translated into actions - and these actions into results on the ground.

There are risks, however, and this is not a time for complacency. Risks can be mitigated, but it is first essential to identify and manage them. This is not an exclusive list, but some risks worth highlighting are:

- Pressures on the global economy. The global financial and economic crisis continues to create challenges both for the governments of high-burden countries and for donor countries. This will continue for some time. Some donors remain cautious and, in the face of competing development priorities and potentially shrinking international development budgets, the importance of demonstrating tangible results cannot be overemphasized. Critically, countries that are major investors in RMNCH, through domestic spending, also need these results to justify their investments.
- Crises and other priorities. New global crises emerge and other health issues (such as noncommunicable diseases) are prioritized. These other, very legitimate, demands on human and financial resources could result in reduced attention on women's and children's health. The challenge to the RMNCH community is to ensure that improvements in the health of women and children continue to be seen as complementary and essential to other health issues, and that the focus is not taken away.
- "Single-issue" focus. There has always been a temptation and potentially now more than ever for policy-makers to focus on "single-issue" topics. Although, in some cases, individual disease or specific vertical interventions have increased focus on previously neglected issues, the case for system-wide approaches remains overwhelming. It is imperative, therefore, that the Continuum of Care approach central to the efforts to improve RMNCH and discussed in more detail in Section 6 below is better explained, the causalities more clearly identified, expected outputs defined and results on the ground demonstrated.
- Global health architecture. The global health and development institutional landscape is crowded and increasingly fragmented. This poses a systemic risk of replicated responsibilities and resources in certain areas of need, with critical gaps in resources and coverage emerging in others.

3. The Partnership's value proposition

The Partnership will continue to focus its attention on areas where it adds discernible value, and contributes to ongoing efforts to improve the health of women and children. This will be mainly in the context of efforts towards achieving MDGs 4 and 5. Where relevant, it will also work with Partners in working towards other MDGs. The Partnership will operate across the entire spectrum of RMNCH¹⁸ covering the whole Continuum of Care (see box), with a focus on integration issues (such as links to MDG 6) and the

importance of social determinants of health.

The Continuum of Care

This was first proposed in the World Health Report 2005, and has since been adapted and evolved to be a more encompassing concept (ANNEX IV: Enable the Continuum of Care). The Partnership agrees that: "The Continuum of Care for reproductive, maternal, newborn and child health includes integrated service delivery for women and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. Such care is provided by families and communities, and through outpatient services, clinics and other health facilities". 19 As it addresses both time and place aspects of health care, this two-dimensional framework approaches women's and children's health in a holistic way. The health of young women from their teenage years is brought into focus within this framework, not only highlighting their needs around reproductive health but also around education, nutrition and social support. Such attention for adolescents, young girls and women is carried through the preconception stage to pregnancy and childbirth. The inextricable links between maternal and newborn health call for continued attention to their care and support, with the subsequent childhood stage then forming the foundation on which adult health and life is based.

The Partnership has helped to renew the focus on this life-cycle approach, and build a consensus on a core package of RMNCH interventions to be delivered across the Continuum of Care,²⁰ which is significant for the efforts to reduce maternal and newborn mortality and improve women's and children's health. Evidence shows that a core package of services delivered across the Continuum of Care improved outcomes.²¹

The Partnership's overall value proposition is that it is the only institutional multiconstituency platform in today's large and fragmented global health space that brings together, in one place, the key Partners focused on improving the health of women and children. It enables Partners to share strategies, align objectives and resources, and agree on interventions.

More specifically, however, the Partnership is:

- A forum for discussing and aligning strategic approaches to policy development and implementation of essential interventions across the Continuum of Care from reproductive through to maternal, newborn and child health and as part of coordinated efforts to strengthen health systems. In this forum, Partners can work together on developing and aligning important advocacy messages, including for resource mobilization, policy development, technical capacity building and public-health educational efforts.
- A vehicle for collecting, translating and disseminating important RMNCH-related knowledge, including tried-and-tested best practices, and valuable experience of policy development and intervention implementation, globally and in countries. The contribution such knowledge makes to the public good is an example of how the Partnership adds value.
- An institutional link between the RMNCH community and the broader activities of national governments, development partners and non-state actors focused on tackling bottlenecks in the social determinants of health such as education of girls, women's rights and gender equality, improved nutrition, provision of water and sanitation infrastructure, upgrading of transport and telecommunication services.

These "value-added" features will be developed and included in the Partnership's detailed Workplan for 2012 to 2015. Translating the Partnership's value proposition into reality will be guided by a set of specific, measurable and costed outputs and activities.

What does the Partnership <u>not</u> do? One specific and critical feature is that the Partnership does not displace, replace or replicate the existing governance, accountability and delivery structures of individual Partners. The Partnership expects primarily to add value by ensuring that these existing Partners' activities are better coordinated and by enhancing collaboration between Partners in order to achieve more effective results in high-burden countries. In essence, its added value is to enable Partners - including high-burden countries - to achieve more together than they would have been able to achieve individually.

This unique role supports the case for the Partnership's continued involvement as a critical stakeholder in the Every Woman Every Child effort to implement the Global Strategy for Women's and Children's Health, and in achieving the MDGs more generally.

This proposed role and value proposition also determines the principles that are set out in Section 6, which define the way that the Partnership expects to function - i.e. its *modus operandi*. These include:

- 1. being partner-centric;
- 2. playing a convening and brokering role for its Partners;
- 3. being guided by country demand and regional priorities; and
- 4. continuing to promote the Continuum of Care.

In acting as the facilitating platform for RMNCH Partners, the Partnership is also well placed to be one of the main international forums, specifically for the RMNCH community. Here, discussions can take place and stakeholders can engage to influence the development agenda beyond the MDGs' deadline of 2015.

4. The Partnership's Vision and Mission

4.1 Partnership Vision

The PMNCH Vision acknowledges the fact that realizing the highest attainable standard of health is integral to many international and human rights treaties, which the international community has endorsed and continues to support. It also recognizes the fact that women and children must be empowered stakeholders, not just passive recipients of health benefits. The MDGs provide a useful reference framework and the achievement of MDGs 4 and 5, and the MDGs more generally, is a central focus for the Partnership. While using this reference framework, the vision also reflects the reality that the efforts to improve women's and children's health will continue beyond the current MDGs target deadline in 2015.

The achievement of the MDGs, with women and children enabled to realize their right to the highest attainable standard of health in the years to 2015 and beyond.

4.2 Partnership Mission

The Partnership Mission has been reshaped to take account of the developments to date, and the role that the Partnership is best placed to play within the global-health architecture. It reflects the discussions at the Board Retreat, the comments made by members during the consultative process and the Board discussion and decision at the June 2011 Board meeting. The Partnership's Mission is as follows:

Supporting Partners to align their strategic directions and catalyse collective action to achieve universal access to comprehensive, high-quality reproductive, maternal, newborn and child health care.

"Health care" in this context is broadly defined as including the social and environmental determinants of health as well as medical care and services. This is aligned with internationally agreed definitions of health care. For example, the 1978 Alma Ata Declaration defines primary health care as: "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community".

The Mission statement helps to focus the activities of the Partnership and its constituent Partners. It focuses on ensuring that all agreed essential RMNCH interventions are accessible to, and therefore implemented by, high-burden countries. This includes advocating and working towards conducive policy environments and sufficient human and financial resources, and meaningful inclusion in these processes of all important stakeholders, including current constituencies of the Partnership.²² For the avoidance of doubt, it is worth repeating that the Partnership does not displace or replicate existing governance, accountability and delivery structures of individual Partners.

There is recognition within the Partnership Mission that health interventions may not be able to achieve the highest desirable impact if they are implemented without consideration for the wider social determinants of health. The Partnership itself will not focus its attention and resources on addressing issues such as access of women and children to education, water and sanitation, adequate nutrition, transport services etc. However, it will continue to develop into an inclusive platform where stakeholders working in these fields are able to communicate their strategic thinking to, and align with, Partners engaged more directly in addressing specific RMNCH-related issues in high-burden countries.

Finally, the Mission also provides the basis for the Partnership to support Partners in thinking, engaging and influencing the post-2015 development agendas.

5. The Partnership's Strategic Objectives

The work of the Partnership towards its Mission and Vision will be delivered through three Strategic Objectives (SOs). These objectives reflect the key elements of the overall Partnership value proposition, and provide the framework for the development of specific, measurable and costed outputs and activities of the Partnership over the years 2012 to 2015. These outputs and activities will be identified and set out in the Partnership's Workplan. The SOs are:

- SO1: Broker knowledge and innovation for action.
- SO2: Advocate for mobilizing and aligning resources and for greater engagement.
- SO3: Promote accountability for resources and results.

Given the Partnership's value proposition, four operational principles have been identified that determine the way in which it expects to work (1. a partner-centric organization; 2. playing a convening and brokering role for Partners; 3. guided by country demand and regional priorities; 4. promoting the Continuum of Care). These are discussed in more detail in Section 6. However, it is important to draw attention to the first operational principle here in order to understand the nature of the Partnership's activities that are likely to contribute to the proposed SOs. In particular, the Partnership is a *Partner-centric* organization. This means that the Partnership relies on its Partners and their work to achieve the Partnership's objectives. It is a platform:

- where Partners, and high-burden countries in particular, are able to both work together to achieve more than can be achieved by working alone; and
- to support alignment and catalyse action by Partners in areas of focus.

The SOs are discussed in turn below. Although distinct in nature and focus, all are intertwined so, for example, work done in the area of "accountability for results" (SO3) will be synergized with "knowledge and innovation" (SO1) and "advocacy" SO2.

5.1 Strategic Objectives

Strategic Objective (SO) 1: Broker knowledge and innovation for action

The outcome associated with this SO is an observable increase in access to, and use of, knowledge and innovations to enhance policy, service delivery and financing mechanisms. The aim is to address key constraints to achieving universal access to comprehensive, high-quality RMNCH care and services in high-burden countries.

In achieving this objective, the Partnership will in general focus on:

- Building consensus and strategic alignment related to RMNCH knowledge and innovations. For example, on essential interventions for RMNCH (which also take account of equity issues), costing and investments. This includes developing products to meet these needs, such as consensus statements, knowledge summaries and syntheses, investment cases and costing tools.
- Facilitating the translation of knowledge and adoption of innovations in policy and practice by promoting understanding of the knowledge needs of different constituencies, and capacities to utilize knowledge and innovations. This involves playing a brokering role with partner organizations and regional knowledge networks to provide relevant RMNCH knowledge support for country policy-making and programme management and practice, and sharing knowledge to promote "south-south" learning.

Providing an overview of RMNCH knowledge and innovations and gaps based on analyses of global progress towards MDGs 4 and 5 e.g. Countdown to 2015 reports. This overview is also facilitated by using strategic mapping exercises and the RMNCH portal, which provides access to the resources of more than 400 Partner organizations.

Strategic Objective (SO) 2: Advocate for mobilizing and aligning resources and for greater engagement

Overall, the Partnership will continue to advance a rights-based argument for women's and children's health through the Continuum of Care, while outlining the investment case for RMNCH. Every country in the world is now party to at least one human rights treaty that addresses health-related rights. This includes the right to health as well as other rights that relate to conditions necessary for health.²³

The outcome of this Strategic Objective will be focused in the following areas:

- **Resource mobilization**. Additional commitments for women's and children's health identified and mobilized through Partners' engagement.
- Visibility of RMNCH issues through a human rights framework. Momentum for women's and children's health maintained in international and national policy and development forums.
- RMNCH policy development and implementation. Consensus on evidence-based policies as well as strategic priorities and efficiencies, and alignment of resources to underpin coherent policy development and implementation.

The Partnership will achieve this by:

- Contributing to joint work towards the United Nations Secretary-General's Global Strategy commitments, by:
 - Advocating for delivery of existing commitments made to the Global Strategy.
 - Working with existing (and new) Partners in identifying new financial, policy and service-delivery commitments from all constituencies, including the private sector, and mobilizing these commitments by using the Partnership's multi-constituency platform to increase the capacity of the Partners to mobilize resources.
 - Working closely with the office of the United Nations Secretary-General and other Partners on the implementation of the Advocacy plan of the Global Strategy, including support for the engagement by United Nations Member States.
- Advocating (through events, dialogue and facilitation) to include the issue of women's and children's health prominently in the landscape of international politics, economics and development. Relevant forums include the African Union, G8, political groups such as the Inter-Parliamentary Union and others, with the aim of encouraging supportive political statements, policy directions and, most importantly, policy change where required. Engaging and mobilizing communities through traditional and social media to maintain, expand and inform the RMNCH constituency.

Convening global, regional, national and local stakeholders to develop a consensus on evidence-based strategic priorities. Advocating for coordinated approaches to resource mobilization in countries and effective use and alignment of resources, and for equitable allocation of resources to agreed strategic directions, country priorities and national plans.

Strategic Objective (SO) 3: Promote accountability for results

The outcome of this objective is expected to be the availability of demonstrably better information to monitor RMNCH results and better and more systematic tracking of actual allocation of resource commitments for women's and children's health. Consensus building and action by Partners will be encouraged by:

- Promoting the recommendations of the Commission on Information and Accountability (COIA). Building on work that will have been undertaken in 2011, the Partnership will use its multi-stakeholder Partner network to ensure that the recommendations of the COIA are carried forward in key areas such as: ensuring that the 11 agreed indicators are promoted, either through a reworded RMNCH Consensus or similar action; and support for monitoring of commitments made to the Global Strategy by all Partners.
- Specifically, this work will be informed by the Partnership's 2011 report on Commitments to the Global Strategy for Women's and Children's Health, which will support the implementation of the COIA recommendations. As stated in the Commission's final report: "exercises like the report on tracking commitments related to the Global Strategy that is currently being undertaken by The Partnership on Maternal, Newborn & Child Health should provide useful and easily accessible baseline data on the financial, policy and programme commitments that were announced in September 2010. The report will also help to clarify issues related to additionality and double counting in commitments. Going forward, all donors should identify clearly both the sources and the intermediaries of financial flows when reporting on commitments, so as to avoid double counting. The greater availability of information will not only raise awareness of women's and children's health, but allow closer scrutiny of whether health improvements are equitable and whether funds are being used responsibly and equitably. Transparency will also greatly facilitate learning and continuous improvement, and transparent information will support more informed decision-making by all partners".²⁴
- The Countdown to 2015 will publish its 2012 report with country profiles for 74 countries up from the traditional 68 to encompass all those included in the Global Strategy. Country profiles will continue to reflect coverage and equity on the implementation of essential interventions, health systems and policies for RMNCH, and the financing for health services. Work is ongoing to adapt the indicators collected through country surveys. At the request from governments to undertake disaggregated country assessments, the Countdown to 2015 will initiate these surveys in a small number of countries. The Partnership hosts the Secretariat for the Countdown to 2015, which gives multiple opportunities to link the evidence in the Countdown reports to advocacy and political opportunities to effect change in line with emerging trends and evidence.
- Accountability is a key element of human rights. Every country in the world is now party to at least one human rights treaty that addresses health-related rights. This includes the right to health, as well as other rights that relate to conditions necessary for women's and children's health.²⁵

6. Cross-cutting, operational principles

As noted in Section 3, the Partnership is the main global platform where Partners from multiple constituencies come together to coordinate and share information on their efforts to improve women's and children's health in high-burden countries. In order to reflect this role, and support the work towards the stated objectives, its Mission and Vision, the Partnership will structure its activities around four operational principles. These are set out and discussed below in turn.

6.1 The way the Partnership operates is Partner-centric

The Partnership has, since 2009, been a *Partner-centric* organization. This means that the Partnership relies on its Partners and their work to achieve the Partnership's objectives. As stated above, the Partnership's role is not meant to replace or replicate either the work or internal governance and accountability processes of individual Partners - i.e. members of the Partnership. Rather, it is a platform where individual Partners have an opportunity to inform others of the work they are doing, learn from existing work and experience, understand what is being done or planned, identify gaps or overlaps and, in discussion, agree and coordinate next steps to the extent that this is appropriate and relevant.

The *Partner-centric* approach therefore mobilizes, engages and empowers the different implementing Partners. It allows them to coordinate their actions and activities and encourages and promotes mutual accountability through inclusiveness and transparency. It is the Partners themselves who continue to have the capacity, and therefore the responsibility, to implement specific activities - but with an opportunity to coordinate with others so as to increase the effectiveness and efficiency of these actions. This may be reflected in, for example, better donor coordination in aid flows, agreement by health-care professionals on common implementation policies and alignment of messages by the NGO community.

The Partnership members are represented by constituency representatives on the Partnership's Board, with each constituency having its own internal governance, communication and operational structure. The Partnership will strive to reach out to and engage with its broad membership, either through relevant Board representatives or directly, as most appropriate.

6.2 The Partnership will play a convening and brokering role for its Partners

In supporting the Partners in their work, the Partnership will focus its efforts on playing a brokering and convening role to engage all Partners in an inclusive and transparent manner, as follows:

- Convening. Its convening role will involve providing a platform for all Partners to discuss and agree on ways to align their existing and new activities (potentially to reshape their approaches in light of new information and to coordinate implementation of interventions) and catalyse new activities and approaches.
- **Brokering.** The Partnership will actively broker (knowledge, innovations, collaborations, etc.) among the Partners, in all Strategic Objectives and areas relevant to improving RMNCH. For example, the Partnership will bring Partners together to discuss and agree on assessments of the current situation and of progress towards the MDGs. This would support Partner discussions on approaches to making essential interventions available in high-burden countries.

6.3 The work of the Partnership will be guided by country demand and regional priorities

The Partnership will adopt an approach that is in alignment with national plans and regional initiatives (such as the CARMMA²⁶). This will ensure that activities are guided by actual demand and national health plans, as articulated by individual countries, and based on global best practices, including the Paris Principles and Accra Agenda for Action.

National governments from high-burden countries are an essential constituency of the Partnership. They provide feedback, share experiences and offer direction to the discussions on how best other Partners can contribute to their activities, and coordinate with in-country development efforts. All activities of the Partnership are therefore guided by the principles of supporting existing country plans. An ongoing cross-cutting theme, across all Strategic Objectives, will be the need to increase efforts to engage the country constituency effectively.

The work on defining best practices and opportunities for strengthened multi-stakeholder country engagement, through Partners, will continue as the Workplan 2012 to 2015 is being developed.

6.4 The work of the Partnership will continue to promote the Continuum of Care (Annex IV)

The Continuum of Care concept is now agreed to be the best approach to improving women's and children's health. It encompasses effective intervention packages for RMNCH - the period from pre-pregnancy to a child's fifth birthday - which are provided either by families and communities or health facilities. The Continuum of Care concept helps to focus attention on the effective delivery of health services, addressing gaps in service provision and highlighting the needs for human and financial resources. It is also both contingent on, and a catalyst for, a well-functioning health system.

The Continuum of Care has: (i) a life-cycle dimension; and (ii) a place-of-care dimension. The key points to note about these are:

- Life-cycle dimension. The relevant life-cycle is assumed to start before pregnancy and, in the context of the reproductive and sexual health of women, to extend through pregnancy, birth and on to the baby's childhood and the health of its mother. The stages of the life-cycle are naturally interdependent. Reproductive health will impact on pregnancy, and the health of a pregnant woman will impact on the health of the newborn child. As such, interventions throughout the life-cycle need to be linked and mutually supportive. For example, where relevant, antenatal care should promote PMTCT,²⁷ skilled attendance at delivery and keeping mothers alive, which in turn should be linked to postnatal care for both mother and newborn. By providing the context for defining integrated packages of care and how they should be delivered, the Continuum of Care can be an effective framework for improving the quality of service delivery.
- Place-of-care dimension. Aspects of where and how care is provided are similarly interdependent. Household education will help to prevent health complications, quality care in communities will reduce the need for hospitalization, and sound primary-care referral systems will support better treatment for acute conditions. Essential interventions addressing the problems affecting women and children therefore need to take place at all levels of the health system, i.e. from the home to the community and through to the hospital. This dimension of the Continuum of Care recognizes the importance of the health system as a whole. It also acknowledges that a well-functioning health

system includes components such as a health workforce, health-service delivery, health-information systems, medical products, vaccines and technologies, health financing, health leadership and governance. In other words, when services identified through the Continuum of Care are put in place, the health system will be strengthened.

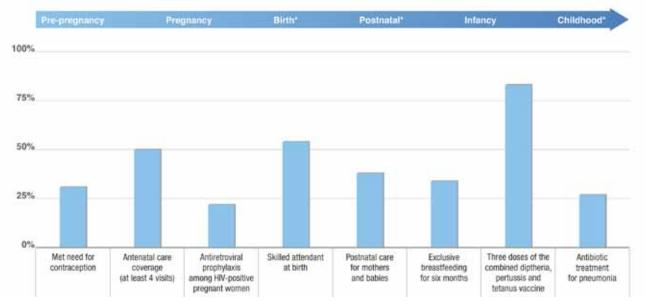
These two dimensions of the Continuum of Care provide a "space" in which evidence-based essential interventions can be defined and implemented in high-burden countries, as illustrated in Figure 1 below.

Figure 1: RMNCH Continuum of Care



In this space, for example, there will exist interventions that are aimed at addressing the pre-pregnancy stage in the life-cycle, but which could be provided in household, community and hospital settings. In the same manner, there are community-based interventions that span the whole life-cycle dimension. The key benefit of using this Continuum of Care approach is that it enables the Partners to define and implement interventions so that they are mutually supportive across the two different dimensions, and that any gaps (e.g. no interventions for dealing with birth in a household setting) are identified and dealt with - such as those identified in Figure 2 below.

Figure 2: Coverage gaps based on the indicators selected by the Commission on Information and Accountability



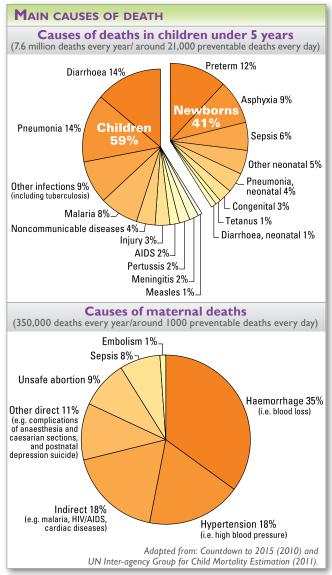
^{*} Times of high risk of mortality for women and children, but with low coverage of essential interventions. PMNCH (2011). Adapted from the Countdown to 2015 (2010), with indicators from the Commission on Information and Accountability for Women's and Children's Health (2011).

Conclusion

As the Partnership prepares its detailed Strategy and Workplan for 2012 to 2015, it will be guided by the principles and objectives set out in this Strategic Framework. Principal among these are the Strategic Objectives to: broker knowledge and innovation for action; advocate for mobilizing and aligning resources and for greater engagement; and promote accountability for results. In working to achieve these, it will observe the operating principles of: being partner-centric; focusing on convening; being driven by country demand and regional priorities; and promoting the Continuum of Care.

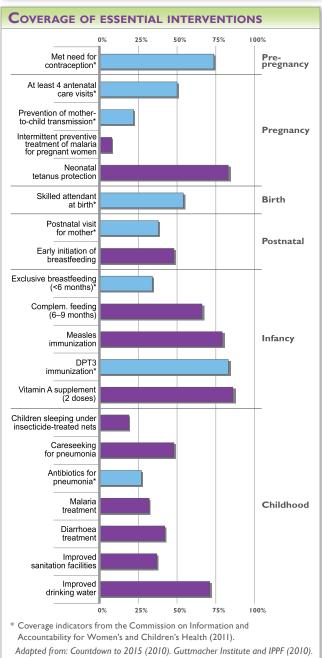
The Continuum of Care is the reference point to which the Partnership will return continually in its work with Partners and other stakeholders. Once effective intervention packages are in place across the RMNCH Continuum of Care, and accessible to Every Women and Every Child, rapid achievement of MDGs 4 and 5 and the objectives of the Global Strategy for Women's and Children's Health will follow.

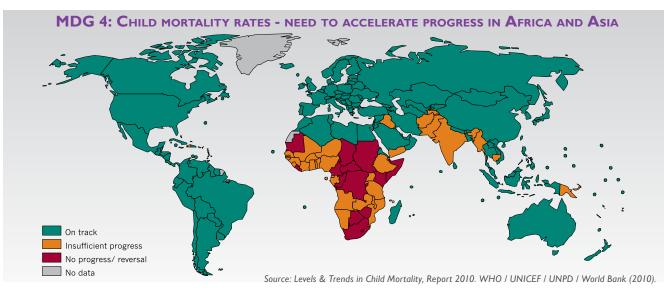
Annex I - Needs and challenges in women's and children's health

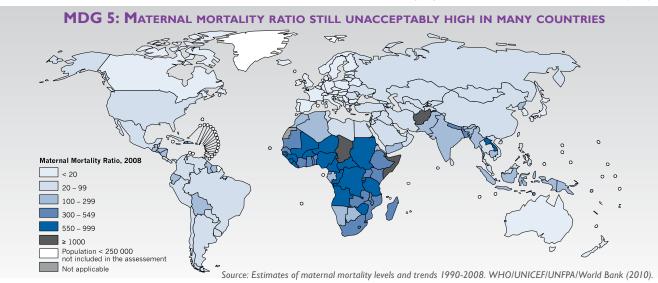


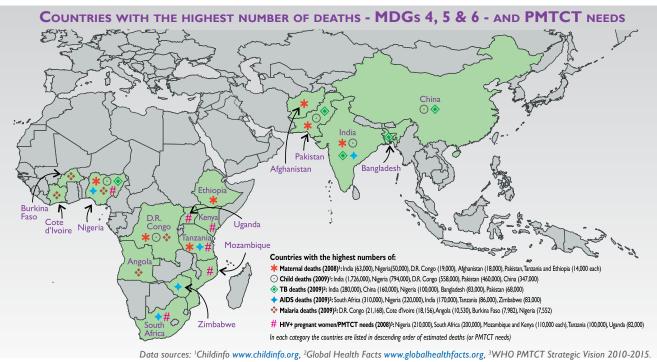












Annex II - Every Woman Every Child

"Every Woman, Every Child. This focus is long overdue. With the launch of the Global Strategy for Women's and Children's Health, we have an opportunity to improve the health of hundreds of millions of women and children around the world, and in so doing, to improve the lives of all people."

- United Nations Secretary-General Ban Ki-moon

What is Every Woman Every Child?

Launched by UN Secretary-General Ban Ki-moon during the United Nations Millennium Development Goals Summit in September 2010, Every Woman Every Child aims to save the lives of 16 million women and children by 2015. It is an unprecedented global effort that mobilizes and intensifies international and national action by governments, multilaterals, the private sector and civil society to address the major health challenges facing women and children around the world. The effort puts into action the Global Strategy for Women's and Children's Health, which presents a roadmap on how to enhance financing, strengthen policy and improve service on the ground for the most vulnerable women and children.

Why does this matter?

Every Woman Every Child provides a new opportunity to improve the health of hundreds of millions of women and children around the world, and in so doing, to improve the lives of all people. The health of women and children is critically important to almost every area of human development and progress, and directly impacts our success in achieving all of the Millennium Development Goals (MDGs), adopted by world leaders in 2000.

Research has conclusively demonstrated that the health of women and children is the cornerstone of public health. Healthy women and children create healthy societies. Healthy societies, in turn, are the foundation upon which nations build successful economies and create prosperity for their people. And prosperity, as we know, is essential to political stability and social harmony.

What can be done?

Every Woman Every Child recognizes that all actors have an important role to play in improving women's and children's health. More than \$40 billion was pledged at the 2010 launch, and numerous partners have made additional, and critical, financial, policy and service delivery commitments, but more help is needed. The Secretary-General is asking the international community for the additional commitments necessary to take Every Woman Every Child past the tipping point. This would mean saving the lives of 16 million women and children, preventing 33 million unwanted pregnancies, ending stunting in 88 million children, and protecting 120 million children from pneumonia by 2015.

This is an enormous and unprecedented undertaking. The stakes are high, and the cost of failure is great. But the rewards of success are greater still. They include a better life for all of us, and a healthy future for women and children everywhere.

Please explore these pages with the desire to ensure that every woman and every child have the same opportunities for health and life and ask yourself what you can do.

www.everywomaneverychild.org

Annex III – Recommendations of the Commission on Information and Accountability for Women's and Children's Health, and the 11 indicators

On May 19, 2011, at the 64th World Health Assembly, The United Nations Commission on Information and Accountability (COIA) for Women's and Children's Health presented its report, Keeping Promises, Measuring Results. This included recommendations to increase the likelihood that pledges for women's and children's health are honoured and that resources are spent in the most effective way to save lives. It also listed 11 indicators of maternal, newborn and child health, from a combination of the 11 MDGs indicators and the 39 indicators used by the Countdown to 2015.

"The report's 10 recommendations include:

- 1. increasing the number of countries with well-developed systems to measure births, deaths and causes of deaths;
- 2. measuring against 11 common indicators [see below] on reproductive, maternal and child health;
- 3. helping countries integrate the use of Information and Communication Technologies in their national health information systems;
- 4. countries with high maternal and child deaths track and report resource indicators;
- 5. country governments and major development partners put "compacts" in place that require reporting, based on country format, on externally funded expenditures and predictable commitments;
- 6. all governments have the capacity to regularly review health spending and to relate spending to commitments;
- 7. countries have established national accountability mechanisms that are transparent, inclusive of stakeholders and recommend action as necessary;
- 8. all stakeholders are publicly sharing information on commitments, resources provided and results achieved annually at both national and international levels;
- the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC) agree on how to better capture all reproductive, maternal, newborn and child health spending by development partners;
- 10. an independent Expert Review Group is reporting regularly to the UN Secretary-General on results and resources related to the Global Strategy for Women's and Children's Health and progress of the implementation of these recommendations.

The 11 indicators of maternal, newborn and child health:

One set of indicators has been selected to monitor the status of women's and children's health:

- 1. maternal mortality ratio (deaths per 100 000 live births);
- 2. underfive child mortality, with the proportion of newborn deaths (deaths per 1000 live births);
- 3. children under five who are stunted (percentage of children under five years of age whose height-forage is below minus two standard deviations from the median of the WHO Child Growth Standards).

"These three health status indicators are essential for monitoring MDGs. Stunting, a nutrition indicator, is important for understanding not only outcomes, but also determinants of maternal and child health. Nutrition is also a useful proxy indicator for development more broadly. These indicators are relatively insensitive to change and do not show progress over short periods (in the absence of birth and death registration systems they can only be measured with substantive time lags). Therefore, more sensitive and timely data that can monitor almost real-time changes in a set of key interventions to improve women's and children's health are needed. This objective can be achieved by monitoring a tracer set of eight coverage indicators:

- 1. met need for contraception; (proportion of women aged 15-49 years who are married or in union and who have met their need for family planning, i.e. who do not want any more children or want to wait at least two years before having a baby, and are using contraception);
- 2. antenatal care coverage (percentage of women aged 15-49 with a live birth who received antenatal care by a skilled health provider at least four times during pregnancy);
- 3. antiretroviral prophylaxis among HIV-positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment-eligible;
- 4. skilled attendant at birth (percentage of live births attended by skilled health personnel);
- 5. postnatal care for mothers and babies (percentage of mothers and babies who received [a] postnatal care visit within two days of childbirth);
- 6. exclusive breastfeeding for six months (percentage of infants aged 0-5 months who are exclusively breastfed);
- 7. three doses of the combined diphtheria, pertussis and tetanus vaccine (percentage of infants aged 12-23 months who received three doses of diphtheria/pertussis/tetanus vaccine);
- 8. antibiotic treatment for pneumonia (percentage of children aged 0-59 months with suspected pneumonia receiving antibiotics)."

Source: Keeping Promises, Measuring Results. Health accountability report and recommendations of the Commission on Information and Accountability, presented at the World Health Assembly, May 19, 2011.

ANNEX IV - Enabling the continuum of care

Continuous care across life stages and from home to hospital is crucial for health - for complete physical, mental and social well-being. In the context of reproductive, maternal, newborn and child health (RMNCH) this takes on a greater significance because a child's health is closely linked to the mother's, from conception through to birth and beyond. Progress towards the Millennium Development Goals (MDGs) 4 and 5 is therefore intricately linked. Evidence shows that an effective continuum of care, which includes intervention packages from pre-pregnancy through to childhood up to age 5, is thus essential to the well-being of this and the next generation, across all developing countries.

"The 'Continuum of Care' for maternal, newborn and child health includes integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. Such care is provided by families and communities, [and] through outpatient services, clinics and other health facilities."

The World Health Report 2005 - Make every mother and child count.

What works?

A review of 191 studies analyzed the effects of various services delivered as intervention packages along the continuum of care.¹ It found particularly strong links between maternal and newborn health outcomes. Poor implementation, inadequate linking between services in the package, or omission of some key interventions made the care ineffective. Interventions included care from pre-pregnancy to childhood and were delivered in various ways, such as outreach services, clinical care, and family and community-level care. Outreach packages had good coverage but missed out key interventions, such as preventing mother-to-child transmission (PMTCT) which could have been combined with a package for pregnancy care.² A review of evaluated HIV/AIDS interventions in 90 countries focused on what worked for women and girls, and found that prevention was key.³ Effective provision of barrier methods of contraception and PMTCT could prevent a substantial number of HIV cases.

Nearly two-thirds of newborn and child deaths could be avoided if essential care was provided along the continuum. The role of the mother is crucial in this regard. One recent study in Bangladesh, for example, found that the death of a mother greatly reduces the chances of the child's survival, especially for those aged between two and five months.⁴ A further study looked at the impact of 16 interventions for newborns, delivered as packages along the continuum. It found that between 0.59 to 1.08 million lives could be saved each year in South Asia, and between 0.46 to 0.8 million in sub-Saharan Africa, with improved coverage and if interventions were delivered effectively throughout the continuum of care (see Knowledge Summary 4).^{5,6} Good nutrition and preventive health care for mothers and children can reduce deaths by 25% among newborns to three year olds.⁷

In addition to well-integrated clinical and outreach services, family and community-level care provide women and children with the knowledge and choices required for their health. A community-based experiment in rural Nepal showed that community links with the local health system were strengthened when women had improved knowledge of their care and greater involvement. This also encouraged other improvements within the health system. In a context where home births were the norm and mortality rates were high, this is felt to have helped to reduce newborn deaths greatly. Community-based interventions, such as community case management of pneumonia in children, can thus strengthen the continuum of care and improve health outcomes.

Where do we stand now?

The latest report from *Countdown to 2015*, shows that, despite some progress in expanding and improving RMNCH services over the past ten years, there are still significant gaps. There have been some gains in coverage of routine interventions such as immunization, and newer interventions such as PMTCT for HIV. However, much remains to be done in the most crucial area - childbirth.

Gaps in the pre-pregnancy to childhood continuum

- Adolescence and pre-pregnancy: Complications during pregnancy and childbirth are the leading cause of death in young women (15 to 19 years) in developing countries. Unmet need for family planning remains high in this age group and in others. Nearly a third of *Countdown* countries in fact showed an increase or no change in unmet need between 2000 and 2008. Lack of family planning is reflected, in part, in the continuing burden of unsafe abortion, which accounts for an estimated 13% of all maternal deaths.¹¹
- During pregnancy: Skilled health care during pregnancy is important; for example, to treat high blood pressure, provide tetanus immunization and test for HIV and syphilis. At least four such contacts are recommended, at which high-quality and effective care is provided. The average coverage of these four visits was 50% across 51 *Countdown* countries since 2000.
- *At childbirth: Nearly 42% of the maternal deaths, a third of the stillbirths¹² and 23% of newborn deaths happen during childbirth. Safe delivery practices, access to skilled attendants and emergency obstetric and neonatal care, and early initiation of breastfeeding can help prevent these deaths. Two-thirds of Countdown countries had coverage levels of less than 5% for the proportion of births by caesarean section, indicative of poor availability of emergency obstetric and newborn care.
- After childbirth: Bleeding and infections after childbirth account for a high proportion of maternal deaths, and about 3 million babies die in the first week of their life. However, there is very little data about the coverage of services in the postnatal period. Only 45% of Countdown countries had any information on postnatal care for women, and only 1% had information on postnatal care for newborns.
- During infancy and childhood: While coverage of immunization has improved, that of exclusive breastfeeding lags behind. Almost a third of the 52 Countdown countries have improved exclusive breastfeeding rates by 20% or more since 2000. The average coverage of exclusive breastfeeding across countries, however, is still only 34%.
- Serious childhood illnesses: Childhood illnesses such pneumonia, diarrhea and malaria require immediate attention and access to 24-hour health services. There has been some progress, for example in treating malaria, but more needs to be done.

Gaps in the home-to-hospital continuum

Saving lives depends not only on high coverage but also on the quality of care delivered throughout the continuum.

Health worker shortages severely weaken the continuum of care

To deliver essential health services, a minimum of 23 midwives, nurses and doctors are needed per 10,000 people. Only 29% of *Countdown* countries now meet this requirement. Efforts to train, recruit and retain health-care workers in priority areas are crucial (see Knowledge Summary 6) across primary, secondary and tertiary levels of care.

Quality issues and supply shortages make care ineffective

Quality of care (see Knowledge Summary 7) is adversely affected, not only by health worker shortages, but also by poor infrastructure and inadequate supplies of medicines, medical products and equipment.

Locally produced commodities and stronger distribution systems are key interventions to overcome these bottlenecks (see Knowledge Summary 5).

Gender inequities, poverty and lack of education affect women's health

Coverage rates are lowest among women and children from the poorest families, who face the greatest health risks (see Knowledge Summary 9). People's demand for care can be adversely affected by factors such as: the cost of health care borne through out-of-pocket payments; local beliefs; and knowledge and misperceptions about the health system. To improve health outcomes, educational attainment must be increased, 14 community-level strategies promoted, and changes in care-seeking behavior encouraged.

Conclusion

The Global Strategy for Women's and Children's Health emphasizes the importance of using effective interventions to strengthen the continuum of care. However, the task of overcoming the high burden of maternal and newborn deaths is hindered by inequitable coverage of services along the continuum (see Knowledge Summary 1). We know which RMNCH interventions are important (see Knowledge Summary 4). A number of established and new ways to help scale-up services, improve service delivery and encourage health care uptake amongst women and children are available. Governments, donors, business communities and global initiatives must now work together to ensure that MDGs 4 and 5 are realized.

Useful resources

- Countdown to 2015 Decade Report (2000-2010): Taking stock of maternal, newborn and child survival www.Countdown2015mnch.org/documents/2010report/CountdownReportAndProfiles.pdf
- Opportunities for Africa's newborns: Practical data, policy and programmatic support for newborn care in Africa www.who.int/pmnch/media/publications/africanewborns/en/index.html
- WHO (2005) The World Health Report 2005 Make every mother and child count www.who.int/whr/2005/en/index.html
- Baby-Friendly Hospital Initiative www.who.int/nutrition/publications/infantfeeding/9789241594950/en/index.html
- WHO recommended interventions for improving Maternal and Newborn Health http://whqlibdoc.who.int/hq/2007/WHO_MPS_07.05_eng.pdf

References

- 1. Kerber K J, et al (2007). "Continuum of care for maternal, newborn, and child health: from slogan to service delivery." Lancet 2007; 370: 1358-69.
- 2. Bhutta Z A, et al. "Interconnections between maternal & newborn health: a systematic review" (Aga Khan University & FCI, forthcoming).
- 3. Gay J, et al (2010). "What works for women and girls: Evidence for HIV/AIDS Interventions." New York: Open Society Institute. www.whatworksforwomen.org
- 4. Ronsmans C, et al (2010). "Effect of parent's death on child survival in rural Bangladesh: a cohort study." Lancet 2010; 375: 2024-31.
- 5. Darmstadt G L, et al (2008). "Saving newborn lives in Asia and Africa: cost and impact of phased scale-up of interventions within the continuum of care." Health Policy and Planning 2008;23:101-117.
- 6. Darmstadt GL, et al (2005). "Evidence-based, cost-effective interventions: how many newborn babies can we save?" Lancet 2005, 365(9463):977-988.
- 7. Bhutta Z A, et al (2008). "What works? Interventions for maternal and child undernutrition and survival." Lancet 2008; 371: 417-40.
- 8. Manandhar D S, et al (2004). Cited in Kerber K J, et al (2007). "Continuum of care for maternal, newborn, and child health: from slogan to service delivery." Lancet 2007; 370: 1358-69.
- Countdown to 2015 Decade Report (2000-2010): "Taking stock of maternal, newborn and child survival." (PDF). www.Countdown2015mnch.org/documents/2010report/CountdownReportAndProfiles.pdf
- 10. WHO (2009). "Women and health: today's evidence tomorrow's agenda." (PDF). http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf
- 11. UNFPA https://www.unfpa.org/public/home/mothers/pid/4382 (accessed 19 October 2010).
- 12. Lawn J E, et al (2010). "Global report on preterm birth and stillbirth (1 of 7): definitions, description of the burden and opportunities to improve data." BMC Pregnancy and Childbirth 2010, 10(Suppl 1):S1 (PDF). www.biomedcentral.com/content/pdf/1471-2393-10-S1-S1.pdf
- 13. Lawn J E, et al (2005). "4 million neonatal deaths: when? where? why?" Lancet 2005, 365:891-900.
- 14. Gakidou E, Cowling K, Lozano R, Murray CJ. "Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis." Lancet 2010, Sep 18;376(9745):959-74.

Annex V - What is reproductive health?

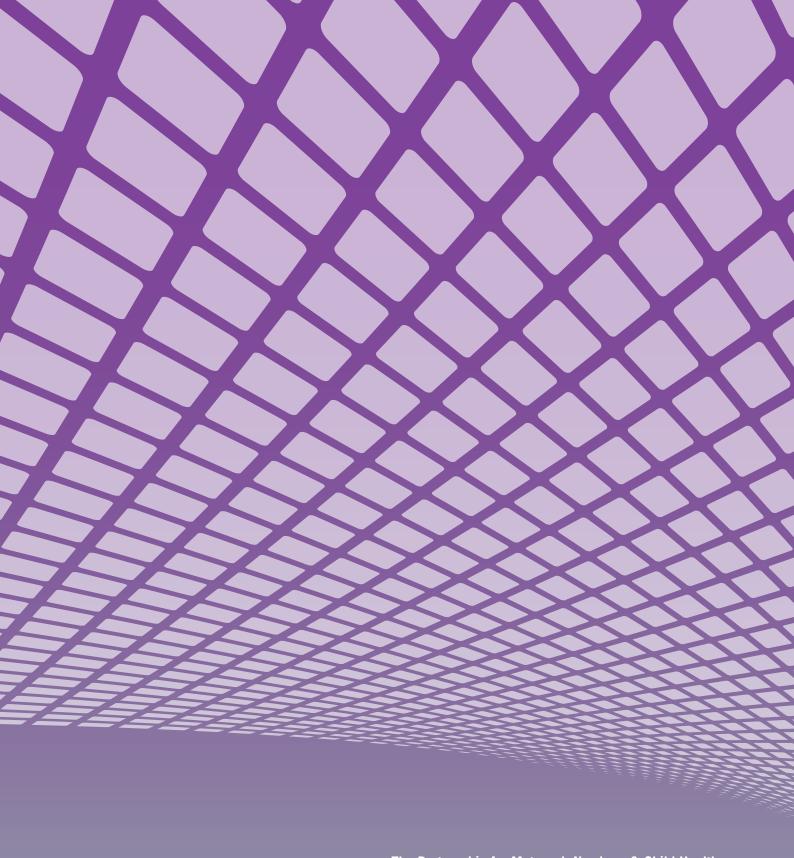
"Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." (Paragraph 7.2)

"Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. ..." (Paragraph 7.3)

Source: Programme of Action of the International Conference on Population and Development, New York, United Nations, 1994.

Endnotes

- 1. The full details of the comments received are available from the Secretariat.
- 2. CEPA is a London-based economic, strategy and finance consultancy (www.cepa.co.uk).
- 3. WHO. Trends in Maternal Mortality: 1990 to 2008, 2010. Estimates developed by WHO, UNICEF, UNFPA and the World Bank. Geneva. 2010.
- 4. Hogan MC, et al. Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. The Lancet, 375:1609-23, Apr 12, 2010.
- 5. Countdown to 2015 Decade Report (2000-2010): Taking stock of maternal, newborn and child survival. (PDF), 2010 www.countdown2015mnch.org/documents/2010report/CountdownFlyerHeadlinesEnglish.pdf
- 6. Cousens S, et al. National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis. The Lancet, published online April 14, 2011.
- PMNCH. Women's And Children's Health: Needs And Challenges. Summary (PDF), 2011 http://portal.pmnch.org/downloads/Needs-and-Challenges.pdf
- 8. UNFP. http://www.unfpa.org/public/home/mothers/pid/4382. Viewed 13.07.2011
- 9. PMNCH . Address Inequities. Knowledge summary 9, 2010. (PDF) http://portal.pmnch.org/downloads/high/Knowledge_for_Action_KS9_highres.pdf
- 10. Boerma T, et al. Mind the gap: equity and trends in coverage of maternal, newborn, and child health services in 54 Countdown countries. The Lancet, 371: 1259-67, 2008.
- 11. WHO. *Keeping Promises, Measuring Results*. Health accountability report and recommendations of the Commission on Information and Accountability, presented at the World Health Assembly, May 19, 2011 http://www.who.int/topics/millennium_development_goals/accountability_commission/en/
- 12. PMNCH. Engage across sectors. Knowledge summary 1, 2010. (PDF) http://portal.pmnch.org/downloads/high/Knowledge_for_Action_KS11_highres.pdf
- PMNCH. Enable the Continuum of Care. Knowledge summary 2, 2010. (PDF) http://portal.pmnch.org/downloads/high/Knowledge_for_Action_KS2_highres.pdf
- 14. Pattinson R, et al. Stillbirths: how can health systems deliver for mothers and babies? The Lancet, published online, April 14, 2011.
- 15. Lule E. Strengthening the Linkages Between Reproductive Health and HIV/AIDS Programs. World Bank, 2004. (PDF) http://siteresources.worldbank.org/INTPRH/Resources/Strengthening_linkages_between_RH_HIV.pdf
- 16. Lawn JE, et al. Stillbirths: Where? When? Why? How to make the data count? The Lancet, published online, April 14, 2011.
- 17. The United Nations Secretary-General. Global Strategy for Women's and Children's Health. 2010 www.un.org/sg/globalstrategy
- 18. The PMNCH Board decided at its 10th Meeting (1 & 2 June, 2011), to use RMNCH consistently, making "R" for reproductive health explicit in the areas covered by its mandate.
- 19. Adapted from WHO, The World Health Report 2005 Make every mother and child count. Also see PMNCH, Enable the Continuum of Care, knowledge summary 3, 2010, for a detailed discussion http://portal.pmnch.org/downloads/high/Knowledge_for_Action_KS2_highres.pdf
- 20. See Table on RMNCH essential packages of interventions by level and commodity requirements http://portal.pmnch.org/downloads/high/Knowledge_for_Action_Annex1_highres.pdf
- 21. PMNCH. Enable the Continuum of Care. Knowledge summary 3, 2010. (PDF) http://portal.pmnch.org/downloads/high/Knowledge_for_Action_KS2_highres.pdf
- 22. The Partnership's membership is divided into six constituencies: Governments or country partners, Donors & Foundations, UN and Multilateral Organizations, NGOs, Health Care Professional Associations and Academia, Research and Training Institutions. The Partnership also works with the private sector and is currently considering adding a constituency in its governance structure.
- 23. WHO. Health and Human Rights: www.who.int/hhr/en/ Viewed on 20.06.2011.
- 24. Pending reference from final endorsed Commission's report
- 25. WHO. Health and Human Rights: www.who.int/hhr/en/ Viewed on 20.06.2011. The Convention on the Rights of the Child (art. 6, 19,20,23, 24), CEDAW (art. 10, 11, 12, 14), the Covenant on Economic, Social and Cultural Rights (art. 7, 10, 12 while written in 1966, also refers to reducing stillbirth rates), The American Declaration of the Rights and Duties of Man (art. 7, 11) and the African Charter on Human Rights (art. 16, 18), African Charter on the Rights and Welfare of the Child (art. 5, 11, 13-17, 21, 27, 28).
- 26. Campaign for the Accelerated Reduction of Maternal Mortality in Africa.
- 27. Preventing mother-to-child transmission of disease.



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