

Strategic Framework for 2012 to 2015

The Partnership for Maternal, Newborn and Child Health

FOR BOARD DECISION

The Board is asked to review and approve the Strategic Framework for 2012 to 2015.

NEXT STEPS

Once the Strategic Framework has been approved, it will provide the required direction to the Executive Committee (EC) and the Secretariat to develop the full Strategy and Workplan for 2012 to 2015. The proposed high level process is as follows:

- The Secretariat will manage the development of the Strategy and Workplan, reporting to the EC, as agreed by the Board at its 9th Meeting in New Delhi.¹
- It is proposed that the EC nominates some or all of its members to form an ad-hoc EC Strategy and Workplan Development Working Group. This group would work closely with the Secretariat to advise on and develop details of the workplan, including outputs, activities and estimated budgets, meeting more frequently than the EC and as required by telephone or in person.
- The document will be developed between June and October 2011, as follows:
 - outline to be presented to the EC at its July 2011 meeting;
 - first draft to be presented to the EC at its August 2011 meeting; and
 - draft final to be presented to the EC at its September 2011 meeting.
- The full Strategy and Workplan 2012-2015 will include a detailed breakdown of proposed outputs, activities and cost estimates for the first year. For the years subsequent to 2012, it is expected that most of the outputs will be identified at this stage, but that less detailed information will be presented on individual activities and related budgets (although overall annual budget ceilings will be estimated). This will enable the Partnership, as requested by the Board, to retain a degree of flexibility in planning its activities, which will be developed on an annual basis.
- The four-year rolling Workplan will be presented for review and approval to the Board at its October 2011 meeting.

¹ The relevant paper (B9-10-5) as endorsed by the Board specified that the EC assumes responsibility for overseeing and directing the overall planning and development of the new four year Strategy and Workplan, reporting to the Board as appropriate. The role of the EC, closely supported by the Secretariat, is to set out the details of the planning process, oversee its implementation, provide advice and guidance to both the Secretariat and / or any consultants, and ensure appropriate and broad Partner engagement.

I. INTRODUCTION

This document sets out the Strategic Framework for the operations of the Partnership for Maternal, Newborn and Child Health (Partnership) over the course of 2012 to 2015. It presents the Partnerships' Vision, Mission and its value added, proposes strategic objectives for delivering these aims and outlines the operational principles under which the Partnership will operate.

The Strategic Framework draws on the discussions and conclusions from the Partnership's Board Retreat held on 9-10 March 2011 and its supporting discussion papers, lessons learned from the previous 2009 - 2011 Strategy and Workplan and from the ongoing global efforts to improve the health of women and children, and achieve the Millennium Development Goals (MDGs). A short version of the document was made widely available in April 2011 as part of a consultation exercise with the whole membership, including the Board and Executive Committee members. Comments received from Partners and other collaborators during the consultation period have also been considered and integrated.²

Once the Strategic Framework is approved by the Board, work will commence to identify and cost specific outputs and activities that will make up the dynamic, four-year rolling Strategy and Workplan for the Partnership. The full Strategy and Workplan will be presented to the Partnership's Board for review and approval at its October 2011 meeting, and in time to guide the Partnership's activities in 2012. The 'dynamic' aspect of the Strategy and Workplan reflects the shared and pragmatic view that the Partnership must retain a degree of responsiveness to a fast moving global health environment and, as agreed by the Board, the Workplan should re-assess and adapt its focus on an annual basis in the years to 2015, as appropriate and relevant.

This document has been developed by the Secretariat, as requested by the Board and on the basis of conclusions from the above mentioned Retreat, with the support of Cambridge Economic Policy Associates (CEPA).³

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 proposed Partnership's strategic objectives.
- Section 6 details the cross-cutting principles to delivering the proposed strategy.
- Section 7 provides a summary of the Strategic Framework.

² The full details of the comments received are available from the Secretariat, should this be required.

³ CEPA is a London based economic, strategy and finance consultancy (www.cepa.co.uk).

2. PROGRESS, CHALLENGES, OPPORTUNITIES AND RISKS IN THE CURRENT LANDSCAPE

2.1 Progress and the challenges ahead

The current 2009 to 2011 Strategy and Workplan is ending this year with much having been achieved by the Partnership and the global health community at large, but with much still to be done. The previous decade has seen some, but still insufficient progress towards achieving the MDGs, and in particular those goals potentially furthest from being achieved – MDG 4 (Reduce child mortality) and 5 (Improve maternal health). The lack of progress has particularly hit the poorest countries, and within countries, the most vulnerable populations and communities.

With respect to the efforts to reduce **child mortality (MDG 4)**:⁴

- Even though mortality rates for under-fives have 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.
- Of the estimated 2.6 million third trimester stillbirths occurring worldwide every year, 98 percent occur in low and middle-income countries. The number of stillbirths worldwide has declined by only 1.1 percent per year - slower than reductions for child and maternal mortality.
- Globally, more than 8 million children each year die before their fifth birthday, more than 40% of them during the neonatal period (the first four weeks of life).⁵
- At least two-thirds of all child deaths are preventable, with pneumonia and diarrhoea as the largest killers of children after the newborn period; malnutrition contributes to more than 1 in 3 child deaths.

With respect to the efforts to **improve maternal health (MDG 5)**:

- New studies suggest^{6,7} that some progress is being made on reducing maternal mortality, but globally and in most high burden countries, progress is not sufficient to achieve MDG 5. The average annual decline in maternal mortality ratio was 2.3% between 1990 and 2008, instead of the required rate of 5.5% per year.
- An unacceptable number of women still die in pregnancy and childbirth each year – estimated at around 350,000.⁸ For every woman who dies, at least 20 others suffer injuries, infection and disability, and their children and newborn are at much higher risk of death. Yet almost all maternal deaths are preventable.

More specifically:⁹

- It is estimated that maternal deaths are caused by, among others, haemorrhage (35%), hypertension (18%), indirect causes (9%), other direct causes (11%), abortions (9%).
- Only 50% of women receive four antenatal care visits throughout their pregnancy, thereby losing an opportunity of contact with the health services.

⁴ Countdown to 2015 Decade Report (www.countdown2015mnch.org/documents/2010report/CountdownFlyerHeadlinesEnglish.pdf)

⁵ Level & Trends in Child Mortality, Report 2010. UN Inter-agency Group for Child Mortality Estimation.

⁶ Trends in Maternal Mortality: 1990 to 2008, 2010. Estimates developed by WHO, UNICEF, UNFPA and The World Bank

⁷ Hogan MC, Foreman KJ, Naghavi M, Ahn SY, Wang M, Makela SM, Lopez AD, Lozano R, Murray CJL. Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. *The Lancet*. 2010 Apr 12; 375:1609–23.

⁸ Source: UNSG Global Strategy for Women's and Children's Health.

⁹ Adapted from: Partnership for Maternal, Newborn & Child Health and University of Aberdeen. 2010. *Sharing Knowledge for Action on Maternal, Newborn and Child Health*. PMNCH: Geneva, Switzerland

- Less than 40% of women receive a post natal visit, and around 40% of births in developing countries not attended by a skilled attendant (in some countries this is as low as 6%).
- Most of these deaths can be prevented if the woman receives the appropriate intervention from a skilled health worker, and with adequate equipment, drugs and medicines.

To start overcoming these challenges across the health MDGs high-burden countries, in particular, need to:¹⁰

- Identify gaps and inequities in coverage and quality of care along the Continuum of Care for RMNCH.
- Improve the delivery and quality of essential and effective interventions and packages through strengthened planning and coordinated implementation.
- Increase resource allocations, as well as encouraging efficiency for RMNCH services and the integration of women's and children's health in national plans, so as to ensure that interventions and programmes are adequately funded.

The global health community at large needs to be working with countries to:

- Advocate for increased funding for RMNCH.
- Advocate for evidence-based and efficient spending (funding the right 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 keep their promises.

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

¹⁰ Adapted from Countdown to 2015 Decade Report

2.2 Capitalising 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 UNSG Global Strategy for Women's and Children's Health¹¹ (Global Strategy) was the culmination of many coordinated global efforts. These included the launch of the Partnership's Strategy and Workplan for 2009 – 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 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 as part of the Global Strategy, there has been increased interest and significant commitments from a large number of high-burden countries, from civil society, donor partners & foundations, and from the private sector. In particular, in 2010, US\$ 40bn 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 also encompass sexual and reproductive health of women.

As facilitator of the Global Strategy, and the platform where all stakeholders participated 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 capitalise on these opportunities. Whilst the details of the Partnership's activities within the context of the Global Strategy are still being developed, examples 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. These initiatives have the potential to deliver significant impact in areas with a high potential return on investment, in relation to advancing the Global Strategy goals;
- advocacy activities related to mobilizing additional commitments to the Global Strategy; and
- 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 and boosting momentum for the Global Strategy campaign.

¹¹ The United Nations Secretary General's Global Strategy for Women's and Children's Health (www.un.org/sg/globalstrategy)

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 is built on, with commitments translated into actions, and actions into results on the ground.

There are risks however – and this is not a time for complacency. Risks can be mitigated, but identifying them and managing them is essential. This is not an exclusive list, but risks worth highlighting are:

- **Pressures on the global economy.** The global financial and economic crisis continues to create challenges both for high-burden country governments and 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 overemphasised. Critically, countries, who are the major investors 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 non-communicable diseases) are prioritised. 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 now more than ever potentially – 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 needs to continue to be made. It is imperative therefore that the Continuum of Care approach – central to the efforts to improve RMNCH – 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 overlapping 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 discernable value and contributes to ongoing efforts to improve the health of women and children – mainly in the context of those efforts towards achieving MDGs 4 and 5, but also, and where relevant, working with Partners engaged in areas related to other MDGs. The Partnership will continue to operate across the RMNCH space.

The Partnership's overall value proposition is that it is the only institutional **multi-constituency platform** in today's large and fragmented global health space which 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 health system strengthening efforts. In this forum, Partners can work together on developing and aligning important advocacy messages, including for resource mobilisation, policy development, technical capacity building and public health educational efforts.
- A **vehicle** for collecting, translating and disseminating important knowledge, including tried and tested best practice, and valuable experience of policy development and intervention implementation globally and in countries.
- An **institutional link** between the RMNCH community and the broader activities of national government, 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, etc.

What the Partnership is not: one specific and critical feature is that the Partnership does not displace, replace or replicate existing governance, accountability and delivery structures of individual Partners. The Partnership expects to add value through ensuring that these existing Partner activities are better coordinated and by enhancing collaboration in order to achieve more effective results in high-burden countries.

Its unique role supports the case for the Partnership to continue to be 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 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:

- (i) being partner-centric;
- (ii) playing a convening and brokering role for its Partners;
- (iii) being guided by country demand and regional priorities; and
- (iv) continuing to promote the Continuum of Care.

4. PARTNERSHIP VISION AND MISSION

4.1 Partnership Vision

The proposed Vision of the Partnership has been updated from that in the 2009 – 2011 Strategy and Workplan. It is believed that the new wording better reflects the Partners' shared vision as agreed both at the March 2011 Board retreat and as reflective of the majority of comments received from the broader membership. The proposed Partnership's Vision is as follows:

The achievement of the MDGs, with women and children enabled to realize their right to the highest attainable standard of health

This new wording makes the achievement of the MDGs a central focus for the Partnership, and aligns its Vision to 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, with an ability and an opportunity to realise their rights to the highest attainable standard of health.

4.2 Partnership Mission

The proposed Partnership Mission has also 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 and, to the extent possible, the comments made by members. The Partnership's Mission is as follows:

Supporting Partners to align their strategic directions and catalyse collective action to achieve universal access to agreed essential interventions for women's and children's health.

'Essential Interventions' are defined as those that are evidence-based, of high quality and sustainable, and take account of the wider social determinants of health.

The proposed Mission statement specifically focuses the activities of the Partnership and its constituent Partners. It focuses on ensuring that the already agreed, and any new RMNCH essential interventions, are accessible to, and therefore implemented by, high burden countries. This includes advocating and working towards conducive policy environments, sufficient human and financial resources, and meaningful inclusion of all important stakeholders, including current constituencies of the Partnership¹², in these processes. For the avoidance of doubt, the Partnership does not displace or replicate existing governance, accountability and delivery structures of individual Partners.

There is also recognition within the Partnership Mission that health interventions may not be able to achieve the highest desirable impact if they are implemented without considerations of 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 those stakeholders working in these fields are able to communicate and align their strategic thinking with Partners engaged more directly in addressing specific RMNCH related issues in high burden countries.

¹² The Partnership's membership is divided in 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.

5. 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 future development of individual outputs and activities of the Partnership.

Given the Partnership's proposition, four operational principles have been identified that determine the way in which it expects to work. 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 Strategic Objectives. In particular, the Partnership is a *Partner-centric* organisation. This means that the Partnership relies on its Partners and their work to achieve the Partnership's objectives. It is a platform:

- where Partners 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 strategic objectives are discussed in turn below, followed by a summary of how the Partnership's overall value proposition translates specifically to the level of each of the objectives.

5.1 Strategic Objectives

SO 1: Broker knowledge and innovation for action

The outcome associated with this strategic objective is an increased access to, and use of, knowledge and innovations to enhance policy, service delivery, and financing mechanisms. This addresses key constraints towards achieving universal access to essential interventions 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 different constituencies' knowledge needs 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, 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 & 5 e.g. Countdown to 2015 reports. This overview is also facilitated by using strategic mapping exercises and the RMNCH portal that provides access to over 400 partner organizations' resources.

SO 2: Promote accountability for results

The outcome of this objective is expected to be better information to monitor results, better tracking of resources for women's and children's health, and better overview of results and resources nationally and globally, through consensus building and action by Partners, 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 indicators are promoted either through a reworded RMNCH Consensus or similar action; support monitoring of commitments made to the Global Strategy by all Partners, etc.
- Specifically, the **Partnership's 2011 report on Commitments to the Global Strategy for Women's and Children's Health** 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"¹³.*
- **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 to adapt the indicators collected through country surveys is ongoing. At the request from governments to undertake disaggregated country assessments, the Countdown to 2015 will initiate these surveys in a small number of countries. Hosting the Secretariat for the 'Countdown to 2015', gives the Partnership multiple opportunities to link the evidence that the Countdown reports provide to the advocacy and political opportunities to effect change in line with emerging trends, and evidence.

¹³ Pending reference from final endorsed Commission's report

SO 3: Advocate for mobilising 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. The outcome of this strategic objective will be: additional commitments for women's and children's health identified and mobilized through Partners' engagement, momentum for women's and children's health maintained in international and national policy and development fora; consensus on evidence-based strategic priorities, efficiencies, and alignment of resources. The Partnership will achieve this by:

- Contributing to joint work towards the UN SG's Global Strategy commitments, by:
 - Advocating for delivery of existing commitments made to the Global Strategy for Women's and Children's Health.
 - 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 through using the Partnership's multi-constituency platform to increase the capacity of the Partners to mobilize resources.
 - Working closely with the office of the UN Secretary-General and other Partners on the implementation of the Advocacy plan of the Global Strategy including support towards UN Member States' engagement.
- Advocating (through events, dialogue and facilitation) to include women's and children's health in the international political economic and development landscape, including the African Union, G8, political groups such as the Inter-Parliamentary Union and others to encourage 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, effective use and alignment of resources for equitable allocation of resources to agreed strategic directions, country priorities and national plans.

Although distinct in nature and focus, all of the Strategic Objectives are intertwined and, for example, work done in the area of "results" will be synergized with the "knowledge and innovation" and "advocacy" Strategic Objectives.

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* organisation. This means that the Partnership relies on its Partners and their work to achieve the Partnership's objectives. 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 to be done, 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 mobilises, 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 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, alignment of messages by the NGO community etc.

The Partnership members are represented through 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, through relevant Board representatives and 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 (to potentially reshape their approaches in light of new information and coordinate implementation of interventions) and catalyse new activities and approaches.
- **Brokering.** The Partnership will actively broker (knowledge, innovations, collaborations, etc) amongst 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 current situation and progress towards 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 which is in alignment with national plans and regional initiatives (such as the CARMMA¹⁴), ensuring activities are guided by actual demand and national health plans as articulated by individual countries and based on global best practice, including the Paris Principles and Accra Agenda for Action.

National governments from high-burden countries are an essential constituency of the Partnership, providing feedback, sharing experience and offering direction to the discussions on how best other Partners can contribute to and coordinate their activities with in-country development efforts. All activities of the Partnership are therefore guided by the principles of supporting existing country plans. Increasing efforts to effectively engage the country constituency will be a cross-cutting theme across all strategic objectives.

The work on defining best practice and opportunities for strengthened multi-stakeholder country engagement¹⁵, through Partners, will continue as the Workplan is being developed.

6.4 The work of the Partnership will continue to promote the Continuum of Care

The concept of Continuum of Care – and coordinated interventions along the continuum – is generally agreed as the best approach to improve women's and children's health. The Continuum of Care concept helps to focus attention on the effective delivery of health services, including gaps in service provision, and highlights 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 two dimensions: (i) a lifecycle dimension; and (ii) a place of care dimension. The key points to note about these two dimensions are:

- **Lifecycle dimension:** The relevant lifecycle is assumed to start from before pregnancy and in the context of reproductive and sexual health of women, through pregnancy, birth and onto childhood for the baby, and maternal health for the woman. Stages of the lifecycle 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 lifecycle need to be linked and mutually supportive. For example, antenatal care should promote where relevant PMTCT¹⁶ and keeping mothers alive, skilled attendance at delivery, 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 the modalities for delivery, the Continuum of Care can be an effective framework for improving the quality of service delivery.
- **Place of care dimension:** In a similar manner that stages in the lifecycle are interdependent, so are the aspects of where and how care is provided. Household education will contribute to preventing health complications, quality care provided at the community level will help avoid the need for hospitalisation, and sound referral systems at primary care level 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 through to the hospital. This dimension of the Continuum recognises the importance of the health system as a

¹⁴ Campaign for the Accelerated Reduction of Maternal Mortality in Africa.

¹⁵ A preliminary paper will be tabled at the 172 June Board meeting.

¹⁶ Preventing mother-to-child transmission

whole and that components or building blocks of a well functioning health system include 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' for evidence-based essential interventions to be defined and implemented in high burden countries, as illustrated in Figure 1 below. In this space, for example, there will exist interventions that are aimed at addressing the 'before pregnancy' stage in the lifecycle, but that could be provided at household, community and hospital setting. In the same manner, there are community based interventions that span the whole lifecycle 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 along the two different dimensions and that any gaps (e.g. no interventions for dealing with 'birth' in 'household' setting) are identified and dealt with.

Figure 1: Continuum of Care dimensions and space for evidence-based essential RMNCH interventions



7. SUMMARY

Table 2 below sets out a summary of the Strategic Framework. Key points to note are as follows:

- The overall strategy is set out using a logframe approach, in which each of the strategic objectives has an individual logframe itself. Although it has not been included in the summary table at this stage, each objective / outcome, output and activity will have Objectively Verifiable Indicators, Means of Verification, and Assumptions and Risks. These will be linked to the aspirations of the Partnership as articulated through the Vision and Mission.
- Activities and outputs will need to be developed, once the Strategic Framework has been approved and when the detailed workplan is developed.
- The four principles (partner-centric; convening and brokering; driven by country demand and regional priorities; promoting the Continuum of Care) will apply across each of the strategic objectives and underpin the strategy as a whole.

Table 2: Summary of Strategic Framework Overview

Overview		
Vision		
The achievement of the MDGs, with women and children enabled to realize their right to the highest attainable standard of health		
Mission		
Supporting Partners to align their strategic directions and catalyze collective action to achieve universal access to agreed essential interventions for women's and children's health.		
Value add		
Unique institutional platform with the ability to bring together key Partners and enhance the interaction of key stakeholders focused on improving the health of women and children, working across the reproductive, maternal, newborn and child health spectrum, enabling Partners to share strategies, align objectives and resources, and agree on interventions.		
Strategic Objectives		
Broker knowledge and innovation for action Increased access to and use of knowledge and innovations to enhance policy, service delivery, and financing mechanisms so as to address key constraints towards achieving universal access to essential interventions in high burden countries.	Promote accountability for results Better information to monitor results, better tracking of resources for women's and children's health, and better overview of results and resources nationally and globally, through consensus building and action by Partners.	Advocate for mobilising and aligning resources and for greater engagement Additional commitments for women's and children's health identified and mobilized through Partners' engagement, momentum for women's and children's health kept in international and national policy and development fora and consensus on evidence-based strategic priorities and alignment of resources promoted.
Outputs [TBC]		
[TBC]		
Activities [TBC]		
[TBC]		
Cross-cutting principles		
Partner-centric		
Convening and Brokering		
Country demand and regional priorities		
Continuum of Care		