PMNCH Board
Retreat,
1-2 December 2014
Background paper for plenary and group discussions

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Introduction

Purpose of the background paper

This background paper is complementary to the issues paper 'PMNCH's Post 2015 Strategy - Issues for discussion' circulated to the Board in September 2014 (Annex A). It was developed in close collaboration with PMNCH with the purpose of facilitating discussion on the strategic options PMNCH might consider when preparing for its post-2015 strategy and to serve as an input for discussion at the Board retreat. The strategic options being proposed in this paper are ideas to foster discussion and are illustrative rather than claiming to be definitive in any way. In fact, they are provided to open the discussion and to help PMNCH brainstorm during its Board retreat.

The paper builds on consultations and significant work already undertaken and/ or overseen by PMNCH during 2014, including but not limited to:

- PMNCH policy briefs on post-2015 development agenda,
- recommendations from the PMNCH external evaluation,
- the Partner's Forum, and
- PMNCH post-2015 Strategy Issues for background paper.

The purpose of this background paper is to:

- 1. recall PMNCH's overarching mandate and outline the strengths and opportunities that it faces post-2015 (Annex B);
- 2. outline proposed strategic options for PMNCH's post-2015 strategy, for discussion by the Board and to achieve consensus on the preferred strategic option(s);
- 3. present the timeline to develop PMNCH's post-2015 strategy, for consideration by the Board;
- 4. provide Board members with background on the RMNCAH landscape PMNCH will be evolving in post-2015 (Annex C).

Therefore this paper aims to provide ideas and background context for the Board to discuss and brainstorm PMNCH's future strategic options post-2015.

PMNCH's mandate

Since its launch in 2005, the mandate of PMNCH has been to promote the well-being of women and children around the world and to accelerate progress towards the Millennium Development Goals (MDGs) 4 and 5.

The external evaluation of PMNCH conducted between January and June 2014 indicated that the Partnership achieved significant visibility in the RMNCAH space, is a valued platform for all of its 600+ members and has demonstrated impactful advocacy efforts for women's, children's and adolescents' health. On the other hand, it noted that it needs to carve out its added value in the

RMNCAH space by being strategically focused post-2015 (see Annex B for further detail on the findings of the external evaluation).

Today, PMNCH is at a cross-road. As noted in the issues paper (see Annex A, Question 1), the Sustainable Development Goals (SDGs) are succeeding the MDGs and the RMNCAH space has become crowded with various initiatives supporting better health outcomes for women and children, with overlapping mandates to the one of PMNCH (see Annex C for further details on RMNCAH's landscape).

The task at hand at the Board retreat is to define the role of PMNCH post-2015 so that it is fit for purpose and for its actions to generate the greatest impact for women and children.



Strategic options for PMNCH post-2015

Proposed strategic options for post-2015

The objective of the Board retreat is to **receive the views of Board Members on possible strategic options**, consider their strengths and weaknesses, and identify the preferred option(s) that will form the basis for the development of the PMNCH strategy.

We invite Board members to consider **4 possible strategic options** to inform PMNCH's strategy post-2015. They are suggestions of the role PMNCH could play post-2015 and will form the basis for discussion at the Board retreat. These are:

- Global RMNCAH advocacy platform
- RMNCAH and health-enhancing sector collaboration
- Multi-stakeholder platform in support of Every Woman Every Child (EWEC)
- Supporting country-led multi-stakeholder alignment processes

These options are not mutually exclusive and Board members are encouraged to share **alternative ideas and suggestions** to shape the discussion.

The proposed four strategic options have emerged from extensive consultations with stakeholders on PMNCH's current and post-2015 role, including:

- the PMNCH policy brief on "Placing Healthy Women and Children at the Heart of the Post 2015 Sustainable Development Framework" developed by the PMNCH Post 2015 Working Group (July 2014)¹,
- the recommendations made by the independent external evaluation of the Partnership (July 2014)²,
- the 2014 Partners' Forum Communiqué (July 2014)3,
- the PMNCH's Post 2015 Strategy Issues for discussion (September 2014)4,
- the presentation of the RMNCAH landscape, Annex A of this background paper (November 2014).

The four strategic options for PMNCH's future role can be described as follows:

1. Global RMNCAH advocacy platform (see Annex A, question 5)

PMNCH will continue to focus on its comparative advantage of **global advocacy** on RMNCAH issues, and continues its efforts in engaging partners and maintaining visibility of RMNCAH issues at the global level. It does so by focusing its efforts on advocating around the Global Strategy and other RMNCAH initiatives of its partners.

¹ http://who.int/pmnch/post2015 policybrief.pdf

² http://www.who.int/pmnch/about/strategy/evaluation.pdf?ua=1

³ http://who.int/pmnch/about/governance/board/post2015 paper.pdf

⁴ http://who.int/pmnch/about/governance/board/post2015_paper.pdf

2. RMNCAH and health-enhancing sector collaboration (see Annex A, question 3)

PMNCH remains the global advocacy platform for RMNCAH, but expands its scope of actions to include engagements of partners and platforms representing **health-enhancing sectors**. This could include education, nutrition, water, sanitation and hygiene, infrastructure, skills and employment. It may also include advocacy while also considering other functions and joint projects. Broadening the dialogue between health and health-enhancing interventions and identifying areas for collaboration will lead to greater impact.

3. Multi-stakeholder platform in support of Every Woman Every Child (EWEC) (see Annex A, question 6)

Through its multi-stakeholder platform, PMNCH could provide **governance and technical support for EWEC.** The aim is to help coordinate, align and harmonise the efforts of partners in the RMNCAH space, including the harmonisation of financing (e.g. Global Financing Facility and other financing mechanisms), support for country-led plans and strengthening of accountability across stakeholders (see Annex A, Question 6).

4. Supporting country-led multi-stakeholder alignment processes

PMNCH increases focus on **supporting country stakeholder alignment** and it achieves this by strengthening national multi-stakeholder platforms. Depending on country priorities, this may also include engaging key actors and platforms representing health-enhancing sectors. Through this approach, increased political commitment and national accountabilities are achieved. PMNCH would focus on tracking partner and country accountabilities to the Global Strategy for Women's, Children's and Adolescents' Health (further referred to as the Global Strategy)

The four strategic options are presented in Figure 1 below:

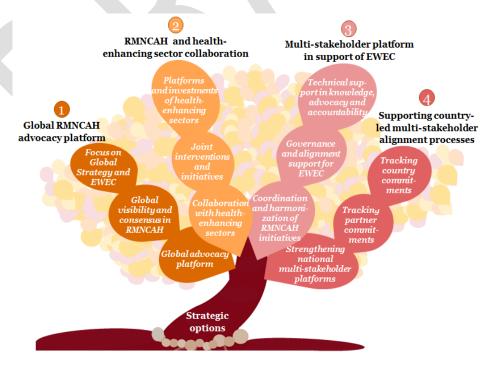


Figure 1: Strategic options for PMNCH post-2015

Strategic lenses for post-2015

In order to guide the discussion on these strategic options, we invite the Board to consider **four strategic lenses**, outlined in Figure 2. The objective of using this analytical framework is to support the Board when assessing the advantages and disadvantages of each of the strategic options.

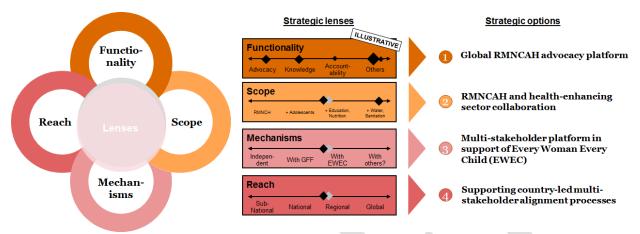


Figure 2: Strategic lenses

As mentioned in the issues paper (see Annex A), each of the strategic options can be analysed through these lenses, as follows:

- scope of interventions (RMNCAH or expansion into other sectors),
- reach of interventions (at global, regional, country level and/or focus on specific countries),
- **functionality** (advocacy, knowledge, accountability, other),
- RMNCAH mechanisms to interact with such as the Every Women Every Child (EWEC) movement.

The strategic options may be composed of one or all of the lenses, to varying degrees of focus. Therefore the lenses can be concurrent and are not mutually exclusive.

We present in Table 1 as a set of questions that relate to each of these strategic lenses and that are proposed to be considered by the Board when it reflects on each of the proposed four strategic options. These questions build on those considered in the issues paper (see Annex A).

Questions to be considered when discussing the strategic options

Scope

- How can PMNCH **broaden its scope of interventions** to RMNCAH and/or to other sectors such as education and sanitation?
- How can PMNCH's strategy **interrelate thematically with the Global Strategy** and with the Sustainable Development Goals?
- How can PMNCH better **engage with its constituencies**?

Reach

- What will be the **geographical focus** of PMNCH's activities (global/regional/countries, high burden countries, fragile states)?
- What role can PMNCH play at the **regional and country level**? How can it steer alignment between the global, regional and country levels?
- How can PMNCH better engage with **national leaders**?

Functionality

- <u>SO 1: Knowledge</u>- How can PMNCH evolve to be a **one stop shop on RMNCAH knowledge** for its partners?
- <u>SO 2: Advocacy</u>- How can PMNCH support the **harmonisation of global financing efforts** for maternal and child health through its advocacy efforts?
- <u>SO 3: Accountability</u>- How will PMNCH contribute, post-2015, in **tracking progress** against the updated Global Strategy?

Mechanisms

- How can PMNCH carve out its added value in **relation to other RMNCAH mechanisms** and initiatives (e.g. Global Financing Facility, the RMNCAH Steering Committee and its Trust Fund)?
- How can PMNCH best **collaborate/contribute** to the work of other RMNCAH actors?
- How can PMNCH's **multi-stakeholder platform** be best leveraged?

Table 1. Strategic lenses and related questions

Timeline for PMNCH strategy

Given that the SDGs, the Global Strategy and the PMNCH strategy are interrelated, the ideal timeline diagram would be to first develop the SDGs, followed by the updated Global Strategy, and finally the PMNCH Strategy which is nested within both strategic frameworks.

The proposal for the SDGs was sent to the General Assembly for consideration on 19 July 2014, followed by a Secretary-General's Report in Q4 2014 with expected endorsement of the SDGs by September 2015.

As the updated Global Strategy evolves out of the SDGs, its development process started after the finalisation of the SDG proposal in July 2014. This was based on an assumption that there is endorsement of the SDGs by 2015. The Global Strategy timeline comprises stakeholder consultations and a *Greentree* retreat of senior stakeholders in March 2015 to agree on the strategic direction of the Global Strategy. Following this, the draft of the Global Strategy will be presented to Member States at the World Health Assembly (WHA) in May 2015. Following a four months consultation process, the

launch of the strategy is planned for end of September 2015 at the 70th UN General Assembly in New York.

Considering the timeline of the SDGs and Global Strategy, we have crafted a timeline that allows PMNCH to take a proactive lead on the development of its strategy (see Figure 3).

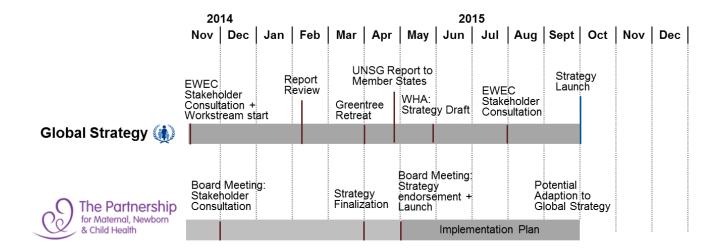


Figure 3: Timeline for the PMNCH strategy

The timeline foresees the development of the strategy based on all available facts about the updated Global Strategy up to March 2015. The endorsement and launch of the strategy would be planned at the PMNCH Board meeting that is tentatively planned for April 2015.

This guarantees that PMNCH is equipped early with a strategy to conduct its resource mobilisation activities. It also allows to rapidly develop its workplans for 2015 and 2016. Even though there might be a need to align the PMNCH strategy once the Global Strategy is launched, these adjustments are expected to be minor given that the development of the PMNCH strategy will have been closely aligned with the Global Strategy consultation process.

Furthermore the adjustments also provide the possibility to incorporate elements in the PMNCH strategy that turned out to be useful after a five month of application period.

Next steps

The next steps for the Board at its retreat in 1-2 December 2014 are to:

- 1) discuss and agree the strategic option(s) that will compose PMNCH's strategy post-2015.
- 2) agree on the timeline for the delivery of the PMNCH strategic framework.

Annex A

PMNCH's Post 2015 Strategy

Issues for discussion

September, 2014

The purpose of this note is to facilitate a discussion of key risks and challenges which the Board and the Secretariat may need to address during the preparation of the post-2015 PMNCH strategy. It takes into account the findings of the recent external evaluation of PMNCH for the period 2009-13. The note tries to highlight the key risks and challenges faced by the Partnership, to set the context for identifying opportunities and stimulating a discussion of strategic options as a basis for a much more detailed examination in the run up to the new Strategy. With the short timeline for preparation, it has not been possible to consult with some key respondents, but the earlier version of this note was widely circulated to all constituencies, and some responses were received.

The PMNCH Partner's Forum in June 2014 was certainly a high point for the Partnership. The forum brought together about 1,200 partners and many global health and other sectoral leaders, at a time when numerous other demands were vying for their attention. The Forum demonstrated the considerable success the Partnership has had in advocacy, in mobilizing new partners from the public and private sectors and foundations, in knowledge generation and dissemination and in developing tools for accountability. As the external evaluation report noted, "PMNCH has achieved significant visibility for the RMNCH cause. PMNCH has established a clear added value in bringing all partners together around a common agenda."

The fact that the Partnership can celebrate its successes, makes this a good time to **analyze the risks** and challenges going forward. Some, but not all, of these challenges are noted in the external evaluation. Over the next few months, a clearer picture will emerge on the post-2015 Sustainable Development Goals. Whatever the final result, the health of women and children will need to remain front and centre of development. The following seven interconnected risks and challenges are discussed in that context as the Partnership begins the process of preparing the post-2015 PMNCH strategy:

1. Overall strategy: Comparative advantage in an increasingly crowded RMNCH space. Despite the best of intentions enunciated at numerous international meetings to increase harmonisation and coherence in the global development architecture, new initiatives in RMNCH proliferate, not all of which bring new resources to countries,. The management burden on countries of handling multiple, and sometimes overlapping initiatives has probably not been given sufficient attention, although the development partners have recognized the issue at the global level. New coordination mechanisms, such as the RMNCH Steering Committee have been created

and discussions have been initiated on a Global Financing Facility (GFF) for RMNCH. The linkage between these ad-hoc coordination mechanisms and existing efforts to coordinate and harmonise development resources is currently unclear. But these new coordinating mechanisms almost certainly add additional complexity to the global RMNCH architecture.

Should PMNCH have a direct role in efforts to harmonise and simplify the global RMNCH architecture? How should it relate to these new initiatives? How should it relate to existing and new global coordinating mechanisms? Or, should PMNCH restrict itself to a monitoring role, identifying opportunities, gaps and accomplishments of the RMNCH harmonisation process in the coming years?

2. **Strategic focus and unfunded mandates**. The Partnership has in the past demonstrated considerable agility and versatility in responding to new demands and new strategic opportunities. This responsiveness brought PMNCH visibility and reach, but also posed challenges for strategic planning and focus. The continued imbalance between demand and resources is a major risk. The very success of the Partnership in its work on advocacy, knowledge and accountability risks ever broader demand on the Secretariat without commensurate human and financial resources. In theory, it is the Partnership, rather than the Secretariat that should undertake the majority of the agreed work-plan. In practice, with over 600 members, many of which have very limited resources of their own, this has proved to be very challenging.

How can PMNCH develop a strategic process that provides the necessary focus, ensures sufficient partner participation, while at the same time preserving the commendable agility to respond to new demands? Is there a need to articulate clearly the rights and responsibilities of members? How would a revitalised membership engagement strategy be developed and resourced? How to engage youth groups constructively?

3. Governance: Voice and participation of different constituencies and sectors. The external evaluation report notes that implementing countries appear to have a rather weak voice in PMNCH. While it is quite natural for the donor countries and other funders to have a strong voice in the deliberations of the Partnership, the weak voice of other key groups risks the long-term credibility and relevance of PMNCH. This is particularly the case as many countries transition to middle income status and the importance of donor resources to finance RMNCH services and investments starts to diminish.

PMNCH has developed a set of resources to facilitate multi-stakeholder engagement in support of country-led health plans, including a Multistakeholder Dialogue Guide, but it can be argued that more is needed. How can PMNCH, with its very limited resources, more effectively engage the low and middle- income countries? During the last Board meeting, there was a suggestion that PMNCH help establish country level partnerships. This might require identifying eligible advocacy groups and developing structure, including new coalitions and networks which align with existing country RMNCH agencies and structures.

- a. As a subset of the discussion on voice and participation, the BRICS⁵ countries are moving to set up a new investment bank which may in time become an alternative source of development finance for low and middle income countries.
 - How, and in what manner, will the Partnership engage with the BRICS countries, which together contain a large bulk of the world's poor people and the associated burden of disease, but are also emerging as donors to countries and global health institutions?
- b. **Reaching out to the health enhancing sectors.** Another major challenge for PMNCH will be to broaden the dialogue between the health community responsible for the delivery of RMNCH services and the much broader community engaged in the health enhancing sectors.
 - Should membership be expanded to include, for example, representatives from education? How can the Partnership work to ensure that investments in water supply and sanitation are much more closely linked to improved health of the recipient population? How can this agenda be made attractive to the other sectors, which are also strapped for resources and may resist "unfunded mandates"?
- 4. Knowledge generation and dissemination. During the last few years, PMNCH has moved successfully into knowledge generation (e.g. through the evidence synthesis on Essential RMNCH interventions, the Policy Compendium, Knowledge Summary series and the Success Factors studies). Knowledge dissemination and facilitating partner consensus on these topics are also key tasks. With its very small Secretariat and resources, there are risks here in terms of overextension, quality control etc. Choosing a few path-breaking topics for the next strategy period, where PMNCH has a clear comparative advantage and the Secretariat has the necessary skills to manage and oversee the tasks, will be very important. One such example may be to follow up on the Success Factors studies. The SF studies identified that about 50% of the improvements in reducing child mortality in low and middle-income countries since 1990 came from investments and factors outside the health sector. While we now know much more about the range of these investments and factors, we know much less about how to "join up" these health enhancing investments to maximize health outcomes and still do not know enough about what really works on integration within the health sector, and between health and the health enhancing sectors.

Should the next phase of knowledge generation be on multi-sector inputs? Are there other priority areas where the Partnership has a comparative advantage? Is there a need in addition to revisit the Partnership's dissemination strategy, including disseminating best practice in policy, program and financial areas? How should the Secretariat engage partners at the global and country level in this regard?

5. Advocacy and partner mobilization. Advocacy has been the cornerstone of the Partnership's work. Highly successful and visible advocacy efforts have included mobilizing support for the UN Secretary-General's Global Strategy for Women's and Children's Health and Every Women Every Child, positioning RMNCH at G8 summits, linking with G20 processes, the Born too Soon campaign and Every Newborn Action Plan. A majority of the advocacy focused on global events, but there has been some regional focus with the African Union and national focus with national NGO coalitions and budget tracking workshops.

⁵ India currently holds the co-chair position on the PMNCH Board.

Following the external evaluation's recommendations, what should be PMNCH's focus or "niche" role in advocacy given the crowded advocacy space with multiple events and partners? How can the advocacy activities of the Partnership link more strongly with the governance, knowledge and accountability activities (currently carried out by different groups of partners and for different events)? One niche might be a data driven analysis of Global Action Plans in terms of investments, gaps, accomplishments and challenges which partners can use in their dialogue with policy makers are different levels. Should PMNCH act as a broker to help PMNCH constituencies with weak voice to get a seat at the table? In the post-2015 period it will be necessary to constantly redefine the space in which PMNCH operates. Is it MNCH or RMNCH or RMNCH+A? Is even RMNCH too narrow for the emerging health agenda? Should 'rebranding' be considered?

6. **Enhancing Accountability for RMNCH.** PMNCH has tracked the commitments made to RMNCH since the issuance of the UN Strategy on Women and Children's Health in 2010. This work, while useful, is also time consuming and expensive, relying as it does on the willingness of commitment makers to provide information. The response rate has steadily diminished and the utility of continuing this process, in its current form, is questionable. Other organizations monitor resource flows and outcomes and it is not clear that the current approach is a cost-effective use of PMNCH's limited resources.

Should the new strategy revisit the role of the Partnership in accountability?

7. **The process of preparing the new strategy** needs consideration. On the one hand, there needs to be adequate consultation with the partners to ensure ownership. On the other hand, as noted in the external evaluation report, there is a risk that this process can lead to blurred objectives and accountabilities. In this context, the Executive Committee, representing the full board, has a crucial role to play in ensuring voice to partners, including countries.

The Secretariat will need to use the full panoply of modern communications to ensure adequate feedback, particularly from some of the more silent partners. A current exercise to look at a communications strategy for PMNCH will inform this process, and can be refined dynamically as opportunities and new challenges emerge. The proposed Board retreat should discuss the process for preparation of the PMNCH post-2015 strategy, as well as the key elements that the strategy should address. There may well be useful lessons from the preparation of the current strategy (2012 to 2015) that can be used to develop the process for the new strategy. It will also be useful to review the key developments in 2014, including GFF, the RMNCH Steering Committee, revisiting the Global Strategy for Women's and Children's Health for the post 2015 period, UNGA etc. since these will shape thinking on the new strategy.

Annex B

Findings of the external evaluation of PMNCH

The findings from the external evaluation of PMNCH conducted between January and June 2014 indicate that the Partnership achieved significant visibility in the RMNCAH space, is a valued platform for all of its 600+ members and has demonstrated impactful advocacy efforts for women's, children's and adolescents' health.

In particular stakeholders consulted as part of the external evaluation stated that PMNCH's strengths are:

- PMNCH has a **clear comparative advantage in global advocacy**. Its multi-stakeholder nature allows it to facilitate and support RMNCAH initiatives and achieve significant impact at the policy level for women's and children's health.
- PMNCH adds value for its partners by providing them with **access to updated and valuable knowledge** and information on RMNCAH through the partnership.
- PMNCH's add value is its **ability to bring together a large number of stakeholders** from various constituencies and to reach consensus on common agendas on RMNCAH.

Some of the challenges facing PMNCH are:

- PMNCH's **country engagement role** needs to be further articulated while it also needs to better track partner actions at global, regional and country levels.
- The strategic objective on **accountability** (SO₃) had less traction than the others since collecting partner country data on RMNCAH commitments is an increasingly challenging task.
- The **linkages between PMNCH and the RMNCAH actors** need to be clarified, given the emergence of a rising number of initiatives and mechanisms in the RMNCAH space.

In light of these strengths and challenges, the evaluation recommended that in order for the Partnership to remain relevant in the post-2015 space, it needs to carve out its additional value and role in an evolving RMNCAH landscape. Specifically the evaluation noted that in order to address some of the challenges identified the Board should:

- Define the **role of PMNCH** at regional and country level, and its role post-2015.
- Identify PMNCH's **comparative advantage** in tracking partner accountabilities in updating the Global Strategy.
- Carry out a review of the **options for interaction**, between PMNCH, the RMNCAH Steering Committee and Trust Fund.

These recommendations set the stage for the discussion at the Board retreat, as it is key for the Board to agree on the role of PMNCH in the evolving RMNCAH landscape. PMNCH's strategy is nested under the overarching framework of the Sustainable Development Goals (SDG) agenda and that of the

Global Strategy. In addition, PMNCH has numerous interactions with RMNCAH actors, initiatives and mechanisms and leveraging these will be critical to position itself as a partnership that adds value, rather than is overlapping, in post-2015.



Annex C

The RMNCAH landscape

Value Proposition of PMNCH in post-2015

Since its launch, PMNCH has enabled partners to share strategies, align objectives and resources, and agree on interventions to together achieve more than they would individually. PMNCH's **value proposition** is as the only institutional **multi-constituency platform** in today's large and fragmented global health space.

It forms an alliance of more than 630 members, spanning **seven constituencies:** academia; research and teaching institutions; donors and foundations; health-care professionals; multilateral agencies; non-governmental organizations; partner countries; youth and the private sector.

PMNCH's last strategic framework identified **three key strategic objectives**, knowledge, advocacy and accountability, with the goal to support all partners to achieve better outcomes for women and children in high burden countries.

In order to translate the Partnership's value proposition into reality in post-2015, collaboration with the actors of the RMNCAH landscape will be critical. As outlined in Figure 1 PMNCH's strategy is nested under the overarching framework of the Sustainable Development Goals (SDG) agenda and that of the Global Strategy for Women's, Children's and Adolescents' Health. Its multi-stakeholder role is therefore key to influence the outcomes of these two strategic frameworks (see Figure 4 below).

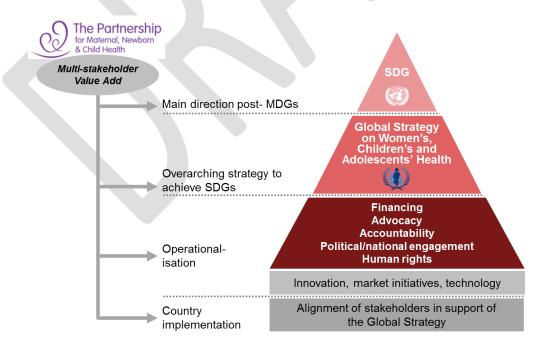


Figure 4: PMNCH in the RMNCAH landscape

PMNCH will be facilitating the operationalisation of the SDGs and the Global Strategy, amongst others, by:

- Contributing to the process of updating the Global Strategy.
- Providing an impartial consultative platform for the Global Financing Facility for women and children.
- Advocating at the global, regional and country levels to prioritise the cause of women and children on government agendas.
- In order to reach women and children, working to secure political commitments and the engagement of national implementers for greatest impact in developing countries.
- Fostering and supporting the implementation of new ideas, notably market initiatives (e.g.
 introduction on injectable contraceptives in developing countries) or innovative financing
 mechanisms.
- Monitoring and reviewing progress at country level and strengthening health delivery systems to reach women and children.

In the next sections, we present the SDGs, the Global Strategy and the Global Financing Facility (GFF) in greater detail.

Sustainable development goals (SDGs)

The RMNCAH-related SDGs will provide the framework within which PMNCH's strategy will be embedded. One of the main outcomes of the United Nations Conference on Sustainable Development in Rio de Janeiro in June 2012 (Rio+20) was the agreement to mandate a working group to develop a set of international development goals for post 2015. A 30-members Open Working Group (OWG) was established in June 2012 to develop the **Sustainable Development Goals** (SDGs), to:

- succeed the Millennium Development Goals (MDGs), that have the target date 2015,
- guide the global development agenda from 2015-2030 and
- are action oriented, global in nature and universally applicable.

The OWG held 13 sessions, 8 of which were used for stock-taking and the remaining five for the preparation of its proposal for SDGs. On 19 July 2014, despite some reservations, the OWG agreed to forward its proposal for SDGs to the General Assembly for consideration by the Assembly at its 68th session (Sept 2015). The proposal contains 17 goals and 169 related targets covering a broad range of sustainable development issues, including ending poverty and hunger, improving health and education, making cities more sustainable, combating climate change, and protecting oceans and forests (for details see Figure 5). It is understood that several countries reiterated they would strengthen the targets over the next year.

Sustainable Development Goals	
Goal 1	End poverty in all its forms everywhere
Goal 2	End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3	Ensure healthy lives and promote well-being for all at all ages
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5	Achieve gender equality and empower all women and girls
Goal 6	Ensure availability and sustainable management of water and sanitation for all
Goal 7	Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
Goal 9	Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
Goal 10	Reduce inequality within and among countries
Goal 11	Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12	Ensure sustainable consumption and production patterns
Goal 13	Take urgent action to combat climate change and its impacts*
Goal 14	Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 15	Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 17	Strengthen the means of implementation and revitalize the global partnership for sustainable development

Figure 5: Proposal for SDGs

The SDGs targets will be further tailored with indicators focused on measurable outcomes. Of special interest for RMNCAH initiatives is **Goal 3**: *Ensure healthy lives and promote well-being for all at all ages*. It is accompanied by 9 targets, of which **6 targets** are relevant for RMNCAH:

- By 2030 reduce the global **maternal mortality ratio** to less than 70 per 100,000 live births.
- By 2030 end preventable deaths of **newborns and under-five children**. By 2030 end the **epidemics** of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases.
- By 2030 reduce by one-third **pre-mature mortality** from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and wellbeing.

- By 2030 ensure universal access to **sexual and reproductive health care services**, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- Achieve **universal health coverage** (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

The health/RMNCAH-related targets provide the framework in which the PMNCH strategy will be embedded.

Global Strategy

The second key strategic framework relevant for PMNCH, is the **Global Strategy for Women's**, **Children's and Adolescents' Health** launched by the United Nations Secretary-General Ban Kimoon during the UN Millennium Development Goals Summit in September 2010. It has the **function** to provide an overarching framework to prevent fragmentation by integrating political, financing, accountability and technical workstreams.

From the available background information to date, the **aim** of the Global Strategy is to save and improve the lives of women and children by increasing visibility and political support, mobilising resources and catalysing a renewed effort to accelerate progress towards the achievement of the health-related MDGs (4,5,6)⁶.

In a similar way, the updated version of the Global Strategy will be launched in September 2015 at the UN General Assembly in New York. It is proposed to support the delivery of the updated **Global Strategy** to support the achievement of the health-related SDGs (mainly SDG 3). Some stakeholders at the Every Woman Every Child Stakeholder Consultation of 6-7 November 2014 in Geneva noted that women and children were not prioritised in the draft SDGs. Since SDGs do not promote women and children in the way the MDGs did, the updated Global Strategy should fill these gaps. It was also noted that the GFF, a dedicated financial mechanism for women and children, was an opportunity to make a difference.

At the same stakeholder meeting, a number of suggestions were provided to improve the updated Global Strategy, these include:

- **Collaboration** between the RMNCAH and other sectors (e.g. education) should be strengthened.
- The new strategy should better address the unmet needs of **family planning**.
- New ways of engaging should be sought with some constituencies, notably the private sector, parliamentarians and humanitarians.
- The Global Strategy has not been disseminated widely enough at **country level** to foster government ownership.

PMNCH Board Retreat, 1-2 December 2014 - Background paper for plenary and group discussions

⁶ MDGs: 4.To reduce child mortality, 5. To improve maternal health 6.To combat HIV/AIDS, malaria, and other diseases.

• The Global Strategy would benefit from being translated into **implementation frameworks** to facilitate implementation at country level.

The development of the updated Global Strategy will be led by the **Every Woman Every Child (EWEC)** initiative in collaboration with other leading partners, notably WHO and PMNCH. EWEC was launched in 2010 by the Secretary-General of the United Nations, to mobilise and intensify international and national action to improve women's and children's health. Since 2010, the movement has mobilised over 300 financial and non-financial commitments from a wide range of constituencies, including NGOs, the private sector, global partnerships, foundations, academia, health care professional organisations, multilateral organisations and governments. In 2010, 40 billion USD was committed to the Global Strategy.

Setting the PMNCH strategy for post-2015 will require close alignment with the updated Global Strategy which is planned to be delivered in September 2015.

Global Financing Facility (GFF)

The Global Financing Facility (GFF) for Reproductive, Maternal, Newborn, Child and Adolescent Health will support EWEC to contribute to the global efforts on women and children by channelling additional international and domestic resources.

It supports the delivery of the updated Global Strategy and aims to serve as a key financing instrument to mobilise resources for it. It will do so by catalysing international and domestic investments in RMNCAH. The **GFF Working Group** is operationalising the GFF which is chaired jointly by the Government of Norway, USAID and the World Bank. The working group includes a broad range of stakeholders such as partner countries, the H4+ agencies (UNICEF, UNFPA, WHO, UNAIDS, UN Women and the World Bank Group), civil society organisations, bilateral and multilateral development partners, foundations, private sector and others stakeholders working in the areas of RMNCAH.

Its set-up and launch is planned for September 2015. The initial expected **donor commitments** are of 4 billion USD, including grants to the amounts of 600 million USD from Norway and 200 million USD from Canada and an estimated 3.2 billion USD from the International Development Association (IDA) (See Figure 6).

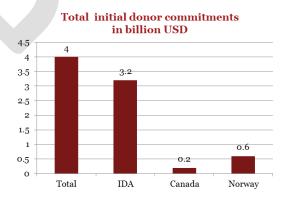


Figure 6: Commitments to GFF

The **main objectives** of the GFF are to:

- accelerate financing of national RMNCAH scale-up plans and measure results by:
 - o developing financing roadmap
 - providing transparency on value-for-money
 - o considering direct contributions in countries by bilateral aid agencies or multilateral channels as well as multi-sectoral financing opportunities
 - o function as a major investor by building on Health Results Innovation Trust Fund (HRITF) at World Bank)
- support countries in the **transition** towards sustainable domestic financing of RMNCAH (e.g. support of domestic resource mobilization)
- finance the strengthening of civil registration and vital statistics systems
- finance the development and deployment of global public goods
- contribute to a better-**coordinated and streamlined financing architecture** (providing a platform for coordination and facilitating convergence and consolidation of fragmented financing streams).

It is envisaged that PMNCH will play an important role in advocating additional funding for RMNCAH which will be channelled through the GFF, post-2015.

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