B16-2015-ITEM8a

Practical implications for PMNCH's new strategy

13 April 2015

Background

The new PMNCH 2016-2020 Strategic Framework is being prepared alongside global efforts to prepare a 2016-2030 Global Strategy for Women's, Children's and Adolescents' Health (Global Strategy). In the context of negotiations to update the Global Strategy and to develop the Sustainable Development Goals (SDGs) for endorsement in September 2015, PMNCH is likely to be asked to take on new and significant roles in implementation. Although the exact contours have yet to be determined, the PMNCH Board and Secretariat need to contribute to and influence these processes, so that the outcomes are consistent with the new PMNCH Strategic Plan. The emerging PMNCH Strategic Framework, with its focus on the four As – advocacy, analysis, accountability and alignment – has implications for the Partnership's architecture, and subsequently the structure and resources required to deliver a new mandate.

Accountability: The Role of PMNCH in delivering the Global Strategy

The working paper on accountability prepared by the Accountability Work-stream of the Global Strategy, chaired by the governments of Tanzania and Canada, envisages a central role for the Partnership in facilitating and coordinating a more unified global accountability framework to improve coherence, cost-effectiveness and greater impact of "monitoring, review and remedial action". The working paper envisages that PMNCH would facilitate the preparation and dissemination of a regular "State of RMNCAH" global (or biannual) report to review progress on the achievement of the objectives and projected outcomes of the Global Strategy. PMNCH would make use of the wealth of monitoring and review work from member organizations and structures, including Countdown, UN and bilateral agencies, foundations, CSOs, academia, professional societies etc. This accountability process would be advised by an expert panel appointed by the PMNCH Board and reporting to the Board chair. The Accountability work-stream paper identifies the need for a much enhanced effort on review and remedial action and, here again, PMNCH is expected to play a major role, to ensure effective dissemination, and to facilitate follow up action with partner agencies and regional bodies. A number of technical issues will need to be considered including:

1. Process of tracking commitments for the 2016-2030 Global Strategy

The Accountability working group proposes that PMNCH should bring together data from a broad range of organizations that already have the mandate and capacity to produce data at the country and global level.

For example, for over two decades OECD (the Organization for Economic Co-operation and Development) has been the agency mandated to collect data from its members on Official Development Assistance (ODA – both commitments and disbursements), including reproductive health and family planning. Last year, in order to improve data on RMNCH, funds from COIA were instrumental in enabling OECD to develop a RMNCH policy marker too. Agreement among partners on the boundaries on what to track of RMNCAH (e.g. to use the OECD database definitions and data) would reduce the reporting burden on stakeholders because they would only report on RMNCAH to OECD and not PMNCH, FP2020, EWEC, and other initiatives. However, not all stakeholders report to OECD so it would be important to collect data from non-OECD members to ensure full multi-stakeholder inputs. An enhanced approach to accountability could then be advanced by using a consistent methodology in order to get comparable data across time, countries and stakeholders. PMNCH could play a coordinating role here, achieving alignment across the global community.

It is noteworthy that in 2014 PMNCH produced data on commitments, as did OECD. Countdown and IHME also produced data on commitments, based on analyses of data from OECD and other sources, but using different methodologies and data manipulation methods, and hence producing different estimates on how much "funds" are going to RMNCAH globally. Again, there is an opportunity for the PMNCH Platform to achieve consensus on one methodology and support alignment and harmonization among stakeholders. This new potential mandate for PMNCH, as the unified accountability mechanism for women's, children's and adolescent health, would need to reduce fragmentation and improve coordination. Ideally this would provide an opportunity to focus the RMNCAH governance and architecture, and to reach agreement on how and what is to be monitored and analysed

2. Alignment of RMNCAH indicators

Alignment of indicators could be addressed through a global process to agree upon what the data is both needed and wanted in order to reduce the pressure on countries to produce and develop different indicators for different donors. There is currently work at the global level with WHO, UNICEF, UNFPA and others looking to reduce the number of indicators that are produced and tracked. Countdown yearly country reports have helped to showcase a variety of indicators standardized through countries. PMNCH could support these processes going forward and ensure that post 2015, the global community reaches consensus on what data we need and is currently not prioritized, what is being produced but not as relevant anymore. Such discussions have already begun through the Consensus Statement in 2014 and are likely to be extended to refine the post-2015 discussions.

3. Analysis

Timely, relevant, up to date analysis disseminated in the correct places needs to be improved, for example to link data related to spending and RMNCAH outcomes, and identifying gaps in knowledge. PMNCH could play a role in bringing the relevant stakeholders to the table for further analysis, that could be undertaken, including through in depth country case studies.

Country Engagement: The Role of PMNCH in securing impact

The focus of the PMNCH Strategic Framework and the full Strategic Plan is to operate globally for local impact. Over the past ten years, PMNCH has taken a range of approaches to engage at country and regional levels and these could be expanded to achieve impact in the future. More information and resources are available on the PMNCH and other websites (see footnotes).

a) Country led multi-stakeholder dialogues (MSDs)

PMNCH has developed a method to support the development of multi-stakeholder partnerships and multi-stakeholder dialogue for RMNCAH. The method, featured in the MSD Guide for Women's and Children's Health[1], applies the principles and best practice of MSDs to RMNCAH and has informed a range of MSD activities undertaken in different countries and regions In 2014 as part of the Success Factors for Women's and Children's Health series of studies, multi-stakeholder dialogues were conducted in 10 countries, which were on track to achieve MDGs 4 and 5. Each MSD process was led by Ministries of Health, and engaged other ministries and national and international health and development partners across sectors. Lao PDR, for example, used the policy dialogue to identify lessons learned across sectors to inform future national policy and planning and the dialogue was integrated in the annual national MCH review meeting, which brings national and

[1] Guide for Facilitators and Conveners of Multistakeholder Dialogues. 2014: http://www.who.int/pmnch/knowledge/publications/msd/en/index1.html

subnational staff together[2]. This approach builds on previous multi-stakeholder efforts, such as the Asia-Pacific Leadership and Policy Dialogue in November 2012[3]. In February 2015, PMNCH co-hosted a training workshop for facilitators of MSDs to train resource persons in countries to facilitate MSDs. Subsequently, in March 2015 the government of Bangladesh used the MSD approach to facilitate an open dialogue to strengthen government leadership in scaling up ICT through effective collaboration with implementing partners. Since the MSD working groups have been set up to scale up the use of ICTs within the health sector. All partners who attended the MSD will be invited to participate in a working group and a detailed implementation plan is being drawn up.

Countries: Bangladesh, Cambodia, China, Egypt, Ethiopia, India, Indonesia, Lao PDR, Nepal, Papua New Guinea, Peru, Rwanda, Solomon Islands& Viet Nam.

b) Facilitating Multi-Stakeholder Action to Support Country-led Health Plans

In 2013, Government of India (GoI) invited PMNCH to be part of an effort to improve the health of women and children in high-priority districts (HPDs) in India. The key objective therefore is to identify mechanisms that can reveal opportunities for multi-stakeholder actions in support of country-led health plans. Building on the leadership and direction provided by GoI, a five-step process was followed to identify opportunities for multi-stakeholder action. This included: 1) GoI providing leadership; 2) RMNCH+A situational analysis conducted to identify policy and implementation gaps; 3) stakeholder mapping conducted; 4) strategic areas for multi-stakeholder action selected; and 5) convening of partners to agree on aligned stakeholder action plan(s).

c) RMNCH and civil society coalitions[4]

Since 2012 PMNCH has provided catalytic financial and technical support for the development or strengthening of RMNCAH civil society (CSO) coalitions in 10 countries. These CSO alliances are proving to be critical platforms in advocating for women's and children's health. They have focused their work on budget advocacy, reversing budget decisions and increasing health financing in some countries, and advocating for specific budget lines in other countries. They have also strengthened the capacities of their members in policy advocacy strategies and encouraged joint planning and implementation of activities. Building on this programme of work, PMNCH partners since 2013 have organized four regional workshops bringing together representatives from over 20 countries aimed at strengthening the capacity of CSO platforms, working with parliaments and the media, to shape policy and promote accountability through budget analysis and advocacy.

Countries: Bangladesh, Burkina Faso, Ethiopia, Ghana, India, Indonesia, Kenya, Nigeria, Tanzania, & Uganda

d) Every Newborn Action Plan (ENAP) consultations[5]

ENAP was officially launched in June 2014 to take forward the 2010 Global Strategy by focusing specific attention on newborn health. Development of the ENAP was guided by an advisory group of 50+ global partners. Seventeen country multi-stakeholder consultations and 2 regional workshops were conducted, and 10 countries analysed bottlenecks and solutions to scaling up of newborn interventions. This process involved constituents including governments, health professional associations, academic institutions, multi-lateral and bilateral agencies, foundations, the private sector and civil society, including women's and parents' groups. As part of the consultation process, over

[2] Success Factors for Women's and Children's Health. 2015: http://www.who.int/pmnch/successfactors/en/index2.html
[3] Asia-Pacific Leadership and Policy Dialogue. 2012: http://www.who.int/pmnch/media/press/2012/20120717_asia_pacific_dialogue/en/index4.html
[4] PMNCH Progress Report. 2014: http://www.who.int/pmnch/knowledge/publications/progress_report2014.pdf?ua=1
[5] Every Newborn. 2015. http://www.everynewborn.org/

300 official comments on ENAP were received. More than 40 new and expanded financial, policy, and service delivery commitments were made to advance the goals of the Global Strategy. At the Global level comprehensive UN Mission outreach and a WHA resolution at the 67th WHA on ENAP stimulated countries to develop their own plans.

Countries: 17 country consultations including Uganda, Pakistan, Kenya, Bangladesh, Afghanistan, Vietnam & Nigeria; Regional workshops in Senegal and Nepal; 10 bottleneck analyses conducted in countries including Pakistan, Uganda, Bangladesh and Afghanistan.

e) NGO regional focal points

NGO regional focal points for Africa and Asia were appointed in December 2014 operate under the guidance of the NGO constituency. They are playing a key role in helping to strengthen engagement and alignment of the PMNCH NGO membership (which constitutes about two thirds of the PMNCH members) in national, regional and global RMNCAH efforts. In 2015 regional focal points will support the more effective implementation of global and regional campaigns and efforts in countries, more immediately focusing on the dialogues around updating the Global Strategy. In reality these focal points are having a wider impact beyond the NGO constituency, reaching out to other PMNCH members in their regions.

Countries: In early 2015 these focal points have supported the organization of regional and national Global Strategy consultations in Burkina Faso, Cambodia, Indonesia, Ivory Coast, Japan and the Philippines among others

f) Collaborating with regional institutions and South-South Collaboration

PMNCH has supported efforts of regional and sub-regional institutions in Africa, in particular the Africa Union (AU) and the sub-regional economic communities including the EAC (East African Community), as well as the G7/G8 and G20, to prioritize women's and children's health. This is now expanding this to the Asian region and to south-south collaborative efforts such as Partners in Population and Development (PPD) and BRICS. As part of the development of the new Global Strategy, PPD, together with the Government of India, is co-convenor of the EWEC workstream on National Leadership.[6] PMNCH supported the AU in developing a position paper on "health at the core of Post-2015" which fed into the Common African Position on the SDGs.[7] PMNCH also supported AU RMNCAH events and knowledge products and is working in 2015 to strengthen linkages between the Global Strategy and regional processes, including the work of the EAC. In addition, PMNCH is making a sustained effort to engage more systematically with emerging regional networks in Asia and to stimulate discussion about a PMNCH-like approach to engaging untapped regional institutions. One such effort was the Asia-Pacific Leadership and Policy Dialogue in November 2012 which included APEC and ASEAN.

PMNCH Architecture: Implementing the PMNCH Strategic Plan

Since there is clear synergy between the envisaged roles for the Partnership in the implementation of the PMNCH strategy, and the development and finalization of the SDGs and the related Global Strategy, it is important to consider architecture and resources as a whole. The precise architecture

[6] Partners in Population and Development. http://www.partners-popdev.org/; Shaping the Future for Healthy Women, Children and Adolescents: Learn more about the process to update the Global Strategy. 2015. http://www.everywomaneverychild.org/global-strategy-2; 10th International Inter-Ministerial Conference. 2013.http://www.who.int/pmnch/media/events/2013/inter_ministerial_conference/en/

[7] Africa post-2015 process. http://www.who.int/pmnch/post2015/en/index5.html

and resource implications will emerge as the contours of these become clear over the coming months, and a business plan with full recommendations will be prepared in due course. However it is not too early to predict emerging priorities[1].

Through the planned Governance Review the Board will consider new arrangements including proposals to constitute a set of Board sub-committees to provide oversight over a number of the PMNCH strategic areas enumerated in the proposed Strategic Framework. In particular, strategic area 2 (catalysing multi-sector and multi-stakeholder forums); strategic area 3, (supporting effective policies and programmes) and strategic area 4 (efficient and effective financing) are candidates. Further consideration may need to take into account the discussions on governance of the Global Financing Facility (GFF) and how future PMNCH structures could best support the GFF as it advances. For strategic area 5, accountability, an independent expert panel would advise the Board chair and the Board, and a separate sub-committee could create perceptions of potential conflict of interest, if sub-committee members were representing partners that were themselves subject to the accountability process. For this reason, a Board sub-committee on accountability is not recommended.

The proposed four *As* of the draft 2016-2020 Strategic Framework – advocacy, analysis, accountability and alignment – may also have additional implications for the architecture of PMNCH, and subsequently the resources and staffing that deliver this mandate. For example, the Secretariat's analytical skills are likely to need to be strengthened to ensure that the Partnership can take on the particular challenges identified in the Strategic Plan; for example, catalysing multi-sector and multi-stakeholder forums, or supporting effective policies and programmes to improve the health of women children and adolescents (see Annex 1). It has not been anticipated that the PMNCH secretariat would establish a direct presence in countries, but rather that the Partnership would play a key role in catalysing country action through a range of activities, building on the approaches detailed above. The direct implications for the PMNCH secretariat will be discussed with the PMNCH Executive Committee following the April Board meeting in order to formulate a Business Plan that will accompany the full Strategic Plan that will be delivered to the Board in October 2015.

[1] The Secretariat would likely need additional capacity to carry out the enhanced roles being envisaged in the Global Strategy to secure accountability. These could include:

- In-house expertise on evaluation and accountability, encompassing the cycle of monitoring, review and remedial action, with operational experience, preferably in an existing national or multinational development partner evaluation group, national audit function and/or academia. The capacity to oversee the technical aspects of the work, liaise with partners and communicate the results at a high level will be vital.
- Enhancement of specific analytical capacity to implement the post-2016 PMNCH strategy, for example in cross-sector analysis. Staff could perhaps be seconded from a partner organization and much of the work would need to be carried out by Partners.
- Enhanced communications capacity to translate the results of the accountability process into messages that can be understood and acted on at the highest policy making levels and by civil society. The same applies to the other pillars of the PMNCH Strategic Framework.
- Administrative support to the Secretariat, Board and Board chair particularly for the Accountability work-program.
- Budgetary support for specified partner activities.