

External Evaluation of the Partnership for Maternal, Newborn and Child Health

27/01/2020

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Appendix B LIST OF KEY INFORMANTS AT THE GLOBAL AND COUNTRY LEVELS

This Appendix lists the stakeholders consulted for this evaluation. Overall, we consulted 84 stakeholders³ between September – November 2019, of whom 56 were global level stakeholders and 28 national level stakeholders.

Table B.1: List of stakeholders consulted as part of the evaluation

#	Organisation/ constituency		Name	Title/Department
PMNCH Secretariat				
1.	Secretariat		Helga Fogstad	Executive Director
2.			Lori McDougall	Coordinator
3.			Nebojsa Novcic	Resource Mobilisation
4.			Miriam Sabin	Accountability Manager
5.			Yajna Moloo	Accountability
6.			Anshu Mohan	Country Engagement Manager and Adolescents Health
7.			Mimi Melles-Brown	Adolescents Health
8.				Veronic Verlyck
Secretariat members involved in a focus group discussion: Nebojsa Novcic; Saverio Bellizzi; Miriam Sabin; Yajna Moloo; Mimi Melles-Brown; Veronic Verlyck				
PMNCH Board, committees and working groups				
9.	Board Chair		Helen Clark	Former Prime Minister of New Zealand, Former Administrator of the UNDP, New Zealand
10.	Strategic Committee (SC) Chair		Anders Nordstrom	Global Health Ambassador, Ministry for Foreign Affairs, Sweden
11.	Vice-chair of Board		Preeti Sudan	Secretary, Health and Family Welfare, Ministry of Health and Family Welfare, Government of India Executive Committee (EC) member
12.	Advocacy Working Group		Lars Grönseth (also from Norad)	Co-Chair
13.	Chair of the Governance and Nominations Committee (GNC)		Flavia Bustreo	Chair of the External Evaluation Reference Group (EERG) Botnar Foundation
PMNCH constituencies				
14.	Academic, Research and Training Institutes (ART)	Population Council (S&FC)	Julia Bunting	President Board member and co-chair of the Knowledge and Evidence Working Group
15.	Adolescents & Youth (AY)	Youth Coalition for Sexual & Reproductive Rights (YCSRR)	David Imbago Jácome	Medical doctor, Board member
16.		Civil Life Association	Enes Efendioglu	Adviser

³ Excluding a written response from USAID late on in the core phase of the evaluation.

#	Organisation/ constituency		Name	Title/Department
				Board alternative and member of the SC
17.	Donors and Foundations (D&F)	BMGF	Ann Starrs	Director, Family Planning Co-chair of the Accountability Working Group
18.			Nosa Orobato	Deputy Director, MNCH Board member
19.			Kate Somers	Programme Officer, MNCH
20.		Bernard van Leer Foundation	Michael Feigelson	Executive Director Board member
21.		DfID	Meena Ghandi	Senior Health Advisor
22.	Global Financing Mechanisms	The Global Fund	Vivianna Mangiaterra	Previously HSS coordinator (ended in October 2019)
23.		Global Financing Facility	Leslie Elder	Head of Nutrition Member of the GNC
24.	Healthcare Professional Associations (HCPA)	International Pediatric Association (SickKids)	Zulfiqar Bhutta	International Paediatric Association and Co-Director Centre for Global Child Health. The Hospital for Sick Children Board member and member of SC Co-chair of Evidence and Knowledge working group (WG)
25.	Inter-governmental organisations (IGO)	Inter Parliamentary Union (EC)	Aleksandra Blagojevic	Programme Manager for International Development
26.	Non-Governmental organisations (NGO)	CORE Group	Lisa Hilmi	Executive Director, CORE Group EC and Board member, Constituency Chair of NGO
27.		White Ribbon Alliance for Safe Motherhood (EC)	Kristy Kade	Executive Director, White Ribbon Alliance for Safe Motherhood Co-chair of Advocacy WG
28.		Gogontlejang Phaladi Pillar of Hope Organisation	Gogontlejang Phaladi	Founder and Executive Director Board and EC member, including chair of AYC
29.	Partner governments	Government of Afghanistan	Ferozuddin Feroz	The Minister of Public Health, Ministry of Public Health Board and SC member
30.	Private Sector	Merck for Mothers	Mary-Ann Etiebet	Mary-Ann is the Executive Director Board and EC member, including Chair of Private Sector Constituency
31.	Multilateral	The World Bank	Sameera Al Tuwajri	Global Lead, Population and Development
32.	United Nations Agencies	WHO	Dr Zsuzsanna Jakab	Deputy Director General
33.			Shyama Kuruvilla	Senior Strategic Adviser, UHC & Life Course. IAP Secretariat Director Acting IAP Director
34.			Anshu Banerjee	Director, HQ/MCA Maternal, Newborn, Child and Adolescent Health, WHO
35.			Peter Salama	Executive Director, Universal Health Coverage/Life Course Board and EC member

#	Organisation/ constituency		Name	Title/Department
36.		UNICEF	Stefan Peterson	Associate Director
37.			Willibald Zeck	Head of Global MNCH Board member
Other				
38.	Youth Coalition for Sexual and Reproductive Rights, Spain		Carles Pericas Escale	Member of the External Evaluation Reference Group
39.	The University of British Columbia (UBC), Vancouver		Dorothy Shaw	Professor Emeritis, Member of the EERG Vice Chair of GNC
40.	BRAC University School of Public Health, Bangladesh		Kaosar Afsana	Professor, Member of the EERG
41.	Independent Consultant, previously CIFF and DfID		Peter Colenso	Independent
42.	LSHTM		Wendy Graham	Professor
43.	IFRC		Emanuele Capobianco	Director of Health and Care
44.	The Lancet		Richard Horton	Editor
45.	Women Deliver		Katja Iversen	CEO Board alternate
46.	NEST360 and LSHTM		Joy Lawn	Founder of NEST360
47.	Path		David Fleming	Vice president of the Global Health Programmes division
48.	World Vision		Dan Irvine	Senior Director, Health and Nutrition
49.	Save the Children		Mary Kinney	Senior Specialist for Global Evidence and Advocacy
50.	International Centre for Migration, Health and Development		Manuel Carballo	Executive Director Board and EC member, including Chair of ART
51.	Midwives - ICM		Franka Cadee	President Board member and Constituency Chair for the HCPA
52.	Canadian International Development Agency		Peter St John	GNC member
53.	Scaling Up Nutrition		Brenda Killen	Director Former IAP member
Corridor discussions in Nairobi				
54.	Open Consultants		Marco Schäferhoff	Founder
55.	WHO		Etienne Langlois	Scientist. Alliance for Health Policy and Systems Research
56.	Norway Government Observer		Sissel Hodne Steen	Consul General Senior Advisor, MFA
‘Less engaged’ Partners at national levels				
57.	AMRO: Youth Coalition for Sexual and Reproductive Rights - Bolivia		Alan Jarandilla Nunez	Activist and advocate
58.	EMRO: The Pakistan Pediatric Association		Mumtaz Lakhani and Asif Habib	Executive Manager of PA office
59.	WPRO: PNG Youth Alliance on HIV/AIDS and Coffey International		Fiona Latoya Fandim	President

#	Organisation/ constituency	Name	Title/Department
Country level stakeholders			
India			
60.	Partner governments	Wished to remain anonymous	N/A
61.	NGOs	Wished to remain anonymous	N/A
62.	Adolescents and Youth	Wished to remain anonymous	N/A
Kenya			
63.	Partner governments	Wished to remain anonymous	N/A
64.		Wished to remain anonymous	N/A
65.	Multilaterals	Wished to remain anonymous	N/A
66.	Academic	Wished to remain anonymous	N/A
67.	Youth Coalition	Wished to remain anonymous	N/A
68.		Wished to remain anonymous	N/A
69.	NGOs	Wished to remain anonymous	N/A
70.		Wished to remain anonymous	N/A
71.		Wished to remain anonymous	N/A
72.		Wished to remain anonymous	N/A
73.		Wished to remain anonymous	N/A
74.		Wished to remain anonymous	N/A
Nigeria			
75.	Federal Ministry of Health	Dr. Adebimpe Adebisi	Director, Department of Family Health
76.	Federal Ministry of Health	Dr. Emmanuel Meribole	Director, Department of Planning, Research and Statistics
77.	Health Sector Reform Foundation of Nigeria (HERFON)/Nigerian Health Sector Reform Coalition (HSRC)	Ms. Aanuolawapo Rotimi	Head of Programs/Focal Point
78.	Africa Health Budget Network	Dr. Aminu Magashi Garba	Executive Director Board member
79.	Education as a Vaccine	Olubukunola Williams	Executive Director
80.	MaMaye/Options Nigeria	Esther Agbon	Senior Health Finance Advisor and Deputy Country Lead
81.	White Ribbon Alliance, Nigeria	Tariah Adams	Communication Advocacy
82.	Ondo state Government	Dr. Dayo Adeyanju	Former Commissioner for Health

#	Organisation/ constituency	Name	Title/Department
83.	Saving One Million Lives Programme for Results	Dr. Ibrahim Kana	Programme Manager
84.	World Bank Country Office	Dr. Umma Yar'Adua	GFF Focal Point for Nigeria

Appendix C **ABRIDGED INTERVIEW GUIDES**

This Appendix includes the abridged interview guide which was further tailored for the various interview groups.

Vision and mission

1. To what extent are you aware of the work of PMNCH? Within the changing context of global health, how relevant is the vision and mission of PMNCH?
 - *In particular given the changing SRMNCAH context, e.g. UHC, GAP, emerging WAH agenda, new partnerships and emergence of new funding mechanisms such as GFF?*
 - *In this context, is the breadth of the Partnership's vision and mission too broad/too narrow/about right to guide priorities?*
 - *How do the vision and mission transfer/ apply at global, regional and country levels? Do you have any examples of this transferability or lack of?*
 - *To what extent do you think PMNCH influences the global SRMNCAH space, as well as the agendas for UHC, GAP, WAH etc?*
 - *Do you have any suggestions for revisiting the vision and mission, or for the emphasis/ prioritisation of specific focus areas?*
2. How can PMNCH be effectively positioned to add value in the context of the SDG3 goals of UHC?
 - *What is the unique value of PMNCH?*
 - *How could PMNCH further advance the Women, Children and Adolescent Health issues as part of the UHC agenda?*

Governance and accountability

3. Does the current governance and management structure of the Partnership contribute to members' existing efforts to achieve results?
 - *Are there particular examples where the governance arrangements (including levels of staffing in the Secretariat) and structure of the Partnership has helped achieve results, or vice versa?*
 - *Is the diversity of the Board membership (for example, the visibility of different constituencies) appropriate and relevant?*
 - *Do the composition and functionality of the Board have specific impacts on agenda setting and decision making? If so, how?*
 - *Is WHO's hosting arrangement a strength or challenge for PMNCH?*
 - *Does the role of the Executive Committee (EC) have any impact on results? How? Could the governance of the EC be improved to achieve improved results, and if so, how?*
 - *Is the approval process for Partnership members to request support efficient and effective? Could this be improved, and if so, how?*
 - *If all partners are responsible in the Results Framework, how are they held accountable for delivering or not delivering results?*
 - *The PWC evaluation suggested there were issues with the Secretariat's capacity, skills and performance. Has any action been taken to strengthen it?*
4. Does PMNCH offer an effective platform for members to build SRMNCAH community and collaborative work?

- *Are there particular examples where PMNCH has been an effective platform for building community and collaborative work for a common agenda? / To what extent has your organisation been able to build community and collaboration with other relevant organisations, using the PMNCH platforms?*
- *Are there any barriers to PMNCH being an effective platform for members to build community and collaborative work?*
- *Are there any missed opportunities for members to build community and collaborative work?*
- *How could the Partnership be made more effective at building community and collaborative work?*
- *In looking forward, will the visibility and impact of PMNCH in the SRMNCAH space be impacted by other global health partnerships?*

5. To what extent do you think that PMNCH offers an effective platform for members to extend their impact?

- *Are there examples of how PMNCH has extended the reach of members? / Has PMNCH been able to extend your platform?*
- *Is the breadth of the Partnership's membership a strength or a challenge?*
- *Do you have specific suggestions of how PMNCH could be a more effective platform for members to extend their reach?*

6. From your experience, is there a culture of transparency and openness? How can PMNCH's internal accountability mechanisms be strengthened?

- *How can progress be more effectively tracked?*
- *Do you ever refer to PMNCH's Theory of Change in your work? Do you think the PMNCH's Theory of Change could be improved for increased accountability? If so, how?*
- *From your experience, how do you think PMNCH can better support broader accountability mechanisms for monitoring progress on SRMNCAH, such as the IAP and EWEC?*

Programming and delivery

7. What reflections do you have on the scope of activities conducted by PMNCH? Do they reflect priority needs?

- *How does PMNCH decide what to fund?*
- *Do you think the scope of PMNCH's work is well-aligned with priority needs around SRMNCAH at the global level / in your country?*
- *What other suggestions do you have?*
- *Are the current funding streams of PMNCH sufficient for the Partnership's programming? Please explain your answer.*

8. Is the buy-in from PMNCH's members sufficient and appropriate?

- *Are the communications between PMNCH Secretariat to members sufficient and appropriate? Please provide any suggestions on improvement.*
- *How could members' involvement be further encouraged?*

Partner and country engagement

- Should PMNCH be engaged at the country level? If so, how can country activity under the Partnership be more effectively supported?

Countries

- *Given the limited resources available for PMNCH to engage at the country level, what activities should be prioritised?*

- *How does PMNCH decide what countries to support? Is it demand led or are there criteria?*
- *Should PMNCH issue grants to country stakeholders? If yes, what added value does it bring? If not, what should be the focus of PMNCH?*
- *To what extent has your organisation contributed to PMNCH activities at the country level? Can you give some examples? Can the impact of these activities be attributed to PMNCH?*
- *How can multi-stakeholder platforms in countries be usefully supported? What is the specific role of the Partnership? To what extent are these a useful tool to advocate for the SRMNCAH agenda at national and sub-national level?*
- *To what extent are the multi-stakeholder platforms country-led or donor-led?*
- *How does it engage with GFF and H6 at country level?*

Broader partnership engagement

- *Is PMNCH taking a strategic targeted approach to identifying new members or is it reliant on organisations asking to join?*
- *Are there additional partners that PMNCH should engage with to reflect the ambition and strategic objectives of the Partnership?*
- *How could PMNCH do this effectively?*

Effectiveness, performance and impact

- What key impacts do you think the Partnership has contributed to?
 - *Are there specific examples at the global, regional and/ or country levels?*
 - *Could similar results/ impacts have been achieved some other or more (cost) effective way?*
 - *How can the Partnership's impact be strengthened?*
- How can the impact of PMNCH be more effectively assessed/ promoted, given the impact attribution challenge?
- Do you have any suggestions on how PMNCH can further share learning around SRMNCAH?
- Do you have any other reflections, comments or suggestions as we look forward to the future of PMNCH?

Appendix D **MAPPING OF EVALUATION QUESTIONS TO OVERALL FINDINGS**

This Appendix maps the evaluation questions (as per the RfP) to the relevant Sections in the report and to the key findings.

Table D.1: Mapping of evaluation questions to the key findings

Evaluation questions (as per the RfP) and location of finding in the report	
Vision and mission	
1. Are the vision and mission and programming efforts still valid and relevant given the evolving global health landscape?	<i>Section 4.1. Issues covered include vision and mission given ‘unfinished business’ of MNCH in the MDGs and concerns of SRMNCAH being diluted within UHC2030 agenda.</i>
2. Should there be further Partnership emphasis/prioritisation of specific thematic, geographic or demographic foci?	<i>Section 4.1. Issues covered include the potential ‘niche’ of PMNCH; whether PMNCH has a clearly defined role; the 4As; discussion around PMNCH focusing on ‘unfinished business’ including practical implications of this; suggestions of other priorities for PMNCH in going forward.</i>
3. Does the Partnership’s theory of change provide a convincing logic model for its programming work? How does it drive programmatic decisions?	<i>Section 4.1. Issues covered include the capacity for PMNCH’s current ToC and Results Framework as an M&E tool; and challenges around the key performance indicators of the 2018-2020 Results Framework.</i>
Governance and internal accountability	
4. Does the structure of the Partnership (i.e. Board, membership and committee structures) encourage value add to members’ existing efforts to achieve results?	<i>Section 4.2. Issues covered include the sustainability of the Secretariat’s workload; a shift in the structure of the Secretariat; discussions around a ‘Secretariat-led’ vs ‘Partner-led’ Partnership; WHO hosting arrangement; the Board’s diversity and convening power</i>
5. Does PMNCH offer an effective platform for members to build community and collaborative work and extend their reach?	<i>Section 4.3. Issues explored included current levels of meaningful participation across the Partnership; clarity around the value-proposition; the level of effectiveness of the current ‘Partner-centric’ approach; cross-constituency collaboration, communication and engagement systems</i>
6. Are decision-making processes (consensus versus majority rule) optimal in terms of delivering decision points that guide achievement of impact?	<i>Section 4.2. Issues covered include reported confusion around the different governing bodies and their individual roles; the value for money and purpose of the Board meetings; the Board composition; PMNCH’s appetite for change regarding decision-making processes</i>
7. How can a culture of transparency and openness be more effectively supported?	<i>Section 4.2. Issues covered included perceptions around internal transparency and increasing communication around financial reporting, amongst other areas.</i>
8. How can accountability mechanisms be strengthened?	<i>Sections 4.1 and 4.4. Issues covered included PMNCH progress with Results Frameworks between 2014-2019; awareness of PMNCH Results Frameworks beyond the Secretariat.</i>
9. How can progress be more effectively tracked?	<i>Sections 4.1 and 4.4. Issues covered included the opportunity to develop a new ToC and revised Results Framework for the new Strategic Period.</i>
Programming and delivery	
10. Has the Partnership developed programmes critical to its vision and mission?	<i>Section 4.4. Issues covered include activities aligned with the vision and mission; how decisions are made on programming; discussion around the volume of programmes and buy-in from members.</i>

Evaluation questions (as per the RfP) and location of finding in the report

11. Is the volume of programming, and buy-in from members, sufficient and appropriate?

Sections 4.4 and 4.1 Issues covered include analysis of the depth and breadth of PMNCH programmes.

12. Do programmes add value to efforts already underway by partners or that partners could not initiate on their own?

Section 4.1. Issues covered include PMNCH focusing and prioritising for an added value; collaboration with other GHPs; diverging views on PMNCH's added value against the 4As; an added value in advocacy in particular.

13. Are programmes envisaged with sufficient depth and breadth to achieve results?

Sections 4.4 and 4.1 Issues covered include analysis of the depth and breadth of PMNCH programmes.

14. Is the Partnership well placed to issue grants (i.e. to be a sub-granting mechanism) to drive achievement of planned work and programmes?

Sections 4.3 and 4.4. Issues covered include PMNCH's role as a sub-granting mechanism and the effectiveness of small grants.

Partner and country engagement

15. How can PMNCH prioritise effective country engagement? How can the Partnership add value in response to country needs? How can multi-stakeholder platforms in countries be usefully supported?

Section 4.3. Issues covered included levels of understanding of PMNCH's country engagement work; perceptions on how PMNCH can 'add value' at the country level; effectiveness of country engagement processes; the impact of PMNCH's country engagement work.

16. How can PMNCH more effectively engage and align a broader range of partners so as to reflect the ambition and strategic objectives of the Partnership?

Section 4.3. Issues covered included the effectiveness of current country engagement mechanisms; current levels of meaningful participation across the Partnership; clarity around the value-proposition; the level of effectiveness of the current 'partner-centric' approach; cross-constituency collaboration, communication and engagement systems.

Effectiveness, performance and impact

17. How effective have PMNCH's advocacy activities been at global, regional and country levels?

Section 4.4. Issues covered include perceptions and documentation review on the effectiveness of PMNCH advocacy and potential bottlenecks to PMNCH effectiveness on advocacy.

18. How can PMNCH share learning so as to accelerate and focus action and financing to deliver the Global Strategy for Women's, Children's and Adolescent's Health?

Whilst we explored this question in our data collection methods did not obtain much data for this question, therefore it was not a central component of our write-up.

19. Overall, what impacts have been achieved by the Partnership and at what cost? Have these been considered value for money?

Section 4.4. Issues covered included breakdowns of PMNCH expenditure; the extent to which PMNCH considers value for money.

20. Could similar results have been achieved some other way or more (cost) effectively?

Section 4.4. Issues covered included the cost-effectiveness and value for money of PMNCH governance meetings and Partners' Forum.

21. How can the impact of PMNCH be more effectively assessed/promoted, given the impact attribution challenge?

Section 4.4 Issues explored included the impact attribution challenge (more generally) and the effectiveness of PMNCH's ToC and Results Framework.

Appendix E **LIMITATIONS AND RISK MITIGATION STRATEGIES**

There are some limitations to the evaluation methodology which are captured in Table E.1 below. Despite these limitations, we are confident that the evidence collected and analysed is sufficient to form a basis on which sound findings and actionable recommendations can be made.

Table E.1: Limitations and risk mitigation actions

Limitation	Implications and mitigation actions undertaken
General	
Timeline: The data collection and analysis were limited by the limited time and budget available .	We believe that the range of data collection sources and analytical approaches, each with explored and accepted limitations, enabled a good exploration of breadth and depth in the enquiry. The entire evaluation team met in person in early December 2019 to review methodology, key findings and recommendations.
While this was not an impact assessment, but a strategic level evaluation, ‘programming, effectiveness and impact’ was an evaluation theme as proposed by PMNCH. However, there are challenges in attributing impact to PMNCH at both global and country levels, as well as challenges in measuring the effect of advocacy generally as a process, rather than an outcome focus.	The challenge of impact attribution has been referenced and discussed throughout the report, especially in Section 4.4 of the main report on effectiveness, performance and impact. Without pre-determined impact metrics (either qualitative or quantitative), the analysis of impact had to be undertaken largely on a qualitative basis.
All robustness rankings are relative and are ultimately judgment-based. While based on a review of the quality and strength of the data across sources, as well as the level of agreement/consistency in findings within and across data sources, these are inherently subjective in nature.	The evaluation team met in early December 2019 to discuss the key findings and recommendations of the main report – this formed a key part of the corroboration exercise and development of robustness ratings of key findings. This meeting allowed time for further collective reflection on both the findings by methodological component, as well as the overall findings. During the drafting process, we continued to cross check the summary findings across evaluation theme to ensure consistency. Limitations of each data collection approach were explored prior to the corroboration/triangulation effort so as to enable effective consideration of the strength of evidence and level of agreement when developing the overall key findings and recommendations.
Based upon specific methodology	
Key informant interviews: Potential selection and interviewee bias. A foreseen limitation in interviewing stakeholders who were either familiar with PMNCH or active members/ Partners (or both) was that it may have resulted in a lack of broad diversity (geographic and opinion based). There was some geographical under-representation among the key informants, with for example only one informant from the Western Pacific region.	A broad range of stakeholders were consulted (beyond the list that was accepted by the EERG during the Inception Phase of the evaluation). During the Inception Phase the evaluation team proposed KIIs with 48 stakeholders from PMNCH Board, Secretariat and Constituencies, the IAP, and other relevant individuals/ organisations. The evaluation team invited all of these interviewees for an interview and repeatedly followed-up with those who did not respond to the invite. There was an 83% response rate to the initial KII list. In addition to the original list, the evaluation team interviewed other representatives of

	organisations identified as key in the Inception Phase (where possible) as well as interviewing other external stakeholders (as per the key informant list in Appendix B), to ensure diversity of opinion across key stakeholders relevant to PMNCH. Whilst many interview informants were either PMNCH Secretariat staff members, Board members or wider partners (which meant that feedback from these individuals may have inherent bias), we also consulted a wide range of independent experts who had external perspectives of PMNCH, whilst being heavily engaged in the SRMNCAH space. In addition, as described in Section 3.2.1, we carried out interviews with ‘less-engaged’ members. These members were identified through a random and also a purposive sampling methodology (whereby a random list of stakeholders was generated from the PMNCH membership database, and individuals from this list were identified purposively) with specific selection factors used to enable a broader representation across geographic region, constituency group, date of joining PMNCH and level (in terms of global, regional, national and sub-national). We initiated contact with key informants for interviews as soon as possible in the core phase of the evaluation. If a key informant was unavailable, we identified a replacement interviewee with comparable insight or experience.
Constituency-based consultations: There was low participation on the calls and also likely response bias given only the most active members were likely to participate in the teleconferences.	Due to low participation in the calls and more insightful data collected through other means (combined with time limitations), we did not continue to prioritise this data collection approach. Instead, to ensure adequate representation of perspectives across all constituencies, we held further KIs with the constituency chairs as well as partners from each of the constituencies.
Partnership e-based open enquiry: The results from the e-based open enquiry should not be considered representative of the overall Partnership. We received 87 responses, which constitutes 8% of total PMNCH membership according to the PMNCH membership database. Although the number of responses may represent a larger proportion of active PMNCH members, this is not statistically representative. The e-based open enquiry was delivered in English, which potentially limits the pool of respondents. Additionally, the quality and completeness of the qualitative sections partially relies on the English language abilities of informants, which may bias the results. Qualitative insights from the survey are limited. 75% of survey responses were fully completed, with most omissions coming from qualitative sections.	The lack of representation and potential biases in responses were accepted, considered and noted at the analysis phase. They were also mitigated through corroboration with other data sources (for instance, in assessing findings from the e-based enquiry with other data sources including KIs, the documentation review, the SNA findings and country case studies). The lack of English may be problematic, although it is noted that English is the language of communication for the Partnership.

Full SNA for the adolescent advocacy toolkit: All nine relevant stakeholders were invited to participate in an online survey (made available in English only) but only seven actually participated.	More qualitative information was collected through KIs and desk review of the existing documents and monitoring tools.
Partial Social Network Analysis (SNA) based on the results from the e-based open enquiry. These should not be considered representative of the overall partnership. The e-based open enquiry was only made available in English (as described above). A total of 87 organisations participated, which constitutes 8% of total PMNCH membership according to the PMNCH member database. Of these 87, an average of 64 informants completed the three questions used for the SNA. Further, there were no responses from either the Global Financing Mechanisms or UN agencies.	No mathematical calculations of the network's metrics were performed as the sample was not sufficient to represent the whole Partnership. For example, insufficient data were available for the two missing stakeholder groups (Global Financing Mechanisms and UN agencies). These members are therefore not represented in the SNA visuals. The potential bias is accepted and considered but mitigated through corroboration with other data sources.
Country case studies: A limitation of the country selection was that it did not include countries where PMNCH has had less traction – it included three key focus countries only – which may have presented a bias view of the role and potential value in a PMNCH country engagement. Due to time and budget constraints, the evaluation team was unable to carry out country visits to all countries, including to sub-national levels which would have enabled the inclusion of a broader range of in-country opinion from those familiar as well as less familiar with PMNCH.	Since an evaluation team member was based in Nigeria, and another participated in the PMNCH Board meeting in November 2019 in Nairobi, Kenya, we carried out in-country enquiry in two of the three countries, which explains the higher number of informants for these case studies compared with India (which relied on remote enquiry). The theme of country engagement was further explored through other data sources, in particular KIs and the e-based open enquiry. The evaluation team also interviewed key informants who had attended the Delhi Forum⁴ to elicit wider perspectives on PMNCH engagement in India, as further explored in the India case study.
Partnership database analysis: Membership entries extend only as far as July 2018, based on an updated list received on 21st November 2019. As reported by the Secretariat, over 60 applications have been submitted to join the Partnership since July 2018 but were not included in this analysis, as their applications are still under review. We assumed that all database entries represented one-member organisation, but in some cases multiple entries may be individuals from the same organisation. We assumed that all entries were considered PMNCH members, and that membership was not contingent on any variables within the database (e.g. acceptance of application). 43% of membership applications had no date attached to them, meaning any time-series analysis would have excluded a significant portion of the membership and therefore could not be done. 47% of accepted	No specific mitigating action was taken, but the potential bias is accepted and considered, but mitigated through corroboration with other data sources.

⁴ The Partners' Forum 2018 (PF2018) was held in India and has been explored in the India case study in Appendix P. Members from all constituencies were invited to participate, and many key informants for this evaluation had participated in the 2018 Forum. The objective of PF2018 was to achieve greater consensus and alignment among PMNCH's 1,000+ partners on priorities, strategies and technical approaches to accelerate implementation of the Global Strategy and progress towards UHC and the Sustainable Development Goals (SDGs).

submissions and 23% of processed submissions are also non-dated entries. There is also no application acceptance date variable within the database. So, if the application has been accepted, date of acceptance is assumed to be equal to date of submission (even though in reality acceptance may come later than submission). Date processed into database is not a proxy for date of acceptance because the database is not used consistently, as clarified by PMNCH Secretariat.	
Funding analysis: It was not possible to break down the expenditure of the partnership in the 2017 financial year by PMNCH workstream as this expenditure information is not available in the financial reports. Therefore, we carried out an analysis of budget allocation (rather than expenditure) against the different workstreams, recognising this may not be representative of the exact amounts spent.	No specific mitigating action was taken, but the potential bias was accepted and considered, and corroborated where possible with other data sources including KIIs. We have noted this limitation in Appendix H.
SWOT analysis: GHPs vary considerably and most evaluations have focused on GHPs that are financing mechanisms or private public partnerships (PPPs), very different in size and structure to PMNCH. The most relevant literature is often not recent, limiting its utility. There are inherent challenges in evaluating the outcomes of partnerships and attributing cause and effect. Additionally, time and budget limitations, as well as the scope of the evaluation did not allow for validation of some of the SWOT findings with other data sources, such as KIIs, or to compare PMNCH financial and institutional arrangements to analogous partnerships.	The SWOT analysis undertaken was based upon the finalised methodology as per the final Inception Report. Thus, the findings need to be contextualised within this scope. Where possible, the findings have been corroborated with other data sources including KIIs, the e-based open enquiry and SNA. Some key sources used in this analysis have limitations to their studies that have also been considered in the SWOT analysis write up in Appendix G.

Appendix F SUMMARY OF PMNCH REPORTED RESULTS 2016-2020

This Appendix presents a table describing some of the key results, as reported by the Partnership for Maternal, Newborn and Child Health (PMNCH), between 2016-2020. The reported results listed in Table F.1 below do not reflect the entire scope of work undertaken by the Partnership from 2016 to 2020 but instead represent a sample of results identified through the documentation review. The references to this documentation are included as footnotes.

Table F.1: Summary of PMNCH reported results 2016-2020

Function area	
Alignment	2016: "PMNCH supported civil society consultations in Cameroon and Senegal which resulted in increased civil society representation on national platforms in both countries."⁵ 2017: "The 150-member Global Financing Facility (GFF) Civil Society Coordinating Group, convened by PMNCH, oversees the development of the GFF Civil Society Engagement Strategy. An implementation plan is developed and approved by the GFF Investors Group in November. Civil society coalitions in five countries start to develop action plans to implement the strategy."⁶ "The Partnership has helped various constituencies to participate in improving health outcomes. For example, it has collaborated for some years with the Inter-Parliamentary Union (IPU) in advocating to parliaments for increased action on SRMNCAL. In 2016 PMNCH supported parliamentary seminars in Sierra Leone, Uganda and Rwanda, allowing citizens to voice their priorities and concerns related to SRMNCAL and to urge their members of parliament (MPs) to elevate women's, children's and adolescents' health to the top of legislative agendas."⁷ 2018: Small grants issued to Cameroon, Kenya, Nigeria and Sierra Leone for improved civil sector engagement in national planning processes.⁸ 2018: Four webinars and quarterly newsletters delivered with the aim of increasing civil society access to information on GFF related processes and ensure consultation around key processes.⁹ 2018: Draft outline of PMNCH political engagement strategy developed and presented by Board Chair.¹⁰ 2018: 'Women's Leaders Network established during UNGA in September.'¹¹ 2019: Ongoing work on the digitalisation on PMNCH's platform.
Analysis	2018 BMJ series 'Making multisectoral collaboration work' (www.bmj.com/multisectoral-collaboration) launched.¹²
Advocacy	"In 2016, through concerted, multifaceted advocacy efforts at global, regional and national levels, the Partnership actively contributed to securing over US\$ 5 billion through 40 additional commitments to the Global Strategy in 2016. PMNCH organized seven high-level events in support of Every Woman Every Child, bringing together over 850 people. Its associated communications efforts reached 9.5 million social media accounts, had over 1,380 mentions and gained over 350 new followers. The Partnership also coordinated, and through its constituencies implemented, partner commitment outreach."¹³ "Notable 2016 pledges included the creation of the BabyWASH Coalition, a multi-stakeholder platform to intensify the focus on integrating programmes for children and their caretakers in the first 1,000 days of life. This coalition, launched by World Vision International, WaterAid, FHI360, WHO, UNICEF and Action Against Hunger, is committed to action, bringing together nearly 30 partners from different PMNCH constituencies in a common effort to advocate for and facilitate integration through programme guidance."¹⁴ "In 2016, PMNCH aligned and coordinated a major advocacy effort across partners, including a letter to Japan's Prime Minister Shinzō Abe with 192 signatories, that helped to convince the G7 to include

⁵ PMNCH (2016) 'Coming of age in a time of transition' PMNCH 2016 Annual Report

⁶ PMNCH (2017) 'A partnership on the move' PMNCH 2017 Annual Report

⁷ PMNCH (2016) 'Coming of age in a time of transition' PMNCH 2016 Annual Report

⁸ PMNCH (2019) 2018-2020 Results Framework

⁹ PMNCH (2019) 2018-2020 Results Framework

¹⁰ PMNCH (2019) 2018-2020 Results Framework

¹¹ PMNCH (2019) 2018-2020 Results Framework

¹² BMJ (2018) [Making multisectoral collaboration work](http://www.bmj.com/multisectoral-collaboration)

¹³ PMNCH (2016) 'Coming of age in a time of transition' PMNCH 2016 Annual Report

¹⁴ PMNCH (2016) 'Coming of age in a time of transition' PMNCH 2016 Annual Report

Function area	
	a section on prioritizing women's, children's and adolescents' health in its final communiqué in 2016."¹⁵ • 2016: "A side event co-hosted by the Partnership and its members at the Global Fund's 5th Replenishment Conference addressed the challenges to improving women's, children's and adolescents' health and survival in fragile contexts and humanitarian crises. At a side event of the 135th Inter-Parliamentary Union (IPU) Assembly, co-hosted by the Partnership, IPU and WHO, parliamentarians discussed how they could leverage their core functions to ensure effective emergency responses and continuity of care for women, children and adolescents in humanitarian and fragile settings, including migration crises."¹⁶ • 2016: "The World Prematurity Day advocacy group's efforts aligned action by over 50 partners that led to 224 buildings being lit with messages and 130 events in 60 countries, Facebook reach of 2.3 million engaging 131,600 users, 38,683 thousand Twitter tweets—including from 6 celebrities—with 247,333,400 impressions, 62,000 profile pictures changed to include Twibbons and 2,100 thunderclap users."¹⁷ • 2016: "Efforts by the stillbirths advocacy working group resulted in the inclusion of stillbirth as an indicator in the Global Strategy monitoring framework and in a recommendation concerning stillbirths in the IAP's report. The Partnership ensured that voices of parents who have experienced a stillbirth were heard at its events during the UN General Assembly, the World Health Assembly and Women Deliver, among others."¹⁸ • 2018: 'The 4th Partners' Forum, convened by PMNCH and the Government of India in New Delhi on 12-13 December 2018.¹⁹ This included the young journalists programme (sponsored by PMNCH in collaboration with the ICFJ) bringing 30 journalists from around the world to New Delhi for the two-day event.²⁰ • 2018-19: SRHR advocates/partners, led by PMNCH, developed a Call to Action on Sexual and Reproductive Health Rights as an essential element to achieving Universal Health Coverage.²¹
Accountability	• "In 2016, the Partnership worked with WHO to provide critical inputs into the Indicator and Monitoring Framework for the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).¹⁷ This report outlines how the Global Strategy's Survive, Thrive and Transform objectives and targets will be monitored, and highlights key challenges in strengthening the collection and use of strategic information to ensure "data for action" and accountability at all levels. Significantly, there is an indicator on stillbirths, which is missing from the SDG indicators and for which many PMNCH members advocated strongly."²² • 2017: "PMNCH, WHO and the International Initiative for Impact Evaluation launch an evidence map of social, behavioural and community engagement interventions relating to reproductive, maternal, newborn and child health, including a report and an interactive online tool. The evidence map is a first step towards ensuring decision-makers have access to information on the effectiveness of these interventions, and it helps pinpoint where new research investments can achieve the greatest impact."²³ • 2017: "PMNCH developed and published the first progress report on the implementation of the updated Global Strategy, which spans 2016–2030."²⁴ • "The 2017 Global Strategy progress report is intrinsically linked to data housed on the WHO Global Health Observatory website's Global Strategy data portal,⁷ an open-access online site launched in May 2017 to report progress on the 60 Global Strategy indicators – another significant monitoring milestone. The portal offers public access to the latest approved data and estimates for all countries where data are available, and for all the Global Strategy indicators. Through dissemination of data from the Global Health Observatory, PMNCH will support greater partner knowledge and action."²⁵ • 2017: "PMNCH has led the tracking and analysis of commitments made by stakeholders to the Global Strategy since the launch of the first Global Strategy in 2010. Chapter 2 of the 2017 progress report gives an overview of the commitments pledged, progress on implementation, and the efforts made

¹⁵ PMNCH (2016) 'Coming of age in a time of transition' PMNCH 2016 Annual Report

¹⁶ PMNCH (2016) 'Coming of age in a time of transition' PMNCH 2016 Annual Report

¹⁷ PMNCH (2016) 'Coming of age in a time of transition' PMNCH 2016 Annual Report

¹⁸ PMNCH (2016) 'Coming of age in a time of transition' PMNCH 2016 Annual Report

¹⁹ PMNCH (2019) 2018-2020 Results Framework

²⁰ PMNCH (2019) 2018-2020 Results Framework

²¹ PMNCH (2019) 2018-2020 Results Framework

²² PMNCH (2016) 'Coming of age in a time of transition' PMNCH 2016 Annual Report

²³ PMNCH (2017) 'A partnership on the move' PMNCH 2017 Annual Report

²⁴ "Progress in partnership – 2017"

²⁵ PMNCH (2017) 'A partnership on the move' PMNCH 2017 Annual Report

Function area	
	by partners at country, regional and global levels. Since 2010, more than US\$ 45 billion of committed money has been disbursed to target a wide range of needs, including midwifery training; improved nutrition for women, children and adolescents; community counselling and education; and improved water and sanitation.”²⁶ • 2018-19: Aligned reporting between H6, Countdown, IAP and PMNCH, resulting in for 2020, a Global Strategy Progress Report developed and launched during WHA 2020, and a joint BMJ series on key issues launched in January 2020 at the Prince Mahidol Award Conference (PMAC).²⁷ • 2018-19: Coordination of the PMNCH Accountability Breakfast at UNGA with 300 participants.²⁸ • 2018-19: EWEC Commitments: (i) Tracked EWEC commitments and its report launched during the Accountability Breakfast and, (ii) conducted deep dive analysis on humanitarian and fragile settings and on adolescents also launched at the PMNCH Accountability Breakfast, (iii) analysed commitments for the small and sick newborns’ report that was launched at the Partners’ Forum.²⁹ • 2018-19: Established and co-chaired the PMNCH Countdown Joint Financial Tracking Working Group.³⁰ • 2018: Co-organised the PMNCH and Citizens Led Accountability Coalition (CLAC) Social Accountability Symposium in advance of the Partners’ Forum, December 2018.³¹
Focus areas	
Workstream 1: Early Childhood Development	• 2017: “Developing a nurturing care framework for early childhood development: PMNCH establishes an advocacy working group and initiates global consultations on a nurturing care framework to scale up action on early childhood development in countries. The framework, due to be launched at the World Health Assembly in 2018, will serve as a guide for policymakers, programme managers and other relevant stakeholders to prioritize and invest in policies and services that enable young children to reach their full potential.”³² • 2018-2019:³³ • Supported the development of the Nurturing Care Framework (NCF), synthesizing latest evidence and agreed action; • Supported the development of a Nurturing Care Toolkit with resources to help dissemination of the NCF; • Supported the Nurturing Care Coordinating Team technically and administratively; • Provided inputs to the Nurturing Care Concept note detailing the way forward for implementation of the Framework; • Established a Twitter Account #Nurturing Care in October 2018. 40 followers as of December 2018, nearly 70 Tweets; • Organised or participated in events to encourage attention to ECD and implementation of the Nurturing Care Framework; • Disseminated the first ever ECD country profiles at the NCF launch and on the nurturing-care website; • Developed two case studies on improvements to ECD through cross-sectoral action, which were launched and disseminated at the Partners’ Forum (Chile and Germany); • Developed three mini case studies on how multisectoral collaborations have supported child outcomes, published as part of an eBook in December 2018; and • Provided technical support to the development of a brief on ending violence in early childhood for Know Violence in Childhood.
Workstream 2: Adolescents’	• “Initiating the development of a youth-led advocacy toolkit for action at national level, reviewed by members in seven countries and the broader AY constituency platform.”³⁴ • “Exploiting opportunities to advocate for the visibility of adolescent health at high-level events at regional and global levels using the Adolescent Health Knowledge Summary, which was produced by PMNCH in 2016.”³⁵

²⁶ PMNCH (2017) ‘A partnership on the move’ PMNCH 2017 Annual Report

²⁷ PMNCH (2019) 2018-2020 Results Framework

²⁸ PMNCH (2019) 2018-2020 Results Framework

²⁹ PMNCH (2019) 2018-2020 Results Framework

³⁰ PMNCH (2019) 2018-2020 Results Framework

³¹ PMNCH (2019) 2018-2020 Results Framework

³² PMNCH (2017) ‘A partnership on the move’ PMNCH 2017 Annual Report

³³ PMNCH (2019) 2018-2020 Results Framework

³⁴ PMNCH (2016) ‘Coming of age in a time of transition’ PMNCH 2016 Annual Report

³⁵ PMNCH (2016) ‘Coming of age in a time of transition’ PMNCH 2016 Annual Report

Function area	
Health and Well-Being	• “Developing an adolescent-friendly package on the Accelerated Action for Health of Adolescents (AA-HA!) Implementation Guidance, a comic book targeted at 10-14 year olds, tested among adolescents and young people in several countries, with plans to launch it at the World Health Assembly in May 2017.”³⁶ • “Advocating for the inclusion of young people on global multi-stakeholder platforms, including, for example, the Global Financing Facility and Partners in Population and Development.”³⁷ • Sharing evidence: “Examples from 2016 include the publication of PMNCH’s 35th Knowledge Summary, “Act now for adolescents”, which was developed under the guidance of an advisory group of 14 organisations and launched at Women Deliver. This short, user-friendly summary sets out why action on adolescents’ health is important, and why it is needed as a matter of urgency. The Knowledge Summary was accompanied by a brief on adolescent-led accountability, seeking to facilitate meaningful youth engagement in improving adolescent health.”³⁸ • Empowering youth: “PMNCH cosponsors the Global Adolescent Health Conference in Ottawa, which marks the global launches of Global accelerated action for the health of adolescents (AAHA!) and the Advocating for change for adolescents! toolkit, both developed in collaboration with PMNCH’s Adolescent and Youth Constituency. PMNCH subsequently supports youth-led organisations in Cameroon, India, Kenya, Malawi and Nigeria to develop and implement country-specific advocacy toolkits and roadmaps for meaningful youth engagement in relevant national programmes and processes.”³⁹ • “PMNCH’s Adolescent and Youth Constituency develops a mentorship programme (including new guidance materials on mentorship). For the one-year pilot phase, 50 young people are matched with 50 mentors from within PMNCH. The programme is an opportunity for young people to network with the EWEC community, learn about key areas of the Global Strategy, build their leadership capacities and learn new skills.”⁴⁰ • 2017: Advocacy: “Facilitating work on the Nurturing Care Framework for Early Childhood Development: PMNCH, together with the Early Childhood Development Action Network, provided support to WHO and the United Nations Children’s Fund (UNICEF) in the initiation of global, regional and country consultations for the development of a Nurturing Care Framework for Early Childhood Development (ECD). In addition to leading partner engagement, PMNCH also facilitated the establishment of a Nurturing Care Framework Advocacy and Communications Working Group to support the process and ensure a successful launch and country uptake in 2018.” • 2017: “Empowering youth voices: advocating for change for adolescents: PMNCH and Women Deliver produced a practical toolkit for young people to drive advocacy and accountability for improved adolescent health and well-being at subnational and national levels. It was developed in close collaboration with young people and through country, regional and global consultations with AYC members, technical partners and others working in the area of adolescent health and well-being. The toolkit, Advocating for change for adolescents!, provides guidance to youth networks on the design, implementation and monitoring of an effective national advocacy action roadmap on adolescent health and well-being. It aims to encourage meaningful youth engagement and drive positive advocacy and accountability efforts to influence national health plans and policy processes. Although it is designed with a youthful audience in mind, the toolkit is also relevant to civil society groups, government departments, and anyone passionate about adolescent health and well-being and ensuring that young people are included in multi-stakeholder partnerships. Following the international launch, five youth-led organisations received small grants to support the roll-out of the toolkit in their respective countries (Cameroon, India, Kenya, Malawi and Nigeria).”⁴¹ • 2018-2019:⁴² • Updated in new edition and launched at the Partners’ Forum, the global ‘Advocating for change for adolescents’ toolkit; • Developed and launched two case cross-sectoral case studies on adolescent health and wellbeing; • Global Meaningful Adolescent and Youth Engagement Consensus Statement was developed and launched in November 2018 with 35+ partners contributing to its development; to date, the Statement has 170 endorsements representing all ten constituencies;

³⁶ PMNCH (2016) ‘Coming of age in a time of transition’ PMNCH 2016 Annual Report

³⁷ PMNCH (2016) ‘Coming of age in a time of transition’ PMNCH 2016 Annual Report

³⁸ PMNCH (2016) ‘Coming of age in a time of transition’ PMNCH 2016 Annual Report

³⁹ PMNCH (2017) ‘A partnership on the move’ PMNCH 2017 Annual Report

⁴⁰ PMNCH (2017) ‘A partnership on the move’ PMNCH 2017 Annual Report

⁴¹ PMNCH (2017) ‘A partnership on the move’ PMNCH 2017 Annual Report

⁴² PMNCH (2019) 2018-2020 Results Framework

Function area	
	• Adolescents and Youth: Driving Change Brochure developed for virtual and event dissemination including the PMNCH Partners' Forum to showcase PMNCH's portfolio on adolescent health and wellbeing; • A second round of six leadership grants were disbursed to PMNCH AYC Lead Coordinators to enable decision-making on capacity building, advocacy and accountability efforts led by the AYC, as well as necessary preparation and participation in governance meetings and activities in 2018; • PMNCH continues to host the GFF CSO steering committee, which includes two AY representatives. A Youth Addendum was approved as part of the CSO engagement strategy, followed by seven capacity building webinars in English and six capacity building webinars in French and an AY briefing at the Partners' Forum with 30 AY leaders; • Seven AY constituency members played a major role in the GFF workshop and other related events including the DRUM conference in Oslo, November 2018; • Provided financial and technical support to Pre-World Health Assembly (WHA) event organized by the International Federation of Medical Students Association (IFMSA). This was a four-day capacity building training that reached 52 youth participants from around the world, in Geneva in May; • The mentorship programme completed its first pilot year; • Efforts were put in place in 2018 to start developing a virtual resource hub, where 50 AY tools were compiled and shared with the all the AYC members; • The Partners' Forum streamlined meaningful AY engagement in all aspects, including communications/advocacy and programme development; • Supported the capacity-building of national coalitions for youth-led advocacy and accountability, which was key to mobilizing a cohesive youth voice to "unleash the power of young people", as recommended by the Independent Accountability Panel (IAP) in their 2017 report; • Provided support to a national AY Coordinator (Malawi) to strengthen the coordination and engagement of the country's 40 youth organisations and networks, and to enable their meaningful participation in district and national SRMNAH technical committees; and • Adolescent Deep Dive Fact sheet on accountability for EWEC commitments on adolescent health, was launched with the EWEC Commitments report.
Workstream 3: Quality, Equity and Dignity in Services	• "Framework for Quality, Equity and Dignity (QED) for maternal and newborn health: As co-chairs of the Every Newborn Action Plan and Ending Preventable Maternal Mortality joint subcommittee on advocacy, PMNCH, the FCI Programme at Management Sciences for Health, Save the Children and White Ribbon Alliance developed a framework for Quality, Equity and Dignity (QED) for maternal and newborn health. Its purpose is to promote the roles of civil society and nongovernmental organisations, women and health workers in planning and accountability for efforts to improve the quality, equity and dignity of care. This is a starting point for a conversation with broader global and national stakeholders, in order to support and guide advocacy planning and action at the national and subnational levels. The framework attempts to integrate advocacy efforts across the newborn health, maternal health, stillbirth, breastfeeding and midwifery communities."⁴³ • "Quality, equity and dignity: agreeing on a joined-up approach for action: The Network for Improving Quality of Care for Maternal, Newborn and Child Health (the Quality of Care Network) was launched by nine countries, WHO, UNICEF and the United Nations Population Fund (UNFPA) in February 2017."⁴⁴ • 2017: "PMNCH established and is coordinating the Quality, Equity and Dignity (QED) Advocacy Working Group (co-chaired by Save the Children and the White Ribbon Alliance) to support the goals of the Quality of Care Network, and as a broader tent for advocacy around QED issues. One of the Working Group's objectives is to generate and showcase demand from local communities for QED both in the provision of care and in patients' experience of care. It will also equip local communities and national coalitions with messages, advocacy tools and knowledge to help them advocate for improved QED in the context of UHC. Global partners will support country coalitions by developing relevant advocacy materials, as well as by identifying and capitalizing on regional- and global-level opportunities to amplify demand from local communities, including through high-profile campaigns that highlight what women themselves want for their own quality reproductive and maternal care."⁴⁵ • 2018-2019:⁴⁶

⁴³ PMNCH (2016) 'Coming of age in a time of transition' PMNCH 2016 Annual Report

⁴⁴ PMNCH (2017) 'A partnership on the move' PMNCH 2017 Annual Report

⁴⁵ PMNCH (2017) 'A partnership on the move' PMNCH 2017 Annual Report

⁴⁶ PMNCH (2019) 2018-2020 Results Framework

Function area	
	• Developed two case studies on achieving QED through cross-sectoral action (Cambodia and India); • Reviewed the Small and Sick Newborn Report and supported the writing team co-chaired by UNICEF and WHO; • Reviewed the Every Newborn Progress Report 2018 and developed the Executive Summary of the Every Newborn 2018 Progress Report; • Launched the QED country case studies at the Partners' Forum and mobilised consensus to implement Quality of Care Framework; • Coordinated two QED sessions during WHA (500+ participants); • Coordinated QED sessions during the Partners' Forum; • Coordinated the Every Newborn management team and coordinated the Every Newborn Country Implementation team; • Led and co-chaired with UNICEF the Advocacy and Communications Working Group for the report Transforming Care for Small and Sick Newborns; • Commenced development of QED Advocacy toolkit; • Coordinated the dissemination of the 2018 Every Newborn Progress Report to regions and countries and developed a plan for a global launch at UNGA; • Supported 25 International Centre for Journalists (ICJF) journalists during WHA to cover QED, resulting in more than 80 articles on this subject in international publications; • Coordinated the development of the 2019-2020 Every Newborn Results Framework with WHO, UNICEF; donors, HPAs and implementing partners. The Framework was endorsed by the Every Newborn Management Team in November 2018 and is now being implemented; and • Supported the commencement of the work on developing specific QED case studies, with a progress report available by the QED secretariat for 2020.
Workstream 4: Sexual and Reproductive Health and Rights	• 2017 – Advocacy: “Prioritizing sexual and reproductive health and rights: To raise awareness of the need for countries and development partners to prioritize sexual and reproductive health and rights (SRHR), and in response to an uncertain funding situation, a time-bound Ad Hoc Working Group on SRHR was established to suggest activities that the Partnership could focus on in 2017 and 2018.”⁴⁷ • 2017: “Making a case for social, behavioural and community engagement: WHO, the International Initiative for Impact Evaluation and PMNCH launched an evidence map of social, behavioural and community engagement (SBCE) interventions for RMNCH. Effective SBCE interventions empower individuals, families and communities, enable them to contribute to better health and well-being, and are essential to reach the targets of the Global Strategy and the SDGs. The report and interactive online tool show that there is a considerable body of evidence and that much has been learned, but also that significant gaps remain in the evidence base for SBCE interventions.”⁴⁸ • 2017: “Supporting integration of human rights in policies and practice: PMNCH continued to support the integration of human rights in policies and practice in 2017. For example, PMNCH, the Office of the United Nations High Commissioner for Human Rights (OHCHR), Harvard FXB Center for Health and Human Rights, WHO and UNFPA produced the Guide for the judiciary on applying a human rights-based approach to health.²² This is the fourth in a series of reflection guides on the application of human rights-based approaches to sexual and reproductive health, maternal health and under-5 child health.”⁴⁹ • 2018-2019:⁵⁰ • Developed two case studies on supporting SRHR through cross-sectoral action (Malawi and Malaysia); • Developed a synthesis of the evidence and coordinated development of draft 'SRHR: An essential element to achieving UHC – A Call to Action'; • Coordinated a sign-on campaign for the Call to Action advocating for SRHR as a core pillar of UHC – the draft was discussed during one of the concurrent sessions at the Partners' Forum in India) and has since been shared widely (7000) to solicit feedback, comments and signatures (approximately 200 signatories); • Supported the SRHR in UHC working group; • Organised event (200 participants) during WHA to launch the Guttmacher-lancet Commission report on Accelerate Progress on SRHR for All to establish consensus; • Coordinated key sessions during the Partner's Forum; • Developed a draft and coordinated the development of the SRHR in UHC Advocacy Road map;

⁴⁷ PMNCH (2017) 'A partnership on the move' PMNCH 2017 Annual Report

⁴⁸ PMNCH (2017) 'A partnership on the move' PMNCH 2017 Annual Report

⁴⁹ PMNCH (2017) 'A partnership on the move' PMNCH 2017 Annual Report

⁵⁰ PMNCH (2019) 2018-2020 Results Framework

Function area	
	- Disseminated widely the Gutmacher-Lancet Commission recommendations, which include adopting and endorsing a comprehensive package of SRHR interventions to be delivered through UHC schemes and supporting efforts to strengthen health care systems to deliver all essential interventions; - Tracked EVEC commitments earmarked for SRHR; and - Undertaken an analysis to estimate SRMNCH ODA, domestic and private financing (which includes components of SRHR) and processes on how these can be tracked.
Workstream 5: Empowerment of Women, Girls and Communities	"In 2018 PMNCH was named as one of 10 high-scoring organisations by Global Health 50/50, based on a comprehensive review of the gender-related policies of 140 major organisations working in and/or influencing the field of global health."⁵¹ 2018-2019:⁵² - Developed two case studies on Empowerment of Women, Girls and Communities (Guatemala and South Africa); - Synthesised evidence on successful social accountability strategies, practices and frameworks in order to support scale-up for positive and nutrition outcomes and increased empowerment and participations of citizens in health; - Completed contract and concept note related to the IPU handbook for parliamentarians on SRMNCAH issues to promote related budget allocation, legislation and review; - Mobilised consensus to address Social Behaviour and Community Engagement for WCAH by conducting scoping study on SBCE investment case, and widely disseminating An Evidence Map of SBCE interventions for RMNCH co-published with WHO and 3ie; - Coordinated key sessions during the Partners' Forum; - Promoted and discussed the pivotal role of parliamentarians in addressing malnutrition in all its forms through legislative measure during a side event at the 139th Assembly of the IPU in Geneva, as well as at parliamentarians role and renewed commitment to WCAH at regional level in SEARO organised by SEARO (New Delhi, 26-27 July 2018). The meeting resulted in a Declaration signed by all the 11 Parliaments present at the meeting; - Amplified key messaging and mobilised greater commitment for the use of and scaling up of social accountability to improve health outcomes, see weblinks provided above; - Disseminated the SCBE Evidence Gap Map and related research prioritisation; and - Co-organised Social Accountability Symposium (side event at Partners' Forum, India) to increase consensus, amplifying key messaging and increase commitment for the use of and scaling up of social accountability to improve health outcomes.
Workstream 6: Humanitarian and Fragile Settings	2018-2019:⁵³ - Support the commencement of the BRANCH Consortium Consultation on the SRMNCAH+N in Conflict Settings Lancet Series, Dubai, August 2018; - As part of the BMJ Multisectoral Series launched during the Partners' Forum two of the case studies were related to HFS (Afghanistan and Sierra Leone); - Established PMNCH HFS Committee (with representation from the ten PMNCH constituencies, the technical and emergency communities, as well as other sectors) to oversee consultations on options for better coordination mechanisms of WCAH continuum in HFS; - Organised high-level briefing session during the WHA, May 2018 on WCAH in conflict in Muslim majority countries (Lancet article); - Organised key sessions during the Partners' Forum; and - Analysis of EVEC Commitments with a deep dive analysis on HFS related commitments developed and launched during the Accountability Breakfast, September 2018 in New York.

⁵¹ GlobalHlth5050 (2018) The Global Health 50/50 Report: How gender-responsive are the world's most influential global health organisations?

⁵² PMNCH (2019) 2018-2020 Results Framework

⁵³ PMNCH (2019) 2018-2020 Results Framework

Appendix G ANALYSIS OF STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS FACING GLOBAL HEALTH PARTNERSHIPS

This Appendix describes the methodology and key findings of a review of key secondary documentation (including recent evaluations and reviews – see Appendix A for the Bibliography) on the strengths, weaknesses, opportunities and threats (SWOT) facing global health partnerships (GHPs).

G.1. METHODOLOGY

A landscape literature review was conducted, focused on PubMed and Google Scholar searches as well as websites of key global health organisations. Table G.1 outlines the search criteria used in the review. Searches were primarily limited to articles published after 2010, though the team explored any relevant citations that extended beyond this time period.

Table G.1: Search criteria used in landscape review

Source	Search criteria	Results
Google Scholar	“global health partnerships” evaluation review <i>Articles published after 2010</i>	1280
	“global public private health partnerships” <i>Articles published after 2010</i>	304
	GHPs review evaluation <i>Articles published after 2010</i>	1080
	“global health initiatives” review evaluation <i>Articles published after 2010</i>	4530
PubMed	("global health partnerships") AND ("2014"[Date - Publication]: "3000"[Date - Publication])	38
GHP websites	Scaling Up Nutrition (SUN)	
	Gavi, the Vaccine Alliance	
	Roll Back Malaria	
	Stop TB Partnership	
	Gavi, the Vaccine Alliance	
	Global Fund	
	Scaling Up Nutrition	
	Global Financing Facility	
	UHC2030	
	Every Woman Every Child	
	Women Deliver	

**We reviewed the abstracts and included all relevant papers in our detailed review. Studies were excluded based on factors including being considered out of scope for this evaluation.*

G.2. LIMITATIONS AND MITIGATING FACTORS

Although extensive, the methodology for this literature review has its limitations. Where feasible, this analysis provides additional references to address these issues and increase the standard of verification.

- GHPs vary considerably and most evaluations have focused on GHPs that are financing mechanisms or private public partnerships (PPPs), very different in size and structure to the Partnership for Maternal, Newborn and Child Health (PMNCH).
- The most relevant literature is often not recent, which limits the ability for a literature review to accurately reflect recent developments.
- There are inherent challenges in evaluating the outcomes of partnerships and attributing cause and effect. Additionally, there was a lack of opportunity to validate some of the findings with other data sources, such as key informant interviews (KIIs) (given time and budget limitations and this would have been outside the scope of the evaluation), as well as to compare PMNCH financial and institutional arrangements to other GHPs operating in similar areas. As such, the SWOT analysis did not look deeply into the organisational arrangements of different GHPs.
- Some key sources used in this analysis have limitations.

Acknowledging these limitations, the SWOT analysis applied the methodology described in the Inception Report. Where possible in the main report, the findings have been corroborated with other data sources including KIIs, the Partnership e-based open enquiry and the social network analysis (SNA).

G.3. EMERGENCE AND GROWTH OF GHPs

The global health architecture has adjusted markedly since the early 1990s.⁵⁴ At that time, it was generally controlled by large donor countries and multilateral organisations, such as the World Bank.⁵⁵ Since then, the private sector has grown into a more prominent role in global health.⁵⁶

With rapid growth between 1998 and 2002, GHPs emerged as an important tool to bypass barriers to drug access “through improved cooperation between the public and private sectors”.⁵⁷ GHPs have continued to grow in the 21st century and have become a significant force in global health, aided by “the availability of unprecedented resources, largely precipitated by the Bill and Melinda Gates Foundation.”⁵⁸

GHPs exist today as diverse entities. Some are financing mechanisms, such as the Global Fund, some are PPPs intended to develop new drugs and products, and others are global health initiatives or partnerships, such as PMNCH. They range in terms of size, budget and have independent, but sometimes overlapping, missions. For example, PMNCH, Every Woman Every Child (EWEC), and UHC2030 have similar goals regarding the advancement of women’s and children’s health.

There is discussion among academics on the objectives of GHPs and their role in the wider global health landscape. Leading academics, such as Kent Buse and Sonja Tanaka, relate the continued growth of GHPs to recognition of the scale and complexity of global issues, paired with disappointment in the current structures designed to tackle such large-scale problems such as global health.⁵⁹ GHPs offer a different approach to addressing global health outcomes that may help alleviate these concerns.

⁵⁴ Buse and Tanaka (2011) [Global public-private health partnerships: lessons learned from ten years of experience and evaluation](#)

⁵⁵ Ruckert and Labonté (2014) [Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly](#)

⁵⁶ Ibid

⁵⁷ Buse and Walt (2000) [Global Public-Private Partnerships: Part I – A New Development in Health?](#)

⁵⁸ Buse and Tanaka (2011) [Global public-private health partnerships: lessons learned from ten years of experience and evaluation](#)

⁵⁹ Ibid

With GHPs present in the world of global health, attention has turned to the impacts such partnerships have had on health outcomes, as well as on global health and recipient country governance. There is a need for GHPs to demonstrate their ‘added value’, particularly for those with overlapping missions, and to ensure they are operating effectively in a context of increasing funding constraints and an evolving global health agenda.

G.4. FINDINGS

Existing evaluations have identified a set of outcomes from GHP interventions, with varied levels of verification. The outcomes suggested below are largely sourced from studies that draw on evaluations from a range of GHPs and report strengths that are broadly applicable. Points in this section reference multiple sources where possible to verify the claims.

Strengths

Raising the global profile of disease, improving country health policy, stimulating Research and Development (R&D), and contributing to technical and financial protocols are some of the key successes of GHPs. This set of strengths can be split into programming outcomes and resource mobilisation, as outlined below.

Programming and delivery

- “Individual GHPs are seen overall as having a positive impact in terms of achieving their own objectives and being welcomed by countries”, including India, Uganda and Sierra Leone.⁶⁰ Being welcomed is positive but perhaps unsurprising given countries are unlikely to decline additional funding.
- “GHPs have improved national health policy making through institutional reforms and health system strengthening”⁶¹. There are examples of this in Botswana, Sri Lanka, Uganda and Zambia.^{62 63}
- GHPs have contributed “to establishing norms and standards in treatment protocols, technical management and financial strategies.”⁶⁴ Most partnerships studied by Druce and Harmer (2004) added value in establishing norms and standardisation, including RBM, Stop TB, and Gavi.^{65,66}

Resource mobilisation

- GHPs have helped give rise to “the availability of unprecedented resources, largely precipitated by the Bill and Melinda Gates Foundation”, as well as DFID funding to the Global Fund, Gavi and others.⁶⁷ Funding data confirms the significance of additional resources through GHPs.⁶⁸
- “GHPs have stimulated new R&D in neglected areas and facilitated access to vaccinations, with more than 50 vaccines and 25 drugs manufactured or in development to address disease”.⁶⁹ Several studies on GHPs provide examples of effective R&D initiatives with tangible impacts.^{70, 71, 72,73}

⁶⁰ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

⁶¹ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

⁶² Caines and Lush (2004) Impact of Public-Private Partnerships addressing Access to Pharmaceuticals in Selected Low- and Middle-Income Countries: A Synthesis Report from Studies in Botswana, Sri Lanka, Uganda, and Zambia

⁶³ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

⁶⁴ Ibid

⁶⁵ Druce and Harmer (2004) The Determinants of Effectiveness: Partnerships that Deliver Review of the GHP and ‘Business’ Literature

⁶⁶ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

⁶⁷ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

⁶⁸ Nishtar (2004) Public-Private ‘Partnerships’ in Health – A Global Call to Action

⁶⁹ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

⁷⁰ Kickbusch and Quick (1998) Partnerships for Health in the 21st Century

⁷¹ Khawaja et al (2012) Evaluating the Health Impact of a Public-Private Partnership: To Reduce Rotavirus Disease in Nicaragua

⁷² Binagwaho et al (2012) Achieving High Coverage in Rwanda’s National Human Papillomavirus Vaccination Programme

⁷³ McKinsey and Company (2005) Building Effective Public Private Partnerships: Lessons Learned from the Jordan Education Initiative

- There has been some progress toward implementing principles of the Paris Declaration on Aid Effectiveness. For example, there have been increases in aid recorded on government budget and multiyear commitments.⁷⁴
- GHPs have helped satisfy the “need to accelerate the development, production and distribution of products to meet health needs of the poor.”⁷⁵

Table G.3 showcases the successes of GHPs portrayed in the literature.

Weaknesses

From the literature, it appears that the most challenging concerns for GHPs occur at the country level, with specific examples offered in India, Uganda and Sierra Leone.⁷⁶ These often relate to poor evaluation frameworks, overlapping jurisdictions, and under-representation of country governments. The main, macro-level issues include governance and accountability, sustainability of financing, transparency, and the inflation of private-sector influence, as further explored below.

Vision and mission

- Previous evaluations have found “weak strategic planning and/or lack of an overarching partnership strategy” across several GHPs,⁷⁷ including the Global Fund⁷⁸, IAVI⁷⁹, Gavi⁸⁰, StopTB⁸¹, the Global Alliance for the Elimination of Leprosy (GAEL)⁸² and the International Partnership for Microbicides (IPM).⁸³
- Partnerships such as the Global Fund and SUN have suffered from overlapping mandates and duplication, and progress to address issues of coherence and coordination has been slow.⁸⁴ Within the context of EWEC and other GHPs, Colenso (2017) indicates that EWEC entities often overlap and the many additional global health initiatives further complicates the issue.⁸⁵
- Structurally, there is “segmentation of health financing, with the emergence of disease silos in GHPs”.⁸⁶ Several studies, including Stuckler et al. (2011) and Nishtar (2004), have explored the distribution of global health financing and find this result.^{87,88} Recently, this has become less of an issue as GHPs take on broader portfolios. For example, the Global Fund shifted from initial focus of Aids, Tuberculosis, and Malaria to also fund health system strengthening and community systems strengthening.⁸⁹

Governance

- Partnerships often have “poorly defined roles and responsibilities of partners”.⁹⁰ A 2011 review by Buse and Tanaka found Roll Back Malaria (RBM), the Global Fund, Gavi, Medicines for Malaria Venture (MMV) and

⁷⁴ Shorten et al. (2012) The International Health Partnership Plus: Rhetoric or Real Change? Results of a Self-reported Survey in the Context of the 4th High Level Forum on Aid Effectiveness in Busan

⁷⁵ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

⁷⁶ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

⁷⁷ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

⁷⁸ Richter (2004) Public-private partnerships for health: A trend with no alternatives?

⁷⁹ Dalberg (2009) Independent evaluation of the Roll Back Malaria Partnership 2004-2008

⁸⁰ Sherry et al. (2009) The five-year evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria Synthesis of Study Areas 1, 2 and 3

⁸¹ Druce et al. (2009) Evaluation of the International AIDS Vaccine Initiative 2003-2007

⁸² McKinsey & Company (2008) Independent evaluation of the Stop TB Partnership

⁸³ Fairlamb et al. (2005) Independent review of Medicines for Malaria Venture

⁸⁴ Colenso (2017) Improving alignment among core partners of Every Woman Every Child

⁸⁵ Mokoro (2015) Independent Comprehensive Evaluation of the Scaling Up Nutrition Movement

⁸⁶ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

⁸⁷ Stuckler et al. (2011) Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest be Addressed?

⁸⁸ Nishtar (2004) Public-Private ‘Partnerships’ in Health – A Global Call to Action

⁸⁹ The Global Fund (2019)

⁹⁰ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

GAEL all experienced this. For example, partnership effectiveness in Gavi has been characterized by a shared sense of purpose, trust and commitment as opposed to having a clearly defined structure.⁹¹

Accountability and transparency

- GHPs tend to suffer from “weak partnership performance evaluation framework, accountability mechanisms...[and] transparency of governance”.⁹² Shorten et al. (2012), in their International Health Partnership Plus (IHP+) review, note that there is a lack of progress in integrating performance reporting frameworks for GHPs, including Gavi, and the Global Fund.⁹³
- Mokoro (2015) finds that SUN lacks clarity in its common results framework and would benefit from better integration of lessons learned from previous activities.
- In the context of GHPs similar to PMNCH, Mokoro (2015) and Colenso (2017) indicate that the issue of poor monitoring and evaluation frameworks extends to SUN and EWEC. Mokoro’s SUN review outlines that the SUN evaluation framework is too subjective and not rigorous enough, while Colenso indicates that EWEC has too many accountability mechanisms lacking purpose and value.^{94,95}

Country engagement

- “Poor harmonisation has led to considerable duplication...and little alignment between recipient countries’ and GHP financial management systems”.⁹⁶ There are many studies, including those by McKinsey and Company (2005), Casper (2004), and Conway et al. (2006) that report similar findings.^{97,98,99,100}

The private-sector influence

- Several studies report poor GHP Board representation of low- and middle-income countries, and an inflated influence of private sector actors.¹⁰¹ The Mectizan Donation Program, Stop TB and Gavi are three examples of GHPs that have failed to involve both public and private sector actors on their decision-making bodies. Multiple synthesis studies report a similar issue.^{102,103}

Table G.2 provides an overview of the main challenges facing GHPs.

Opportunities

Buse and Tanaka (2011) and Caines et al. (2004) reported some positive lessons and opportunities for GHPs. The lessons include ensuring GHP programming goals are simple and compelling, with a clearly defined scope; including country partners in decision-making processes; and having robust governance and accountability mechanisms.

⁹¹ Chee et al (2008) Evaluation of the GAVI Phase 1 Performance (2000-2005)

⁹² Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

⁹³ Shorten et al. (2012) The International Health Partnership Plus: Rhetoric or Real Change? Results of a Self-reported Survey in the Context of the 4th High Level Forum on Aid Effectiveness in Busan

⁹⁴ Mokoro (2015) Independent Comprehensive Evaluation of the Scaling Up Nutrition Movement

⁹⁵ Colenso (2017) Improving alignment among core partners of Every Woman Every Child

⁹⁶ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

⁹⁷ McKinsey and Company (2005) Building Effective Public Private Partnerships: Lessons Learned from the Jordan Education Initiative

⁹⁸ Casper (2004) Updated Discussion Paper on the Core Business Model of a Mature Global Fund

⁹⁹ Carlson (2004) Assessing the Impact of Global Health Partnerships: Country Case Study Report

¹⁰⁰ Conway et al. (2006) Building Better Partnerships for Global Health

¹⁰¹ Overseas Development Institute (2007) Global Health: Making Partnerships Work

¹⁰² Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

¹⁰³ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

Programming and delivery

- Successful GHPs need “a simple and compelling goal, and a clearly defined and focused scope (disease, geography, population, activities).”^{104,105}
- “Partnerships must define their value proposition not only by ambitious goals, but by their distinctive contribution and comparative advantage in reaching those goals.”¹⁰⁶
- Impactful partnerships include “implementation of capacity-building strategies, technical assistance and resources.”¹⁰⁷
- Partnerships must plan for and implement sustainability using the political decisions, policy resources and administrative inputs in place.¹⁰⁸

Governance and accountability

- Successful alliances must be mutually beneficial. A significant barrier to successful collaboration is a lack of understanding or appreciation of the pressures and incentives faced by different partners.¹⁰⁹
- “Processes to select board members should be transparent, fair and inclusive, with explicit selection criteria based on an agreed balance of diversity and expertise.”¹¹⁰
- Visionary leadership is required to convene arrays of organisations to work collaboratively.¹¹¹ The GHP review by Caines et al. (2004) determined that effective GHPs can shift public sector mindset for global health outcomes.¹¹² In the context of EWEC, Colenso (2017) adds that securing the influence of the UN Secretary General (UNSG) and Deputy Secretary General is particularly useful for furthering GHP goals.¹¹³
- The majority of GHP outputs should be determined by “mechanisms for measurement of performance against the strategic and operating plans”.¹¹⁴
- GHPs need to address governance issues and the need for rigorous assessment of relevance and impact.¹¹⁵
- Colenso (2017) explicitly mentions the opportunity for EWEC bodies to benefit from greater efficiency and alignment of its functions, institutions and governance.¹¹⁶
- “As GHPs mature, and their portfolios and partnerships grow, professional management structures and strategies become increasingly critical to optimise partnership performance, monitoring and accountability.”¹¹⁷
- Transparency is necessary to attract donor support in resource-competitive environments, combat duplication, and highlight operational gaps.¹¹⁸

¹⁰⁴ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹⁰⁵ McKinsey & Company (2002) Developing Successful Global Health Alliances

¹⁰⁶ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

¹⁰⁷ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹⁰⁸ Ibid

¹⁰⁹ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

¹¹⁰ Ibid

¹¹¹ Ibid

¹¹² Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹¹³ Colenso (2017) Improving alignment among core partners of Every Woman Every Child

¹¹⁴ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹¹⁵ Ibid

¹¹⁶ Colenso (2017) Improving alignment among core partners of Every Woman Every Child

¹¹⁷ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

¹¹⁸ Ibid

- A formal system of accountability of partners – including work plans, deadlines, deliverables, and sanctions for non-performance – is increasingly important as GHPs move from loose arrangements into durable, strategic partnerships.¹¹⁹

Partner and country engagement

- Involving development partners, government and others in-country actively is seen as critical success factors of African Programme for Onchocerciasis Control (APOC), Onchocerciasis Control Programme (OCP), the Global Polio Eradication Initiative (GPEI), Gavi (and STOP TB in India).¹²⁰
- It is critical for GHPs to better understand their interaction with health systems at national and local levels, and how this interaction affects their ability to improve health outcomes more effectively and efficiently.¹²¹
- “GHPs should pursue strategies for harmonisation and integration both with national systems and with each other”.¹²²

Table G.4 showcases the key lessons and opportunities for GHPs moving forward.

Threats

According to the literature, the threats that GHPs face in the future will be precipitated by their existing weaknesses and the changing global health landscape. Financial sustainability; representation and alignment; and engaging effectively with countries will be the key challenges to address.

High transaction costs

- “Evaluation studies have raised concern over the high transaction costs and financial sustainability of the GHP approach for partners and countries”.¹²³

Representation and alignment

- According to Ruckert and Labonté (2014), GHPs have achieved positions of seniority within Global Health Governance to the detriment of other traditional actors, notably national ministries of health, which have declined in importance and lost financial support.¹²⁴ A study by Ravishankar et al. (2009) found that, between 1990 and 2007, the proportion of development assistance for health funding increasingly came from the Global Fund and Gavi in place of UN agencies and development banks.¹²⁵
- “Powerful GHPs operate in parallel to many multilateral organisations and directly compete for donor attention and resources. Global Health Governance has thus become more fragmented, uncoordinated and donor-driven.” The Global Fund, MAP international, and the US President’s Emergency Plan for AIDS Relief (PEPFAR) are examples of GHPs that have proven to distort national priorities by imposing donor implementation conditions.¹²⁶

Country engagement

- “Non-alignment between GHPs and recipient governments’ existing mechanisms and policies may undermine the effectiveness of global health programming.”¹²⁷ For example, some GHPs (e.g. Gavi) have

¹¹⁹ Ibid

¹²⁰ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹²¹ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

¹²² Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹²³ Ibid

¹²⁴ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

¹²⁵ Ravishankar et al (2009) Financing of global health: tracking development assistance for health from 1990 to 2007

¹²⁶ Biesma et al. (2009) The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control

¹²⁷ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

specific medicine bulk-buying requirements, which have increased the cost of medicines for developing countries and reduced public bulk-buying powers.¹²⁸

These threats are summarised alongside other challenges facing GHPs in Table G.2.

¹²⁸ Carlson (2004) Assessing the impact of global health partnerships: country case study report

G.4.1. Main findings identified in the literature, not specific to PMNCH

Challenges

This section provides a summary of the main challenges that the GHP literature have identified.

Table G.2: GHP Challenges

Key finding	Source	Method
Previous evaluations have found “weak strategic planning and/or lack of an overarching partnership strategy” across several GHPs, including GFATM, IAVI, Gavi, Stop TB, GAEL and IPM. ¹²⁹	<i>Buse and Tanaka (2011) “Global public-private health partnerships: lessons learned from ten years of experience and evaluation”</i>	Review and synthesis of eight independent evaluations concerning the role, structure and operations of GHPs.
GHPs tend to suffer from “weak partnership performance evaluation framework, accountability mechanisms...[and] transparency of governance”. ¹³⁰		
Partnerships often have “poorly defined roles and responsibilities of partners”. ¹³¹		
There is a “specific need for GHPs to tighten the focus on securing pro-poor and gender related objectives” as private providers with profit motives have reduced pro-poor targeting. ^{132 133}	<i>Caines et al. (2004) “Assessing the Impact of Global Health Partnerships”</i>	Assessment based off existing evaluations of GHPs and three country studies in India, Sierra Leone and Uganda
“Evaluation studies have raised concern over the high transaction costs and financial sustainability of the GHP approach for partners and countries”. ¹³⁴		
GHPs have achieved positions of seniority within Global Health Governance to the detriment of other traditional actors, notably national ministries of health, which have declined in importance and lost financial support. ¹³⁵	<i>Ruckert and Labonté (2014) “Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly”</i>	Study provides review of existing qualitative and quantitative literature,

¹²⁹ Buse and Tanaka (2011) [Global public-private health partnerships: lessons learned from ten years of experience and evaluation](#)

¹³⁰ Buse and Tanaka (2011) [Global public-private health partnerships: lessons learned from ten years of experience and evaluation](#)

¹³¹ Buse and Tanaka (2011) [Global public-private health partnerships: lessons learned from ten years of experience and evaluation](#)

¹³² Caines et al. (2004) [Assessing the Impact of Global Health Partnerships](#)

¹³³ Malmberg et al. (2006) [Can Public-Private Collaboration Promote Tuberculosis Case Detection among the Poor and Vulnerable?](#)

¹³⁴ Caines et al. (2004) [Assessing the Impact of Global Health Partnerships](#)

¹³⁵ Ruckert and Labonté (2014) [Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly](#)

Key finding	Source	Method
“Powerful GHPs operate in parallel to many multilateral organisations and directly compete for donor attention and resources. Global Health Governance has thus become more fragmented, uncoordinated and donor-driven.” “Poor harmonisation has led to considerable duplication...and little alignment between recipient countries’ and GHP financial management systems”.^{136 137 138} “Non-alignment between GHPs and recipient governments’ existing mechanisms and policies may undermine the effectiveness of global health programming.”¹³⁹		with an added theoretical component on global governance arrangements
Structurally, there is “growing segmentation of health financing, with the emergence of disease silos in GHPs”. ^{140 141}	<i>Stuckler et al. (2011) “Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest be Addressed?”</i>	Study explores relationships between tax-exempt foundations and for-profit corporations using a case study of five large private global health foundations.
Health system strengthening suffers when “aggregate donor commitments do not match the rhetoric surrounding the issue”. ¹⁴²	<i>Hafner and Shiffman (2013) “The Emergence of Global Attention to Health Systems Strengthening”</i>	Using qualitative methods, the authors construct a case history and analyse the issues affecting global political attention for health systems strengthening.
Several studies report poor GHP Board representation of low- and middle-income countries, and an inflated influence of private sector actors. ¹⁴³	<i>Overseas Development Institute (2007) “Global Health: Making Partnerships Work”</i>	Analysis of board members and their affiliations in 23 GHPs

¹³⁶ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

¹³⁷ McKinsey and Company (2005) Building Effective Public Private Partnerships: Lessons Learned from the Jordan Education Initiative

¹³⁸ Casper (2004) Updated Discussion Paper on the Core Business Model of a Mature Global Fund

¹³⁹ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

¹⁴⁰ Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

¹⁴¹ Stuckler et al. (2011) Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest be Addressed?

¹⁴² Hafner and Shiffman (2013) The Emergence of Global Attention to Health Systems Strengthening

¹⁴³ Overseas Development Institute (2007) Global Health: Making Partnerships Work

Successes

This section tables a summary of successes resulting from GHP interventions.

Table G.3: GHP Successes

Key finding	Source	Method
“Key areas of success have been raising the profile of disease, mobilising commitment and funding, accelerating progress, and leading innovation” ¹⁴⁴	<i>Caines et al. (2004) “Assessing the Impact of Global Health Partnerships”</i>	Assessment based off existing evaluations of GHPs and three country studies in India, Sierra Leone and Uganda.
“Individual GHPs are seen overall as having a positive impact in terms of achieving their own objectives and being welcomed by countries studied.” ¹⁴⁵		
“GHPs have improved national health policy making through institutional reforms and health system strengthening” ^{146 147 148}	<i>Caines and Lush (2004) Impact of Public-Private Partnerships addressing Access to Pharmaceuticals in Selected Low- and Middle-Income Countries: A Synthesis Report from Studies in Botswana, Sri Lanka, Uganda, and Zambia</i>	50+ interviews with government and other stakeholders from Botswana, Sri Lanka, Uganda, and Zambia
GHPs have contributed “to establishing norms and standards in treatment protocols, technical management and financial strategies.” ^{149 150 151}	<i>Druce and Harmer (2004) The Determinants of Effectiveness: Partnerships that Deliver Review of the GHP and ‘Business’ Literature</i>	Two literature reviews aiming to synthesise evidence for determinants of effective partnerships from GHP evaluation and wider business and political science literatures

¹⁴⁴ Caines et al. (2004) [Assessing the Impact of Global Health Partnerships](#)

¹⁴⁵ Caines et al. (2004) [Assessing the Impact of Global Health Partnerships](#)

¹⁴⁶ Ruckert and Labonté (2014) [Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly](#)

¹⁴⁷ Caines and Lush (2004) [Impact of Public-Private Partnerships addressing Access to Pharmaceuticals in Selected Low- and Middle-Income Countries: A Synthesis Report from Studies in Botswana, Sri Lanka, Uganda, and Zambia](#)

¹⁴⁸ Ruckert and Labonté (2014) [Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly](#)

¹⁴⁹ Ruckert and Labonté (2014) [Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly](#)

¹⁵⁰ Druce and Harmer (2004) [The Determinants of Effectiveness: Partnerships that Deliver Review of the GHP and ‘Business’ Literature](#)

¹⁵¹ Ruckert and Labonté (2014) [Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly](#)

Key finding	Source	Method
“GHPs have stimulated new R&D in neglected areas and facilitated access to vaccinations, with more than 50 vaccines and 25 drugs manufactured or in development to address disease”. ¹⁵² Several studies on GHPs provide examples of effective R&D initiatives with tangible impacts. ^{153 154 155 156}	<i>Kickbusch and Quick (1998) Partnerships for Health in the 21st Century</i>	Results of WHO working group aiming to clarify the nature of partnerships for health, categorize GHPs and outline principles
There has been progress toward implementing principles of Paris Declaration on Aid Effectiveness, e.g. increases in aid recorded on government budget and multiyear commitments. ¹⁵⁷	<i>Shorten et al. (2012) “The International Health Partnership Plus: Rhetoric or Real Change?”</i>	Monitored commitments using framework with measures for partners and country governments via a survey
“Visionary leadership to convene arrays of organisations to work collaboratively”. ¹⁵⁸ Caines et al. (2004) review mirrored the view that effective GHPs can shift public sector mindset for global health outcomes. ¹⁵⁹	<i>Buse and Tanaka (2011) “Global public-private health partnerships: lessons learned from ten years of experience and evaluation”</i>	Review and synthesis of eight independent evaluations concerning the role, structure and operations of GHPs.
GHPs have helped precipitate “the availability of unprecedented resources, largely precipitated by the Bill and Melinda Gates Foundation”. ¹⁶⁰ Funding data confirms the significance of additional resources through GHPs. ¹⁶¹		

Lessons

Buse and Tanaka (2011) and Caines et al. (2004) outline a set of initiatives for GHPs to adopt and serve as guiding principles in furthering their operations and ensuring the many potential pitfalls are avoided. These lessons serve as a summary of GHP issues and many equally pertain to PMNCH. They are largely sourced from the previously mentioned authors and their sources, as the two papers each provide syntheses of existing evaluations.

Table G.4: GHP Opportunities for Learning

Buse and Tanaka (2011) – Lessons for GHP Practice	Caines et al. (2004) – Determinants of [GHP] Effectiveness
“ <u>Identify and play to the Partnership’s comparative advantage</u> : partnerships must define their value proposition not only by ambitious goals, but by their distinctive contribution and comparative advantage in reaching those goals.	“ <u>A simple and compelling goal, and a clearly defined and focused scope</u> (disease, geography, population, activities) ... [are] two prerequisites for partnership success”. ¹⁶²¹⁶³
“ <u>Practice good management</u> : as GHPs mature, and their portfolios and partnerships grow, professional management structures and strategies become increasingly critical to optimise partnership performance, monitoring and accountability.”	“Mechanisms for <u>measurement of performance</u> against the strategic and operating plans” is a determinant of the majority of GHP outputs. ¹⁶⁴
“ <u>Practice good governance</u> : representation, transparency and accountability represent evolving challenges and highlight why good governance is essential to the sustained impact of GHPs.”	“Means to <u>involve development partners</u> , government and others in-country actively were seen as critical success factors of APOC, OCP, GPEI, Gavi (and STOP TB in India).” ¹⁶⁵

“Prioritize representation: Processes to select board members should be transparent, fair and inclusive, with explicit selection criteria based on an agreed balance of diversity and expertise.”

“Determinants [of indicators of impact] include implementation of capacity-building strategies, technical assistance and resources.”¹⁶⁶

“Enhance transparency: Transparency is increasingly vital... to attract donor support in resource-competitive environments, ...combat duplication [and] highlight operational gaps.”

“Planning and implementing for sustainability – defined as having the political decisions, policy resources and administrative inputs in place to continue a programme over time – is felt to be a critical determinant of all three aspects of impact.”¹⁶⁷

Be accountable: A formal system of accountability of partners – including work plans, deadlines, deliverables, and sanctions for non-performance – is increasingly important as GHPs move from loose arrangements into durable, strategic partnerships.

“Take into account absorptive capacity and...HR and financing issues.”

Acknowledge and respect partners’ divergent interests: Successful alliances must be mutually beneficial. A significant barrier to successful collaboration is a lack of understanding or appreciation of the pressures and incentives faced by different partners.

Governance issues and the need for rigorous assessment of relevance and impact need to be addressed.

Ensure operations impact positively on national and local systems: Critical for GHPs to better understand their interaction with health systems, and how this interaction affects their ability to improve health outcomes more effectively and efficiently.

“GHPs should pursue strategies for harmonisation and integration both with national systems and with each other”.

¹⁵² Ruckert and Labonté (2014) Public-Private Partnerships in Global Health: The Good, the Bad, and the Ugly

¹⁵³ Kickbusch and Quick (1998) Partnerships for Health in the 21st Century

¹⁵⁴ Khawaja et al (2012) Evaluating the Health Impact of a Public-Private Partnership: To Reduce Rotavirus Disease in Nicaragua

¹⁵⁵ Binagwaho et al (2012) Achieving High Coverage in Rwanda’s National Human Papillomavirus Vaccination Programme

¹⁵⁶ McKinsey and Company (2005) Building Effective Public Private Partnerships: Lessons Learned from the Jordan Education Initiative

¹⁵⁷ Shorten et al. (2012) The International Health Partnership Plus: Rhetoric or Real Change? Results of a Self-reported Survey in the Context of the 4th High Level Forum on Aid Effectiveness in Busan

¹⁵⁸ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

¹⁵⁹ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹⁶⁰ Buse and Tanaka (2011) Global public-private health partnerships: lessons learned from ten years of experience and evaluation

¹⁶¹ Nishtar (2004) Public-Private ‘Partnerships’ in Health – A Global Call to Action

¹⁶² Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹⁶³ McKinsey & Company (2002) Developing Successful Global Health Alliances

¹⁶⁴ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹⁶⁵ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹⁶⁶ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

¹⁶⁷ Caines et al. (2004) Assessing the Impact of Global Health Partnerships

“More investment in operational research may be required to identify best implementation practices and opportunities for fruitful collaboration across disease programmes.”

Appendix H **FUNDING ANALYSIS**

H.1. INTRODUCTION

We carried out a funding analysis to provide insight on the evaluation questions relating to governance and accountability, as well as impact and the value-for-money of the Partnership for Maternal, Newborn and Child Health (PMNCH). As regards the forward-looking analysis, we conducted a funding analysis to understand PMNCH's donor base and changes in this over time, in order to understand PMNCH's reliance on donors and whether this creates any risk in terms of the stability of PMNCH's future funding.

We conducted a quantitative analysis of financial data, including PMNCH Secretariat expenditure based upon data publicly available in the 2010-18 financial reports, as well as an analysis of PMNCH's budget allocation based on PMNCH's business and workplans between 2016-20. We also explored sources of PMNCH funding and how these have changed over time, based upon PMNCH's donor funding database.

H.1.1. Limitations and mitigating factors

It was not possible to break down the expenditure of the Partnership in the 2017 financial year by PMNCH workstream as this expenditure information is not available in the financial reports. Therefore, we carried out an analysis of budget allocation against the different workstreams, recognising this may not be representative of the exact amounts spent.

No specific mitigating action was taken to address this limitation, but the potential bias was accepted and considered in the main report, and where possible corroborated with other data sources including key informant interviews (KIs).

H.2. SUMMARY OF FUNDING TO PMNCH AND CHANGES OVER TIME

H.2.1. Summary of overall funds to PMNCH

Since 2018, the essential budget¹⁶⁸ for the Partnership has been set at US\$10m per year, and the comprehensive budget at US\$15m per year.¹⁶⁹ PMNCH Secretariat stated that the essential and comprehensive budgets were set for the 2018-20 Business Plan based on a consultative process between the Board, Executive Committee, PMNCH partners and the Secretariat, which was supported and facilitated by an independent consultant who was working on developing the 2018-20 Business Plan. The levels were based on historical precedence of both Partnership's budgets to date and the Board's view on what may be feasible in terms of fundraising to support the set of agreed activities by the Partnership. In the end, the 2018 to 2020 Business Plan was reviewed, scrutinised and approved by the Executive Committee during a period from 18 October and 26 October 2018.¹⁷⁰

A broad range of governments, bilateral and multilateral donors and private foundations have supported the Partnership's work to deliver on both the 2012-15 and 2016-20 Strategic Framework's and related annual work plans. As shown in Figure H.1 below, bilaterals have been the largest donors to PMNCH since 2010.¹⁷¹ On average, between 2010-19 bilaterals provided 67% of the overall funds to PMNCH; private foundations 22%; multi-lateral organisations and UN agencies 6%; other (unspecified and brought forward) 5%, and; private-sector organisations 0.18%.

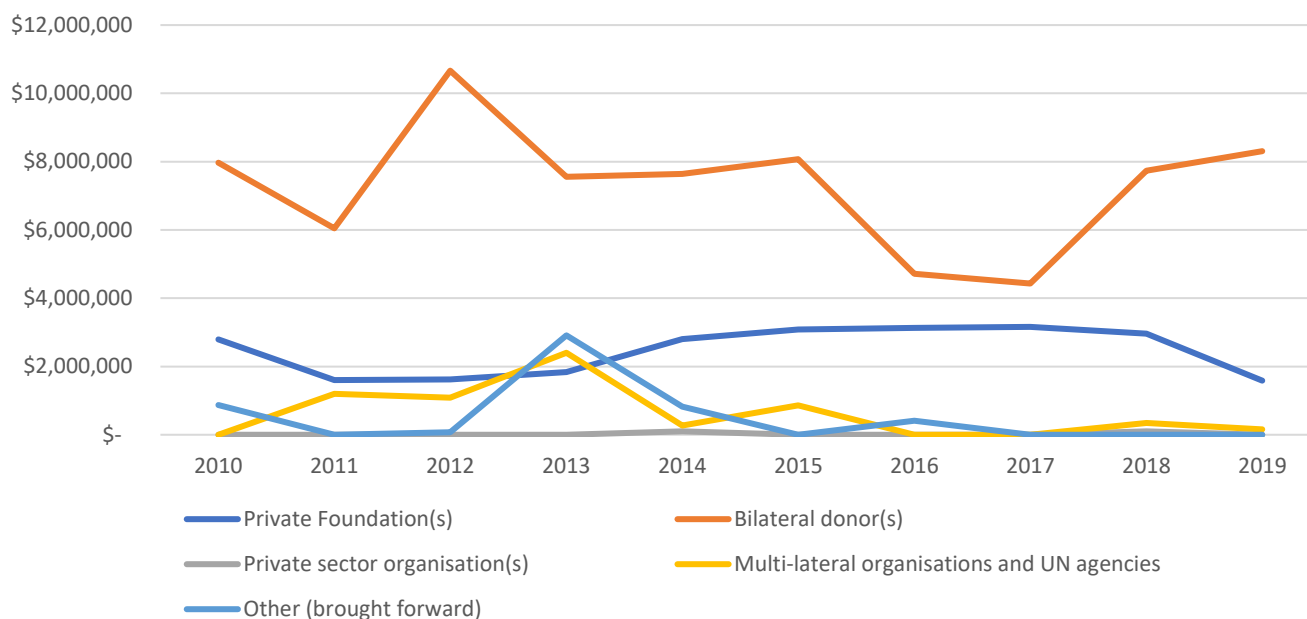
¹⁶⁸ PMNCH's Board has a two-level budgetary planning process: "The first level refers to a **Comprehensive budget**, planned for a maximum set of activities that the Partnership would likely be able to deliver in any one year. This was set at US\$15m per year, should resources be available. The second level was an **Essential budget**, which noted a prioritised set of activities deemed most important by the Board." Source: PMNCH (2018) Financial Report.

¹⁶⁹ PMNCH (2018) Financial Report

¹⁷⁰ Private communication between PMNCH Secretariat staff and CEPA, December 2019.

¹⁷¹ Recurrent government funders have included the Governments of Australia, Canada, Germany, the Netherlands, Norway, Sweden and the UK. The Government of Finland also provided funding in 2014, and the Government of Switzerland has provided funding more recently in 2018 and 2019.

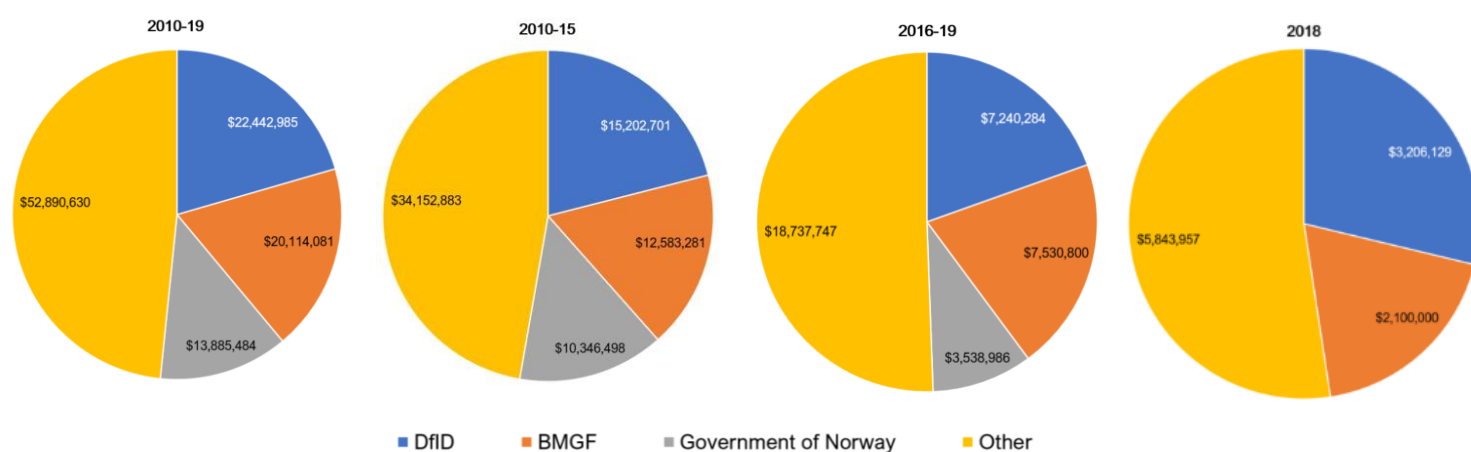
Figure H.1 Donor funding to PMNCH between 2010-19¹⁷²



Source: CEPA analysis. PMNCH (2019) Donor funding tracker (as of November 2019).

As seen in Figure H.2 below, the largest funder to PMNCH between 2010-19 has been the UK Department for International Development (DfID), providing US\$22.4m to PMNCH between 2010-19, (20% of total funding). The second largest donor has been the Bill and Melinda Gates Foundation (BMGF) providing US\$20.1m between 2010-19, (18% of total funding). The third largest donor is the Government of Norway, which has provided US\$13.8m between 2010-19, (12.7% of total funding). Hence, half of the PMNCH budget between 2010-19 has been provided by three donors alone. Bilaterals, including USAID, have consistently provided funding between 2010-19, with for example USAID providing US\$4.85m in total, with an average of US\$485,000 per annum. This reliance on essential funds from a small group of donors creates high risk for the stability of PMNCH's future funding in view of any decline in funding from this small group of "traditional" donors.

Figure H.2: Ratio of donor funding (total confirmed) to PMNCH between 2010-19



Source: CEPA analysis. PMNCH donor funding spreadsheet (2010-19).

¹⁷² Private sector organisations donated US\$200,000 between 2010-19, with US\$100,000 donated in 2014 and US\$100,000 in 2018. Hence why the grey line is not too visible on the graph.

H.2.2. Changes over time of PMNCH funders

PMNCH has broadened its donor base in recent years, increasing from ten donors in 2010 (six of whom were governments), to 18 donors in 2018 (eight governments, four private foundations, four multi-lateral, one bi-lateral and one private sector organisation). Seven of these donors in 2018 were new donors: two private foundations (Bernard van Leer Foundation and Ford Foundation), one private sector organisation (Merck Sharp and Dohme Corp) one government (the Government of Switzerland), and three multilateral organisations and UN agencies (the Global Financing Facility (GFF), UNICEF and UNFPA).¹⁷³ Furthermore, between 2017-18, six existing donors provided new, or increased their existing grants: BMGF; the Children's Investment Fund Foundation (CIFF); Government of Germany; Government of India; Government of Sweden; and Government of the USA. However, as seen in Figure H.2 above, despite the increase in diversity in donors in 2018, 47.6% of the overall budget comes from just two donors; DfID and BMGF, and therefore there is a continued high risk for the stability of PMNCH's future funding.

H.3. FINDINGS (A): EXPENDITURE AND BUDGET ALLOCATION

H.3.1. Expenditure for the 2017 and 2018 calendar years

As shown in Figure H.3 below, the largest expenditure in both 2017 and 2018 was for professional staff costs.¹⁷⁴ In 2017 staff costs were US\$4m, amounting to 54.2% of total expenditure of the Secretariat. In 2018, staff costs were just under US\$3.9m, amounting to 40% of total expenditure. These costs are inclusive of charges for base salary, post adjustment and other entitlements (e.g. pension and medical insurance, etc). As per PMNCH's 2018-20 Business Plan, the Secretariat has 15 core positions, in addition to three Independent Accountability Panel (IAP) related positions, with an average 2018 cost per person of US\$216,000. Of the 15 staff positions, according to the PMNCH Secretariat, two to three are considered administrative in nature. Unfortunately it is not possible to disaggregate costs associated with administrative support staff, nor is it possible to break down staff costs into separate governance related activities (such as management of constituencies, committees, working groups and Board meetings) as PMNCH has not adopted a time recording system. Programme Support Costs (PSC) charged by WHO on the basis of the existing hosting arrangement amount to a 13% charge on donor grants received by PMNCH. In 2017 this cost US\$661,100 (8.9% of total expenditure) and in 2018 this cost US\$528,000 (5.4% of total expenditure).¹⁷⁵ Combined, the direct staff costs and 13% service charge came to 63% of the total budget in 2017, and 45% of the budget in 2018.

The staff costs described above do not include contractual services (which represent expenses associated with public procurement of service providers and sub-grants to counterparts, including: (i) agreements for performance of work (APW) and short-term consultants (STCs); and (ii) letters of agreement for research or capacity building grants issued to institutions and implementing partners). In 2018, contractual services cost US\$3.6m, 37.4% of the total expenditure for that calendar year, and in 2017 contractual services cost US\$5.5m, 25.2% of the total expenditure for that calendar year.¹⁷⁶

Travel expenditure¹⁷⁷ in the same year cost US\$1.2m, 13.4% of the annual expenditure. This was a substantial increase from 2017's travel expenditure which cost US\$737,000 (9.9% of the total expenditure) as the 2018 expenditure included all travel associated with PMNCH's 2018 Partners' Forum in New Delhi (in which the Secretariat financed approximately 300 qualifying participants to attend). General operating and other direct costs such as equipment and materials to support the office were relatively lower than other expenditure in both 2017 (US\$128,000, 1.7% of total) and 2018 (US\$373,000, 3.8% of total).

¹⁷³ PMNCH (2018) 2018 Financial Report: PMNCH.

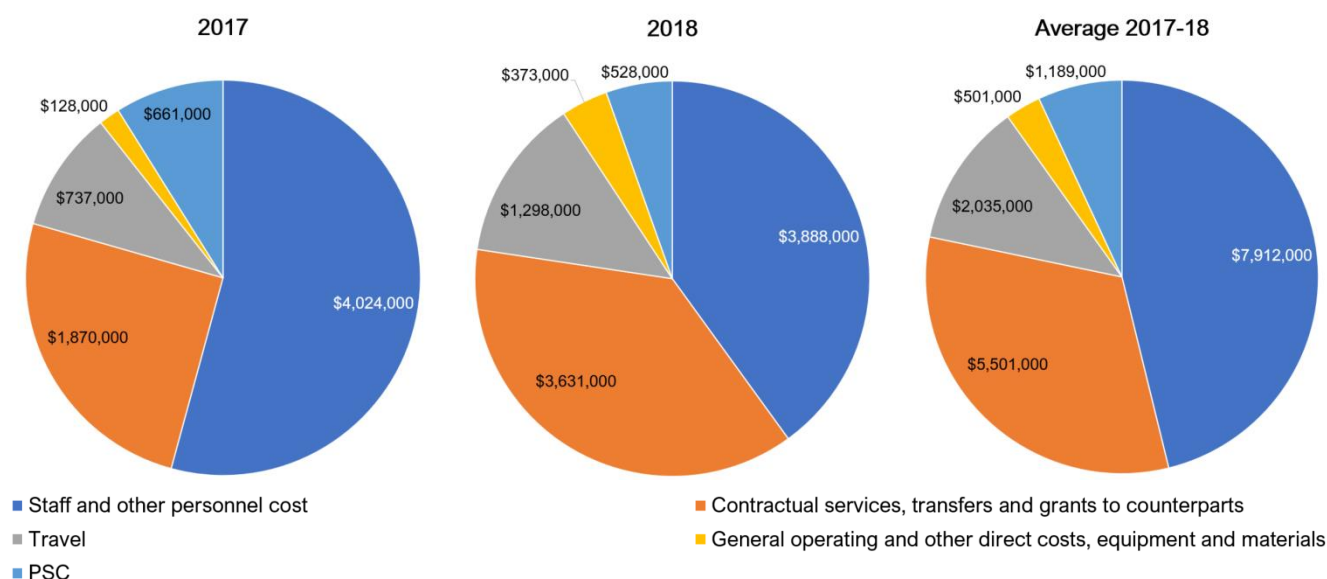
¹⁷⁴ PMNCH Financial reports for calendar years 2017 and 2018.

¹⁷⁵ Ibid

¹⁷⁶ Ibid

¹⁷⁷ Travel expenditure reflects the cost of travel for qualifying representatives of PMNCH governing and advisory bodies (e.g., PMNCH Board members, Executive Committee members, etc.), qualifying broader partner participants in PMNCH organised meetings, some consultants and PMNCH staff members.

Figure H.3: PMNCH Secretariat expenditure breakdown for calendar years 2017 and 2018 and average for 2017-18



Source: CEPA analysis. PMNCH Financial reports 2017 and 2018

H.3.2. Budget allocation against current PMNCH workplan and as compared to the identified strategic direction of the Partnership

During the PMNCH's 2016-20 strategic period the bi-annual Business Plans have organised the Partnership's budget differently: In the 2016-18 Business Plan the Partnership budget was organised against the four strategic objectives (SOs),¹⁷⁸ whereas in the 2018-20 Business Plan the budget is organised around six workstreams, corresponding to the six focus areas of the 2020 EWEC Partners' Framework, and the four PMNCH functions (analysis, alignment, advocacy and accountability). For each workstream, the 2018-20 Business Plan describes deliverables and multi-year budgets.¹⁷⁹ As shown in Figure H.4 below, SO 3 "focusing action on results" was allocated the highest level of funding (US\$7.4m) in the 2016-18 Business Plan and SO 2 on accountability received the second highest allocation of US\$11.6m, of which US\$5.2m was allocated to IAP activities (with US\$841,525 allocated to dedicated IAP staff per annum). The IAP's budget is fully integrated into PMNCH's overall budget, i.e. IAP has a portion of the US\$10m essential or US\$15m comprehensive budget.¹⁸⁰

Within the governance budget, the cause of the large increase in funding in 2017 was due to the Partners' Forum, which was allocated US\$1.5m in the Business Plan, and subsequently US\$1.7m in the 2017 workplan and budget.^{181,182} In addition to this budget allocation within 'governance', US\$700,000 was allocated annually for Board and governance meetings (representing 5.2% of the total budget across the three-year Business Plan). This figure does not represent the total Board costs as many partners finance travel for Board members out of their own budgets. In addition, US\$350,000 was allocated annually for constituency support (representing 2.6% of the total budget across the three-year Business Plan).¹⁸³

¹⁷⁸ PMNCH (2016) Business Plan 2016-2018

¹⁷⁹ PMNCH (2018) Business Plan 2018-2020

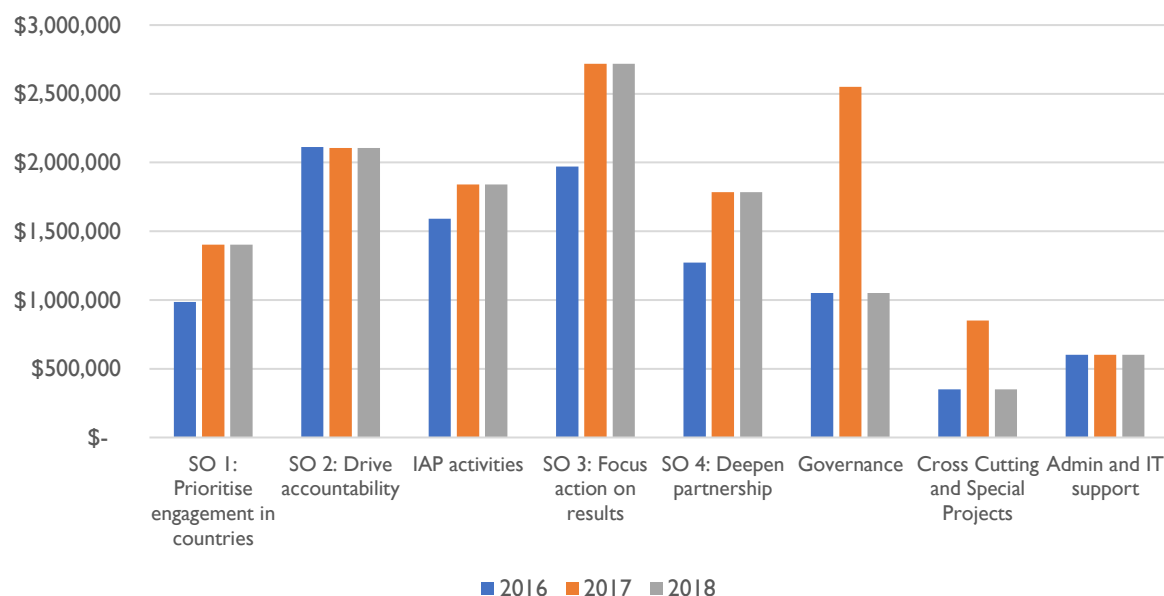
¹⁸⁰ Some donors who fund PMNCH, earmark to the IAP some of the grant funding they provide. Last year this was, for example, DFID. Otherwise, IAP is funded from PMNCH's available unearmarked resources.

¹⁸¹ PMNCH (2017) Partnership 2017 Budget: Complete and Essential.

¹⁸² Costs associated with the Partners' Forum have been categorised in a number of different ways by the PMNCH Secretariat. As per a communication from the Secretariat, "In the 2016 to 2018 Business Plan it was noted under as a 'governance' category of expenditure. In the development of the 2018 to 2020 Business Plan many partners noted that the Partners' Forum is in fact much more than a strictly 'governance' event, but a major deliverable of the Partnership in promoting its overall vision and mission. As such, and to reflect this evolved thinking, the budget associated with the Partners' Forum was mainly housed within the overall 'advocacy' category although some costs were also reflected in the 'analysis' category."

¹⁸³ PMNCH (2016) Business Plan 2016-2018

Figure H.4: PMNCH budget for the 2016-18 Business Plan



Source: CEPA analysis. PMNCH (2016) Business Plan 2016-2018

As per the 2016 annual workplan,¹⁸⁴ the activities that received the highest budgets (over US\$250,000) in 2016 include:

- SO 1 on prioritising engagement in countries:
 - US\$440,000: “National Plans and Investment cases in countries developed and implemented through engagement with all key stakeholders and constituencies”
- SO 2 on accountability:
 - US\$375,000: “Civil society, youth, Parliamentary and media supported and strengthened to drive accountability in countries, including developing mechanisms to hold duty bearers to account”, and “expanded opportunity for citizen voice, including youth, to be heard in accountability mechanisms at country, regional and global levels”
- SO3 on focusing action for results:
 - US\$260,000: “Advocacy for commitments to and increase and improved domestic spending on health in countries”
- SO4 on deepening partnership:
 - US\$420,000: “Growing virtual and physical participation especially at country and regional level in EWEC, Partnership, and/or other processes aimed at achieving the four core targets”
 - US\$485,000: “Enhanced, dynamic, efficient and effective governance structures in place, enabling full participation of all partners” and “increased satisfaction of Partners through implementation of plans of action following annual Partner Satisfaction Surveys”.

As per the 2017 workplan and budget, the three outcomes of the workplan that received over US\$1m in allocated funding include:

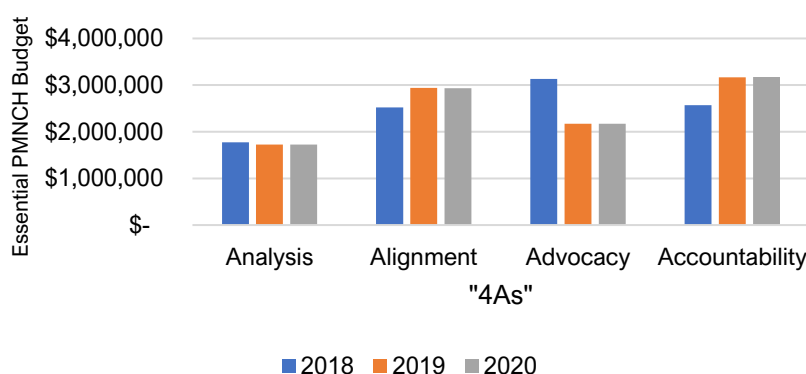
- SO2 on driving accountability:

¹⁸⁴ PMNCH (2016) 2016 Workplan and Budget

- US\$1.4m: Outcome: 2.2: “Holistic, unified global accountability framework, with multi-stakeholder inclusion and participation, focused on equity, and driving action and redress”
- US\$1.4m: Outcome: 2.3: “Independent Accountability Panel established, and producing widely read and acted upon annual reports on the State of Women’s Children’s and Adolescents’ Health that track results, resources and rights and focus action”
- SO3 on focus action for results:
 - US\$1.1m: Outcome: 3.1: “Domestic and global political and financial commitment and engagement sustained and enhanced at all levels to drive impact”

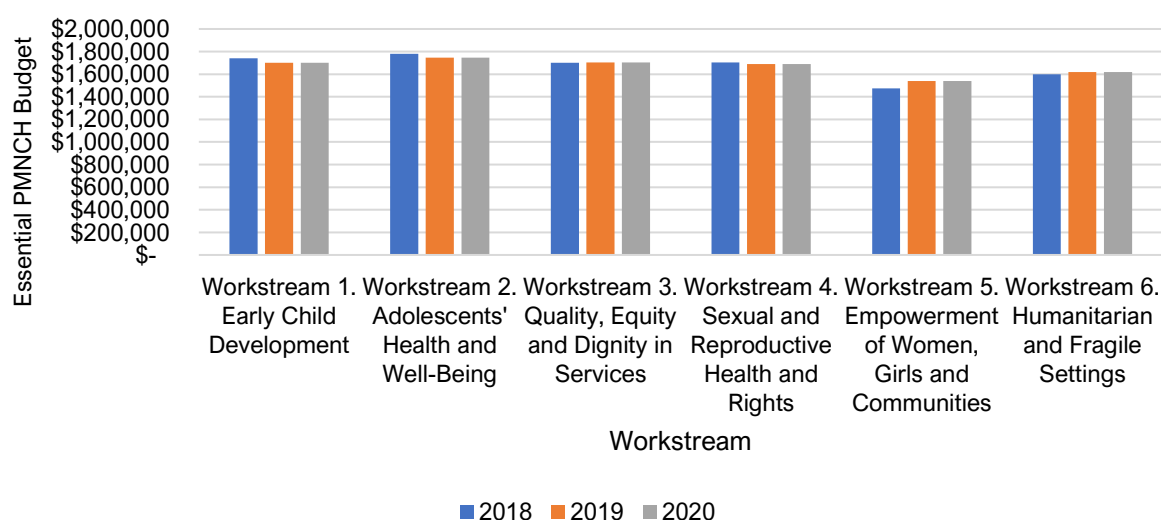
As shown in Figures H.5 and H.6 below, whereas the essential budget is relatively similar across the six priority areas of the Business Plan for 2018-20, the essential PMNCH budget is variant across the PMNCH functions, with the lowest funds being allocated to analysis between 2018-20 (US\$5.2m, 17.4% of total) and the highest level of funding being allocated to accountability (US\$8.9m, 29.7% of total). These accountability funds included those allocated to the IAP.¹⁸⁵ US\$7.4m (24.9% of total) was allocated to advocacy and US\$8.4m to alignment (28% of total).

Figure H.5: ‘Essential’ PMNCH Budget of the 2018-20 Business Plan by function (\$US)



Source: CEPA analysis. PMNCH (2018) Business Plan 2018-2020

Figure H.6: ‘Essential’ PMNCH budget for the 2018-20 Business Plan by focus area (\$US)



Source: CEPA analysis. PMNCH (2018) Business Plan 2018-2020

¹⁸⁵ As per PMNCH’s 2018-20 Business Plan, the IAP Secretariat has three additional technical and administrative positions.

H.3.3. Transparency of expenditure allocation information

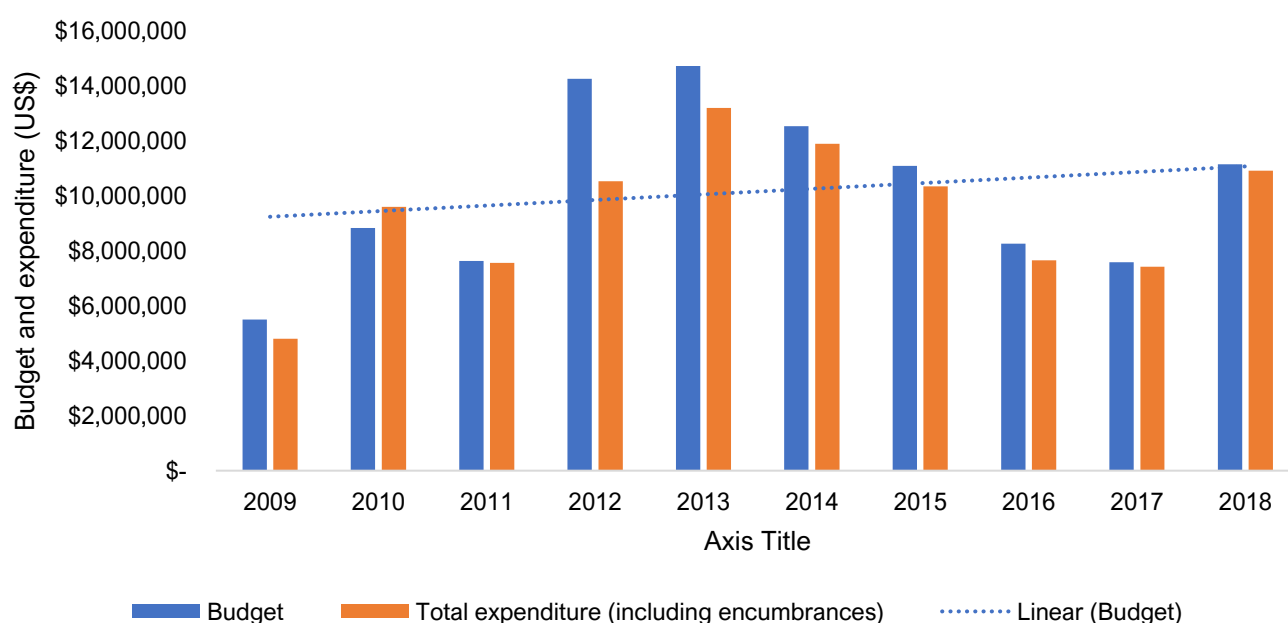
In the 2012-16 calendar years, PMNCH's financial reports included a breakdown of budget and expenditure as per the workplan's strategic objectives/ activities, with some information on the Secretariat's core functions (including office management; strategy, workplan and resource mobilisation; Secretariat admin support; IT support; and contingency).¹⁸⁶ In 2017, PMNCH streamlined its budgeting and reporting processes as per WHO's internal financial recording system and categories, with a breakdown of the Partnership costs for PMNCH activities (including staff and other personnel costs, contractual services, transfers and grants to counterparts, travel and general operating and other direct costs, equipment and materials). All PMNCH's financial reports (i.e. between 2009-18) are available on the PMNCH website.¹⁸⁷ The 2019 Financial Report is planned to be published in June 2020.

H.4. FINDINGS (B): FUNDING ANALYSIS

H.4.1. Budget and expenditure between 2009-18

Between 2010-19, the Partnership has been allocated over US\$109m from 26 donors.¹⁸⁸ As shown in Figure H.7 and Table H.1 below, overall PMNCH's funding was US\$5.5m in 2009 and US\$11.1m in 2018, with large fluctuations between years: PMNCH's annual budget peaked in 2013 at US\$14.7m (largely due to the cross-cutting funding for Countdown to 2015 which amounted to US\$4.5m). Following this, between 2013 – 2017, PMNCH's annual budget followed a decreasing trend over four years, from US\$14.7m in 2013 to US\$7.5m in 2017, before increasing again in 2018 to US\$11.1m.¹⁸⁹

Figure H.7: Annual budget and expenditure between 2009 – 2018



Source: Source: CEPA analysis of PMNCH financial reports; workplans and budgets

As shown in Table H.1, PMNCH's implementation rate against available funds has been over 93% since 2014, reaching 98% in 2017 and 2018.

¹⁸⁶ PMNCH (2019) Strategy and Finance Committee: Financial reports 2009 - 2018

¹⁸⁷ Ibid

¹⁸⁸ This includes funds confirmed. Source: PMNCH (2019) 'PMNCH financial position - 2010 to 2022, as at Nov 2019'.

¹⁸⁹ PMNCH (2009-18) Financial reports; workplans and budgets

Table H.1: Annual budget and expenditure between 2009 – 2018, and PMNCH's implementation rate

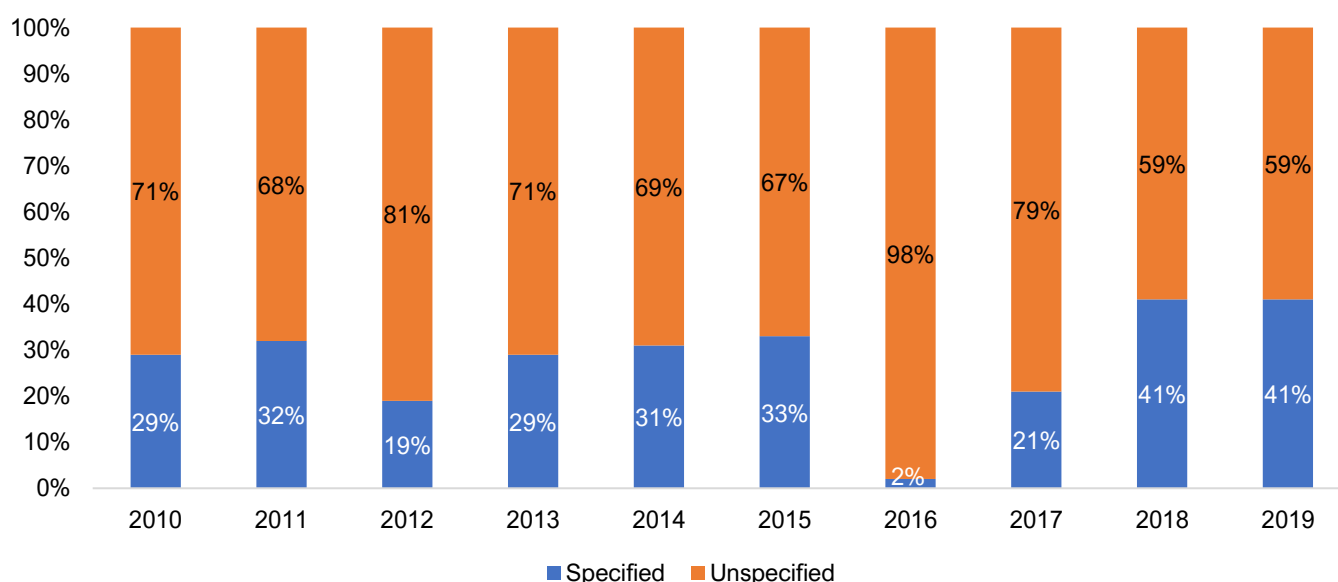
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Budget	\$5.5m	\$8.8.	\$7.6m	\$14.2m	\$14.7m	\$12.5m	\$11.1m	\$8.2m	\$7.6m	\$11.1m
Total expenditure	\$4.8m	\$9.6m	\$7.5m	\$10.5m	\$13.2m	\$11.9m	\$10.3m	\$7.6m	\$7.4m	\$10.9m
Implementation rate	87%	109%	99%	74%	90%	95%	93%	93%	98%	98%

Source: CEPA analysis of PMNCH financial reports; workplans and budgets

H.4.2. Multi-year awards and undesignated contributions

As described in the 2016 financial report,¹⁹⁰ the PMNCH Secretariat reportedly worked hard to encourage donors and foundations to provide their grant support as unspecified funding, to support planning and operational stability. As seen in Figure H.8 below, the level of unspecified funding (un-earmarked) has remained above 59% since 2010, with 98% of grants in 2016 being unspecified. In 2018 and 2019, the percentage of grants being unspecified reached its lowest since 2010 (59%), perhaps driven by the Partnership reaching out to less traditional donors. Whatever the reason, this trend needs to be reversed to reduce transaction costs.

Figure H.8: Specific versus unspecified funding to PMNCH between 2010-19



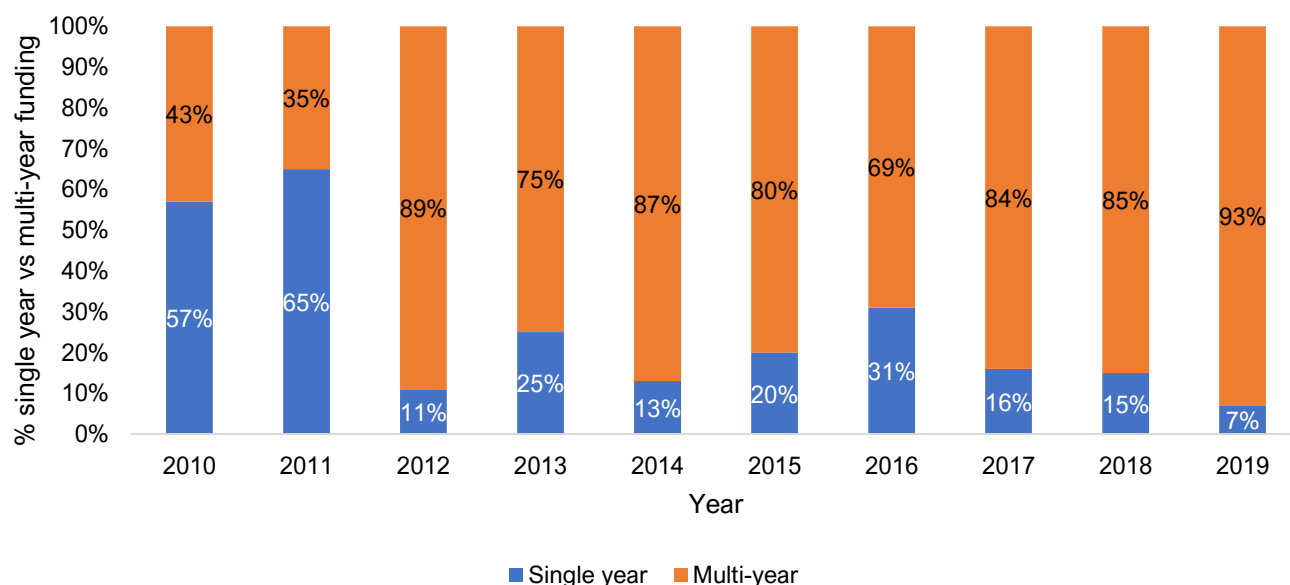
Source: CEPA analysis. Data from PMNCH (2019) 'PMNCH financial position - 2010 to 2022, as at Nov 2019'.

As seen in Figure H.9 below, overall, multi-year grant funding has increased from 43% in 2010 to 93% in 2019, which will be beneficial to the Partnership, allowing greater predictability in funding and being able to apply resources to activities across its entire workplan in the most effective manner.¹⁹¹

¹⁹⁰ PMNCH (2016) DRAFT for Board Approval: 2016 Financial Report: PMNCH

¹⁹¹ PMNCH (2018) 2018 Financial Report: PMNCH.

Figure H.9: Multi-year versus single year funding to PMNCH between 2010-19



Source: CEPA analysis. Data from PMNCH (2019) 'PMNCH financial position - 2010 to 2022, as at Nov 2019'.

H.4.3. Sources of PMNCH funding and changes over time

Renewed efforts in resource mobilisation

PMNCH has developed a resource mobilisation strategy which defines the principles inter alia underpinning the resource mobilisation efforts. An ad-hoc Resource Mobilisation Taskforce was established in 2017 to assist the Secretariat in resource mobilisation efforts, however an external audit of PMNCH in 2018 found that this has not been functioning due to changes in membership and because its responsibilities had been moved to the Strategy and Finance Committee.¹⁹² Overall, the PMNCH approach to resource mobilization is tailored to each individual donor. The 2018 audit recommended that the PMNCH Secretariat “consider developing and combining all documents on resource mobilization activities for each donor into a single document for a more focused and coordinated approach to resource partners”.¹⁹³ However, PMNCH management commented that tailoring approaches to each donor is deemed essential and their experience suggests that this is the key to their success – a general approach would have a much lower success rate.

H.5. FINDINGS (C): REPORTING TO DONORS ON PMNCH ACTIVITIES

PMNCH’s current reporting on activities varies from donor to donor, making it likely that there is multi-reporting of results. This is concerning in terms of transparency (with different reporting on the same activities to different donors), and efficiency – with multi-reporting placing an enormous burden on the PMNCH Secretariat that manages the reporting across all PMNCH awards. For example, in 2018 the Secretariat provided its donors 35 separate reports.¹⁹⁴ According to the 2018 Financial Report, “most PMNCH donors are aware of the reporting burden that PMNCH Secretariat manages across all PMNCH awards. Reflecting this, many have been flexible in accepting some standardisation of reporting formats and information. Nevertheless, the Partnership had around 35 reporting points

¹⁹² Commission on Audit (2018) External audit of the Partnership for Maternal, Newborn and Child Health (PMNCH) as at 31 December 2018.

¹⁹³ Commission on Audit (2018) External audit of the Partnership for Maternal, Newborn and Child Health (PMNCH) as at 31 December 2018.

¹⁹⁴ PMNCH (2019) Donor reporting tracker.

during 2018, which is expected to go up to over 50 in 2019, reflecting new donors coming on board”.¹⁹⁵ Indeed, as per the PMNCH Secretariat’s donor reporting tracker, the Secretariat will be required to respond to donors through 56 different reporting requirements in 2019 alone.¹⁹⁶

Another burden placed on the Secretariat through the management of grants is the variety of financial years and resource timing. “The Partnership has received grants from governments and organisations that operate on different financial years to each other and WHO. This has both assisted the Partnership in managing its cashflow over the years but has also added a degree of complexity in grant management processes.”¹⁹⁷

This very heavy reporting burden undoubtedly has heavy opportunity costs in terms of excessive staff time, duplication and blurred accountability.

¹⁹⁵ PMNCH (2018) 2018 Financial Report: PMNCH.

¹⁹⁶ PMNCH (2019) Donor reporting tracker.

¹⁹⁷ PMNCH (2018) 2018 Financial Report: PMNCH.

Appendix I **PARTNERSHIP E-BASED OPEN ENQUIRY**

I.1. INTRODUCTION

The e-based enquiry was undertaken to better understand the views of the wider membership of the Partnership for Maternal, Newborn and Child Health (PMNCH). The goal was to get input from PMNCH affiliates beyond the key informant interviews. In carrying out the enquiry, a 28-question e-survey was sent to all PMNCH members using contact details from the PMNCH member master list. The survey consisted of questions¹⁹⁸ on:

- the organisations that participants represent;
- the PMNCH mission and vision;
- PMNCH governance; and
- PMNCH effectiveness and impact.

The evaluation was clearly marked as anonymous to encourage honest and constructive feedback from participants. The survey was open between the 18th and 30th of November 2019.

I.1.1. Limitations and mitigating factors

- The results from the e-based enquiry should not be considered representative of the overall partnership. We received 87 responses, which constitutes 8% of total PMNCH membership according to the PMNCH membership database. Although the number of responses may represent a larger proportion of active PMNCH members, this is not statistically representative.
- The Partnership e-based open enquiry was delivered in English, which potentially limits the pool of respondents. Additionally, the quality and completeness of responses to the qualitative sections relies in part on the respondent's English language abilities, which may bias the results.
- Qualitative insights from the survey are limited. 75% of survey responses were fully completed, with most omissions coming from qualitative sections.

The lack of representation and potential biases in responses were accepted, considered and noted at the analysis phase. They were also mitigated through corroboration with other data sources (for instance, in assessing findings from the Partnership e-based open enquiry with other sources including key informant interviews (KIIs), the documentation review, the social network analysis (SNA) findings and country case studies).

I.2. FINDINGS

I.2.1. Descriptive statistics

- We received 87 e-based open enquiry responses out of 1,077 members, 65 of which were fully complete.
- USA, Nigeria and India had the largest country representation. 16 informants were from the USA (18%), 15 from Nigeria (17%) and nine from India (10%). These three countries also have the largest representation in the overall partnership membership (Appendix J).
- 34 (39% of) informants had operations in the Africa Region (AFRO); 22 (25%) had operations in the South East Asia Region (SEARO); 30 (34%) had global operations. AFRO also has the largest regional representation among total PMNCH membership (Appendix J).

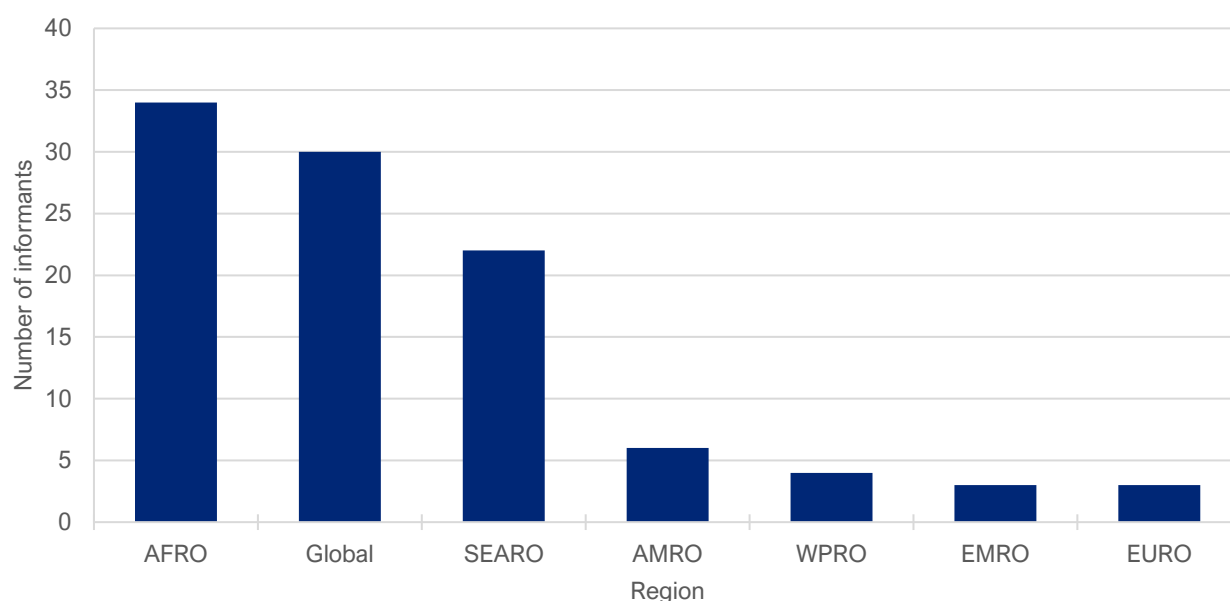
¹⁹⁸ Full set of survey questions can be found at the end of this Appendix.

- Informants with operations in the Americas Region (AMRO) and the European Region (EURO) made up 7% (six) and 5% (four), respectively, despite having the second and third largest regional representation of the total PMNCH membership (Appendix J). This may be because organisations focus their operations in low-income, high poverty countries, while being based in AMRO or EURO.
- 61% of informants represented non-governmental organisations (NGOs), inclusive of both national and international NGOs. This is consistent with constituency membership, since 59% of members are from the NGO constituency (Appendix J).
- There were no responses from Global Financing Mechanisms or United Nations Agencies. This is also not surprising as they represent 1% of the total partnership, according to the PMNCH member database (Appendix J).
- 53 (61% of) informants were from organisations with budgets of less than US\$1m.
- 41 (47% of) informants were from organisations that joined PMNCH within five years; 46 (53%) joined PMNCH more than five years ago. This indicates an even distribution of recent joiners and long-term members among Partnership e-based open enquiry respondents.
- Three donor/foundation organisations and two partner governments participated in the survey.

Table I.1: Informants by constituency

Constituency	Responses	Percentage
NGOs	53	60.9%
Adolescents & Youth (AY)	11	12.6%
Academic, Research and Training Institutes (ART)	5	5.8%
Inter-Governmental Organisations (IGOs)	5	5.8%
Healthcare Professional Associations (HCPA)	4	4.6%
Private Sector (PS)	4	4.6%
Donors and Foundations (DF)	3	3.5%
Partner Governments (PG)	2	2.3%
Total	87	

Figure I.1: Number of informants by region



I.2.2. Vision and mission

- **63 (86% of) informants felt the vision and mission of the Partnership is still relevant** given the evolving global context; only 3% felt it was not relevant. The only informants to indicate that the vision and mission was not relevant were from IGOs and International NGOs. Those that have concerns about its relevance (ten out of 73), mention that it should be more closely aligned with the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC) agenda or that it needs to better articulate its value in the context of many other partnerships.
- **67 (92% of) informants felt that the mission of PMNCH is relevant at the global level; 50% thought it was relevant at the country level.** Some responses indicated PMNCH is not well-known or understood at the country level and that it is difficult to add value without a presence in-country. Others mention that, while PMNCH may be most relevant at global level, the work should be driven by country priorities and that the key outcomes occur at the country level. Only 18% of informants from the AY constituency felt PMNCH is relevant at the country level. Six informants, of which the large majority are NGOs, believe that PMNCH's value is only at country level.
- **47 (64% of) informants felt that PMNCH still fills a unique niche** to address women, children and adolescent health priorities, even with all the new partners in health; 27% said it does somewhat; while 4% thought it does not fill a unique niche in this area. All participating ART members agree that PMNCH still fills a niche, compared to only 25% of HCPA informants.

I.2.3. Programming and delivery

- **38 (58% of) informants felt the scope of activities could be improved but there was strong disagreement on how to improve the scope of activities.** Three out of 26 informants believed the scope should be narrowed and more country-focused, while five out of 26 believed the scope should be widened, adding new topics for the Partnership to take on, such as marginalised groups.
- **Five informants reported that they either did not know how to take part in structures such as the working groups, or had applications rejected.** One informant reported that they felt some of the work is done on a 'who knows who' basis, and another felt that AYC involvement in the executive committee had been halted.

- **30 (46% of) informants reported that PMNCH had not contributed to their organisation's achievement of outcomes**, compared to 16 (25%) reporting it had contributed. No informants from ARTs, DFs, IGOs or PS claimed definitively that PMNCH had contributed to their organisation's outcomes. Three participants said their involvement with PMNCH extended only as far as online surveys and that they are unaware that PMNCH's scope extends to contributing to member outcomes. Three informants claimed PMNCH had helped guide and position their organisation to encompass a wider range of stakeholders.

I.2.4. Partner and country engagement

- The PMNCH Partners' Forum (30 informants, 54%), the PMNCH Board (19 informants, 36%) and the Advocacy working group (16 informants, 31%) were the PMNCH governance structures that had the most representation from informants' organisations.
- **52 (79% of) informants think PMNCH needs to boost involvement of partners across constituency groups.** Participants felt there could be clearer avenues for meaningful involvement of members and that some members could be working on similar topics without knowing about each others' efforts.
- **30 (46% of) participants reported that there were other partnerships which are more effective at supporting and promoting their interests.** Three informants from HCPAs, one from DFs and two from IGOs thought other partnerships were more effective. Examples of these partnerships were FP2020, Women Deliver, Global Fund, Gavi, Stop TB, Maternal Health Task Force, Scaling Up Nutrition (SUN), UN agencies (such as WHO, UNFPA, and UNICEF), and local governments.
- **33 (45% of) informants felt PMNCH added value to their organisation's efforts to achieve results;** seven (16%) said the Partnership did not. Among those that recognised the value of PMNCH, the three most common reasons were their ability to collaborate and network with others, the access to information and the fact that PMNCH raises awareness on women's, children's, adolescent's health (WCAH). The AY was the only constituency where the majority of informants (four out of six) agreed that PMNCH adds value to their organisations' efforts. Among the ART informants, only one (out of five) informants felt PMNCH adds value to their organisation.
- Three informants believe PMNCH activities are failing to make a difference at country level.
- **44 (67% of) informants are in contact with the PMNCH Secretariat at least once per quarter;** 13 (20%) are in contact less than once per year.
- **Informants had mixed views on the scope of activities conducted by PMNCH, and whether these activities reflect priority needs.** Three informants felt activities were very narrow, mainly addressing mortality and access to services, without looking to expand the Partnership or actively engage with young people, and had too many events that lack meaningful discussion. Three other informants thought the Partnership is well-established in low- and middle-income countries, and that priorities were continually revised according to emerging needs. Four out of six informants from the AY constituency and two out of two informants from the PG constituency indicated that the scope of activities reflect priority needs.

I.2.5. Governance and accountability

- **24 (36% of) informants think the current governance and management structure of PMNCH is effective;** 22 (33%) think it is somewhat effective; 14 (21%) think it is not effective. Some participants commented that the Secretariat considers constituency priorities and feedback, and that there has recently been a positive shift in governance structure.
- **Three out of 29 informants raised concerns that PMNCH fails to maintain regular communication, underrepresents some constituencies (e.g. AY) and does little to facilitate cross-constituency collaboration.** Other informants (nine out of 66) believe the governing structure is not entirely transparent, or very political and controlled by a small group. One informant indicated that the Board is an effective decision-making platform.

- **22 (33% of) informants think there is a culture of transparency and openness within PMNCH;** 17 (26%) said somewhat; and nine (14%) said PMNCH does not have a culture of transparency and openness. 'Don't know' was the second most frequent response (18 informants, 27%). Three informants mention that there is a lot of information available online and that email updates are received from time to time. Others (five informants) are not aware of how they can engage more actively with the Partnership.
- **Individual informants had thoughts on improving partner engagement.** Suggestions included tracking member engagement, response times and response quality; sending monthly or quarterly activity reports; implementing social audits; and having Monitoring and Evaluation (M&E) processes inclusive of grassroots members. No informants from ARTs, DFs, IGOs, International NGOs, or PS definitively said that progress of PMNCH activities were effectively tracked/measured.

I.2.6. Effectiveness and impact

- **24 (37% of) informants think PMNCH has been impactful over the last five years.** 24 (37%) believe PMNCH has been somewhat impactful and seven (11%) do not see any impact. A third of informants from AY responded that they did not know whether PMNCH had been impactful. The main impact of PMNCH appears to be regarding the alignment of partners around common targets, and the PMNCH advocacy campaigns. Main successes include the establishment of the Global Strategy, the Global CSOs Coordinating Group for the GFF, the Every newborn Action Plan (ENAP), and publications. Those that are more sceptical about PMNCH's impact **reported that organisational results were likely to have happened regardless of PMNCH input.** There is also limited awareness of PMNCH activities beyond its strategy.
- All informants from DFs (two out of two) indicated that they did not know whether PMNCH had been impactful and stated that there needed to be more partner engagement from the PMNCH Secretariat, and that activities should be improved.
- **29 (44% of) informants indicated PMNCH adds value at country level.** Two informants said PMNCH was effective at strengthening partner alignment at country level, particularly through multi-stakeholder partnerships. Others (four informants) reported that PMNCH involvement is broader than the country level, or that they did not know of partnership interventions at the country level (one informant).
- **Three out of 24 participants indicated that clearly defined scope and objectives would be important to strengthening PMNCH's impact.** Nine out of 35 (26%) written responses mentioned it would better for PMNCH to increase its involvement at the country level or establish regional partners.
- 29 (45% of) informants consult the PMNCH website for knowledge resources and/or news less than once a month. One participant noted that the website was outdated and had poor functionality.

I.2.7. Statistical summary

Table I.2: Descriptive statistics

Criteria	Option	Number/Percentage
Responses	<i>Total</i>	87
	<i>Fully complete</i>	65
Type of constituency	<i>NGOs</i>	52%
	<i>AY</i>	13%
	<i>ARTs</i>	6%
	<i>IGOs</i>	6%
	<i>HCPAs</i>	5%
	<i>PS</i>	5%
	<i>DFs</i>	3%
	<i>PGs</i>	2%

Criteria	Option	Number/Percentage
Region of operations	<i>AFRO</i>	39%
	<i>Global</i>	34%
	<i>SEARO</i>	25%
	<i>AMRO</i>	7%
	<i>WPRO</i>	5%
	<i>EMRO</i>	3%
	<i>EURO</i>	3%
Organisational budget	<i>< US\$1m</i>	61%
	<i>US\$1 - 5m</i>	22%
	<i>> US\$5m</i>	17%
Year organisation joined PMNCH	<i>Within last 5 years</i>	47%
	<i>Beyond last 5 years</i>	53%
Country	<i>USA</i>	18%
	<i>Nigeria</i>	17%
	<i>India</i>	10%
	<i>Pakistan</i>	6%
	<i>Bangladesh</i>	6%
	<i>DRC</i>	5%
	<i>Belgium</i>	3%
	<i>Ghana</i>	3%
	<i>South Africa</i>	3%
	<i>Switzerland</i>	3%
	<i>Uganda</i>	3%
	<i>UK</i>	2%
	<i>Australia</i>	1%
	<i>Bolivia</i>	1%
	<i>Burundi</i>	1%
	<i>China</i>	1%
	<i>Ethiopia</i>	1%
	<i>France</i>	1%
	<i>Germany</i>	1%
	<i>Kenya</i>	1%
	<i>Malawi</i>	1%
	<i>Mexico</i>	1%
	<i>Namibia</i>	1%
	<i>Netherlands</i>	1%
	<i>Papua New Guinea</i>	1%
	<i>Peru</i>	1%
	<i>Philippines</i>	1%
	<i>Spain</i>	1%

Appendix J **PARTNERSHIP DATABASE ANALYSIS**

J.1. INTRODUCTION

This Appendix details the results from our analysis of the Partnership for Maternal, Newborn and Child Health (PMNCH) membership master list, sourced from the PMNCH Secretariat. The purpose of the partnership database analysis was to gain insight into the composition of PMNCH membership in terms of regional and organisational characteristics. The findings help distinguish various characteristics of PMNCH members, which provides context for the overall evaluation.

J.2. METHOD

The PMNCH Secretariat provided the PMNCH membership master list, which this analysis is based on. The data extends from May 2009 to July 2018. The analysis consists of cross-sectional and time-series data analysis. The variables in the master list used in this analysis include:

- Organisation
- Constituency
- Geographic region
- Country
- Website
- Accepted status
- Submission date
- Date processed in database

J.2.1. Limitations and mitigating factors

- Partnership database analysis: Membership entries extend only as far as July 2018, based on an updated list received on the 21st November 2019. As reported by the Secretariat, there are over 60 applications that have been received to join the Partnership since July 2018, which are not included in this analysis as their applications are still being reviewed.
- We assumed that all database entries represented one member, but in some cases, members may be individuals, rather than organisations. We assumed the variables indicating acceptance of application and processing of application were also not required to be considered a member.
- 43% of membership applications had no date attached to them, meaning any time-series analysis would have excluded a significant portion of the membership and therefore could not be done. 47% of accepted submissions and 23% of processed submissions are also non-dated entries.
- There is also no application acceptance date variable within the database. So, if the application has been accepted, date of acceptance is assumed to be equal to date of submission (even though acceptance may come later than submission).
- Date processed into database is not a proxy for date of acceptance because the database is not used consistently, as clarified by PMNCH Secretariat.

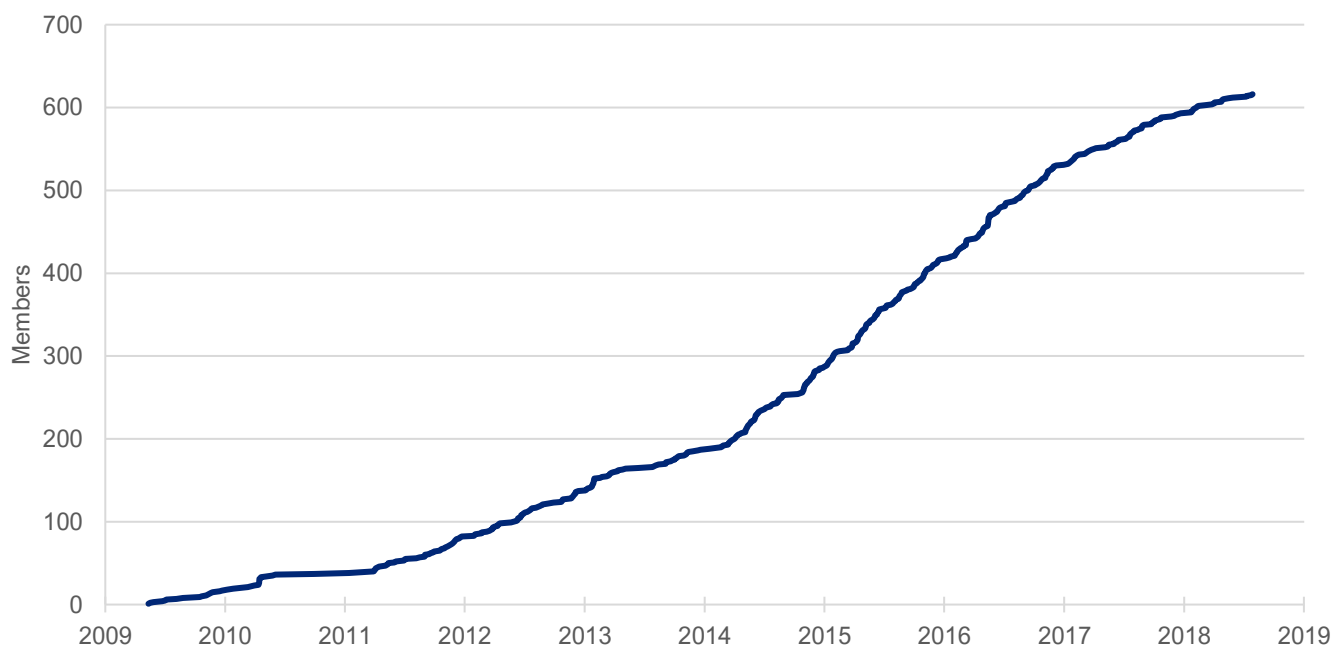
No specific mitigating action was taken, but the potential bias is accepted and considered but mitigated through corroboration with other data sources.

J.3. KEY FINDINGS

J.3.1. General

- **As of July 2018, total membership was 1,077 members.** Overall membership grew at an average rate of 33% per year between 2013 and 2017.

Figure J.1: PMNCH membership growth since inception



Note: 461 entries do not contain a membership application date so are not included in Figure J.1

- **There is on average one membership per organisation.** The exceptions include Aga Khan University (eleven members), Y-Peer (four members), Aga Khan Foundation (three members), and Maternity Today (three members).
- **Non-governmental organisations (NGOs) make up 59% of PMNCH partner organisations,** followed by Academic, Research and Training Institutes (ARTs) (17%) and Adolescents & Youth (AY) (8%). UN Agencies (UNAs) and Global Financing Mechanisms (GFMs) have the lowest representation, both making up less than 1% of total membership.¹⁹⁹

Table J.1: Overview of partnership membership (as of July 2018)

Constituency	AFRO	AMRO	EMRO	EURO	SEARO	WPRO	Grand Total
NGO	222	153	42	89	112	14	632
ART	27	49	26	43	23	14	182
AY	51	12	6	13	5	3	90
Healthcare Professionals Associations (HCPA)	5	19	4	22	4	3	57
Private sector (PS)	8	16	0	15	7	1	47
Donors & foundations (DF)	0	8	0	15	1	3	27

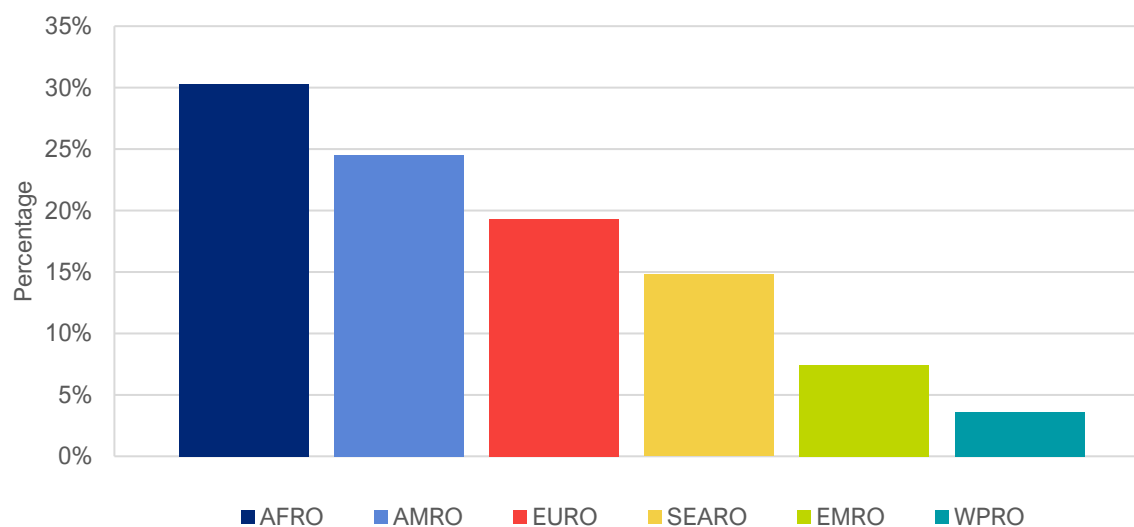
¹⁹⁹ This is expected given there are more limited UNAs and GFMs relative to other potential members, such as NGOs.

Partner Governments (PG)	11	2	2	1	5	1	22
Inter-Governmental Organisations (IGOs)	2	1	0	3	1	0	7
UNA	0	2	0	4	0	0	6
GFM	0	1	0	3	0	0	4
Undefined	0	1	0	0	1	0	2
Grand Total	326	263	80	208	158	39	1,076

Note: One entry has an undefined region and constituency

- **AFRO has the largest regional representation (30%)**, followed by AMRO (25%). WPRO has the smallest regional representation (4%).

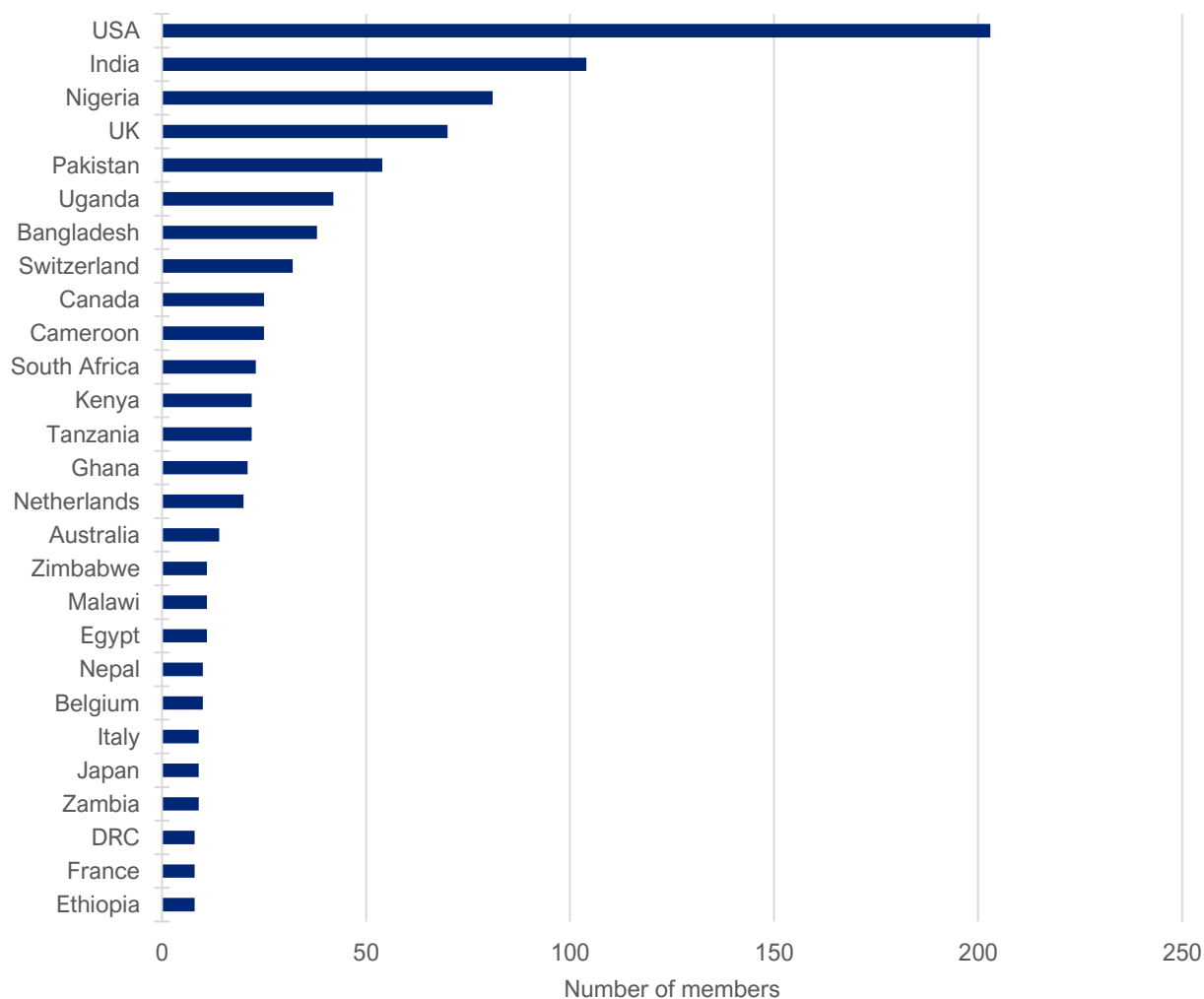
Figure J.2: Regional distribution of PMNCH members as of July 2018



J.3.2. Regional

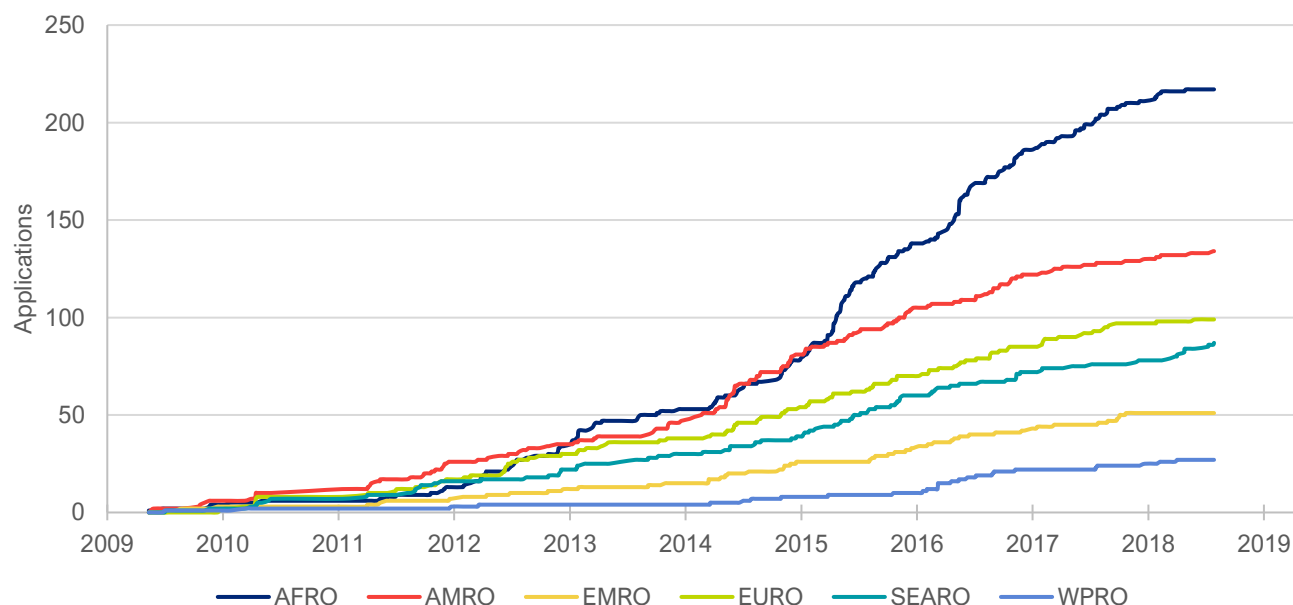
- **The US has the largest number of members by country**, making up 19% of total membership. The US also has nearly double (195%) the membership of India, the second largest country by membership.

Figure J.3: Membership by country (top 25 countries)



- **PMNCH membership in Africa has diverse country representation.** AFRO has the largest proportion of members (30%), yet AFRO only has one country (Nigeria) in the top five countries by membership. This implies low quantity of members per country but high diversity among African countries.
- **Since 2015, Africa has consistently had the highest application rate** (average of 15% per year). As of July 2018, 30% of total membership applications came from Africa, and 25% from the Americas. The Americas had the largest volume of membership applications until 2013 (26%).

Figure J.4: PMNCH membership applications by region time-series

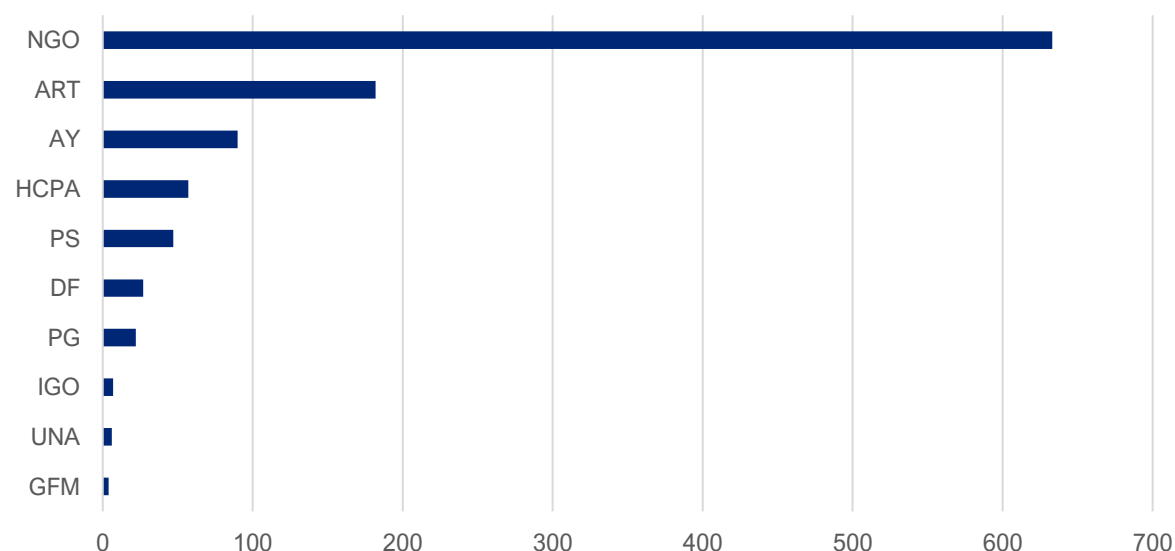


- **Membership applications from AFRO surged between 2014 and 2017;** membership grew by 167% over that time period at a rate of 39% per year.

J.3.3. Constituencies

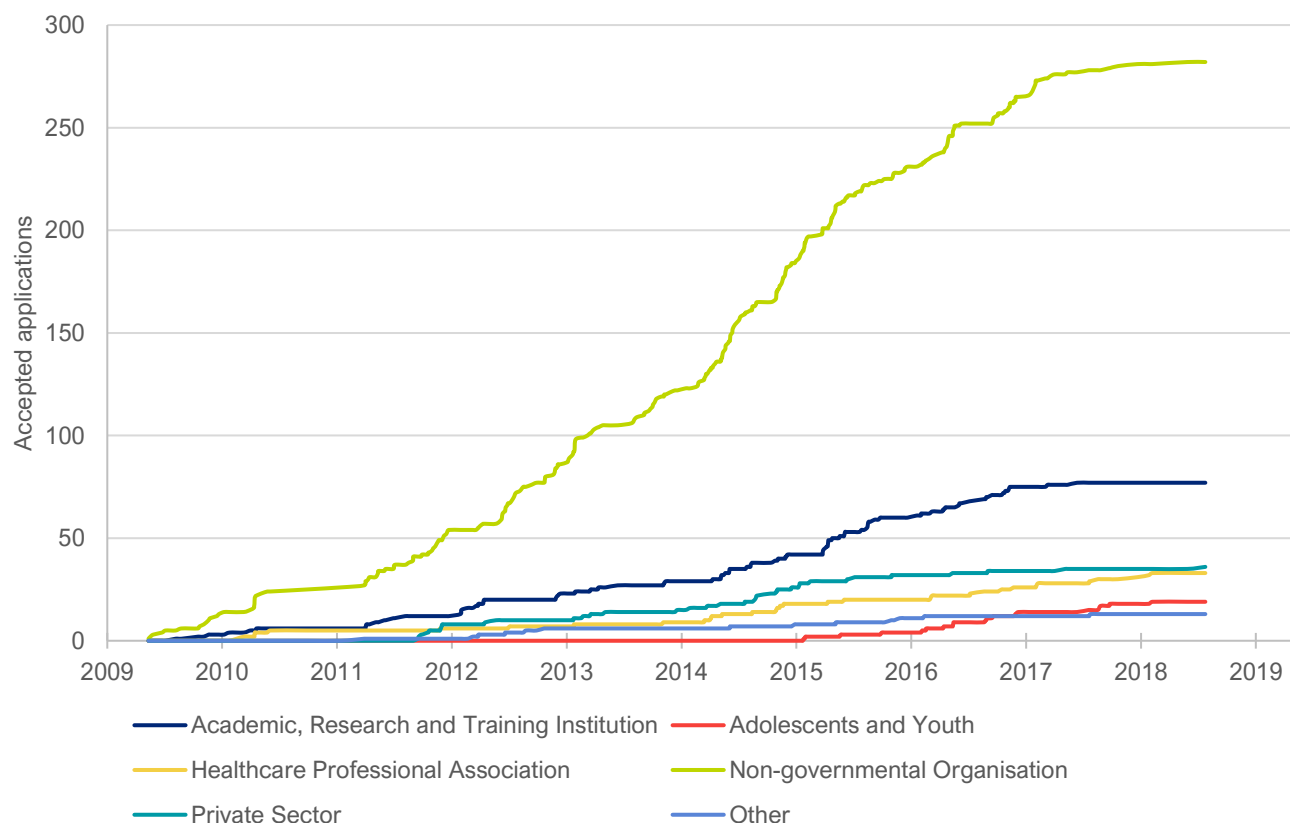
- **NGOs make up the overwhelming majority (59%) of PMNCH membership.** Analysis by constituency is useful but provides limited insight given the diverse nature of organisations under the umbrella of NGO.

Figure J.5: PMNCH members by constituency



- **NGOs have consistently been the largest constituency since the inception of PMNCH.** The constituency has, on average, added more than 42 PMNCH members per year, between 2009 and 2017.
- **ARTs are the second largest constituency and grew significantly between 2014 and 2017.** ARTs added more than 18 PMNCH members per year on average during that time period.

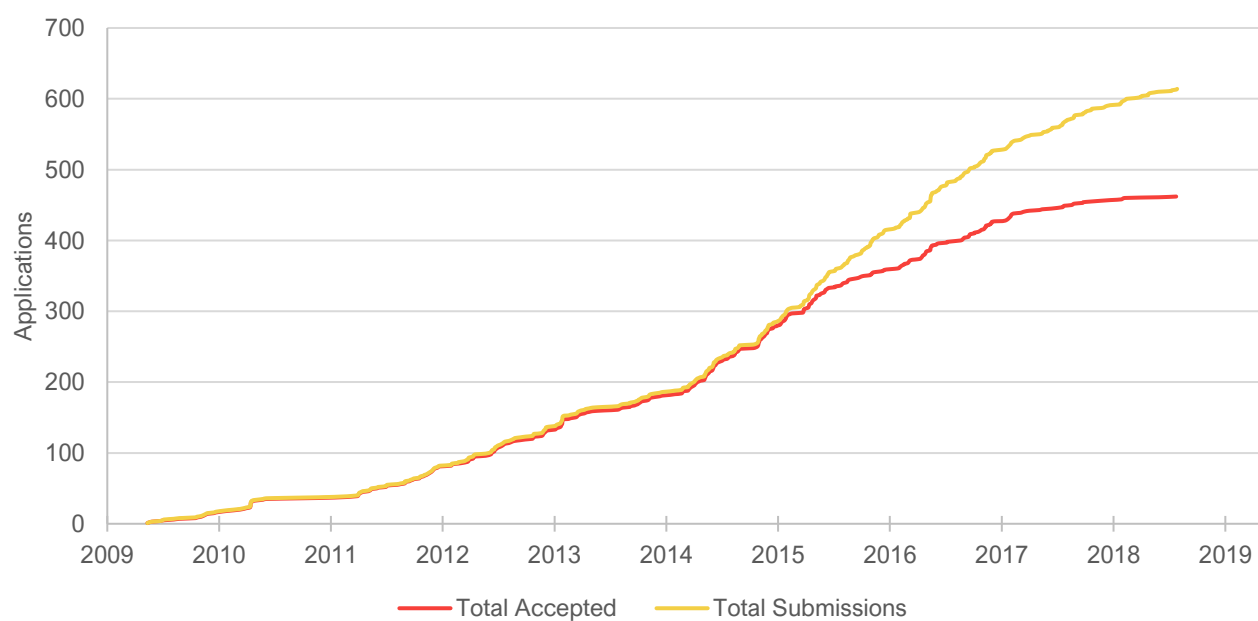
Figure J.6: PMNCH membership applications by constituency, time-series



J.3.4. Database administration

- In 2015, the rate of received applications and accepted applications diverged (Figure J.7). This appears to have coincided with the introduction of the database.

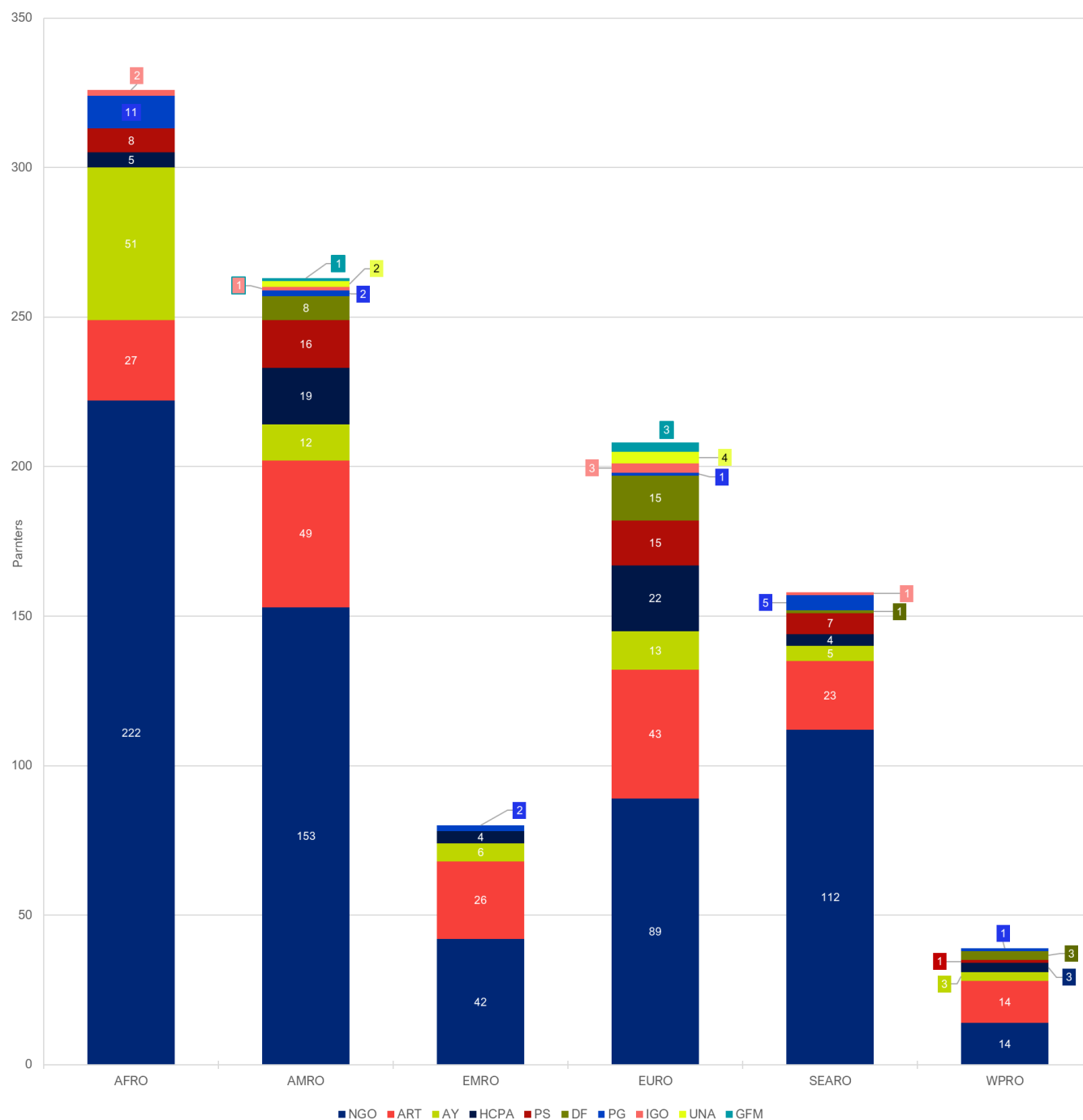
Figure J.7: PMNCH membership applications vs accepted applications, time-series



J.4. ADDITIONAL GRAPHICS

Additional regional analysis

Figure J.8: Partners by region and constituency, as of July 2018



Processed membership applications

Figure J.9: Total processed PMNCH applications, time-series

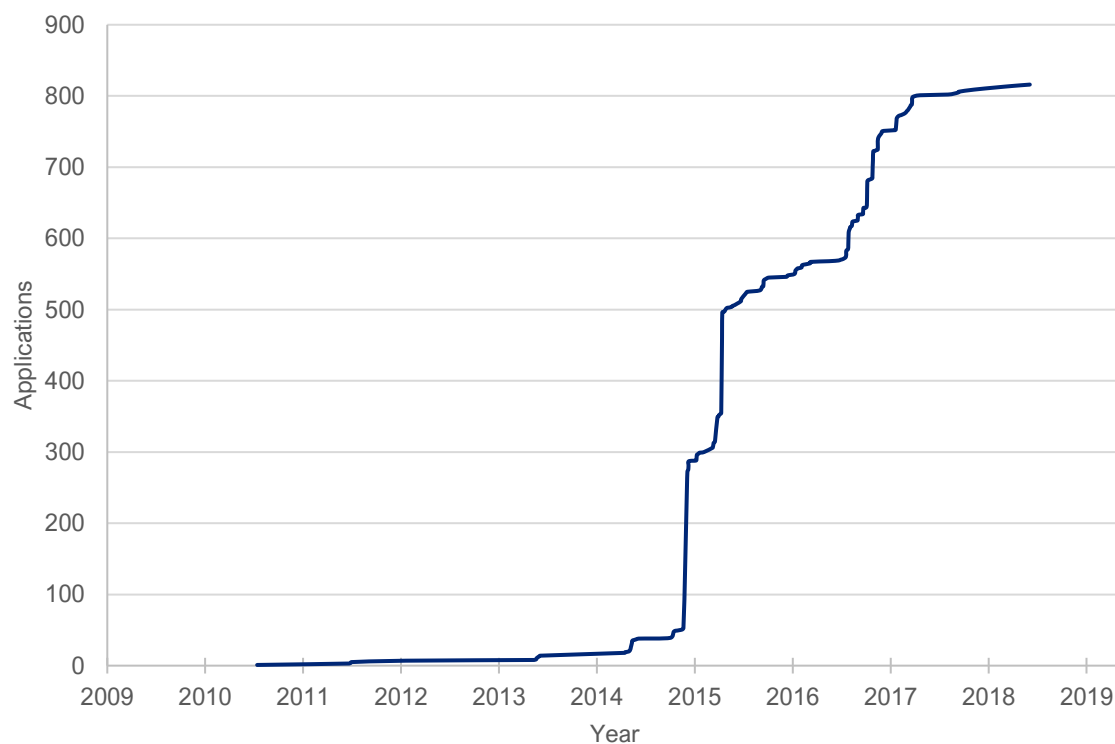


Figure J.10 Processed applications by constituency, time-series

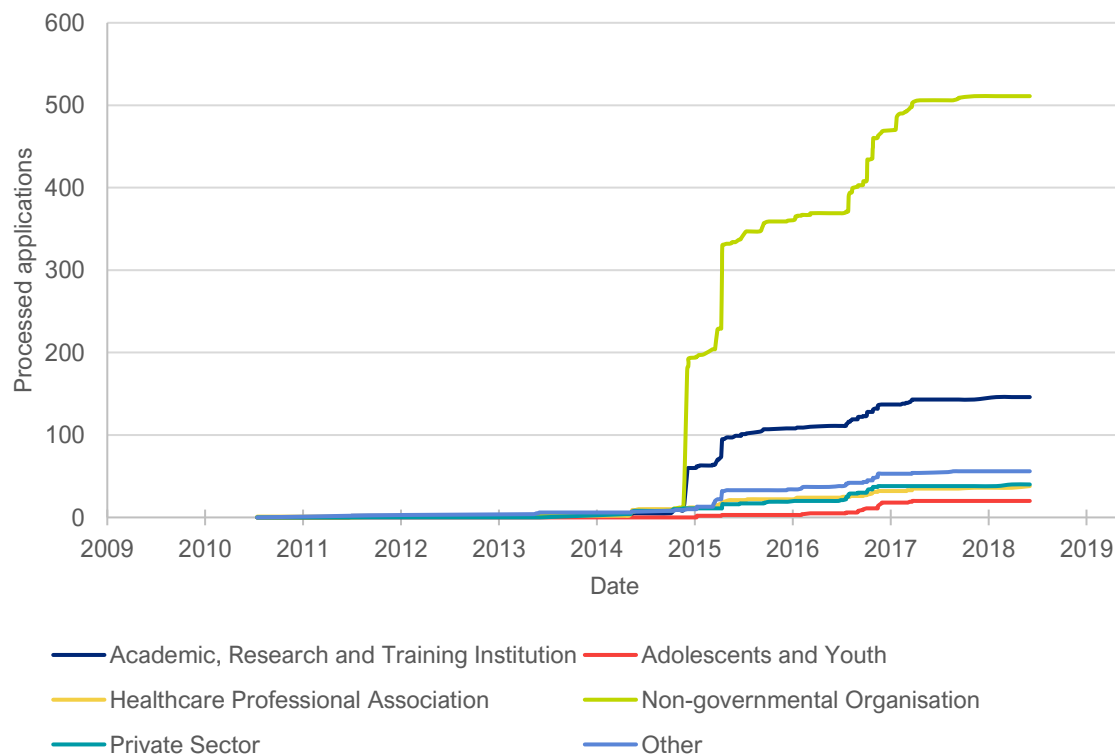
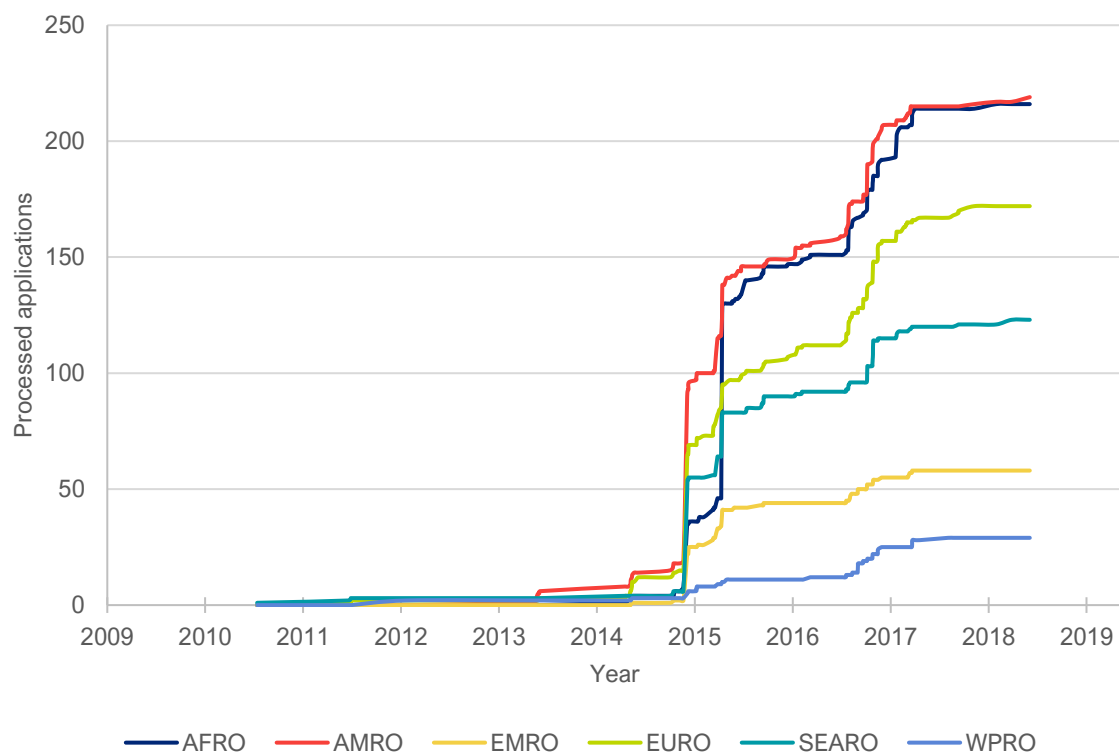


Figure J.11: Processed applications by region, time-series



Appendix K RECOMMENDATIONS AND ACTIONS BY THE SECRETARIAT FROM PREVIOUS EVALUATIONS AND REVIEWS

This Appendix outlines the key recommendations for the Partnership for Maternal, Newborn and Child Health (PMNCH) from previous evaluations, as well as key actions taken by the Secretariat to address them.

Table K.1: Recommendations and actions taken from previous evaluations of PMNCH

Recommendation	Actions taken – described by the Secretariat
PWC (2014) External Evaluation of the Partnership for Maternal, Newborn and Child Health Final report²⁰⁰	
In summary: • “Meaningful country engagement for greater impact requires stronger interface between the Partnership’s global-level activities and in-country platforms and processes. • Partnership implies a two-way relationship: The broad, inclusive multi-stakeholder platform is the Partnership’s key strength. The Partnership can do more to ensure that being a Partner becomes more meaningful, with quality engagement and contributions fully galvanised. • Prioritisation and purpose: The Partnership has to prioritise carefully in order to balance the breadth required to address the full continuum of care with the depth needed to focus on ‘leaving no one behind’. • Knowledge & analysis underpins all that the Partnership does. High quality and rigorous analysis focusing on neglected areas and gaps is highly valued by Partners. • Definition of future success requires clear metrics, outcomes and results which allow the Partnership to monitor and be held accountable for these results.”	The 2016-20 Strategic Plan followed by the 2016 to 2018 Business Plan and then the current 2018 to 2020 Business plan all attempted to adhere to these recommendations. The latest of these documents, the 2018 to 2020 Business Plan best reflects these recommendations as the work at PMNCH evolved. More specifically: • Vision, mission and strategy. Continues to be reflected in all strategy and business planning documents. It is also aligned with the Global Strategy for Women’s, Children’s and Adolescents’ Health, and the EWEC Partners’ Framework. • Governance. Governance strengthening process that followed the last evaluation made significant changes to governance structures, such as empowering the EC, and setting up the Governance and Nominations Committee and Strategy Committee, as examples. • Operations, monitoring and delivery. The 2018 to 2020 Business Plan specifically notes what is expected from the Secretariat and what from the Partners (see Annex 2 of Business Plan). • Performance and impact. This is ongoing core work of the Partnership. As an example, the Partnership recently established an Evidence and Knowledge working group and has hired a new staff member at the Secretariat to support this workstream.
• “PMNCH board to define its role in the context of an evolving RMNCH landscape prior to the new Strategic Framework, including: (i) the role of PMNCH at regional and country level, and especially the role in the post-2015 era. There is a real opportunity to reach out to national leaders through advocacy efforts, with the support of partner data to improve the lives of mothers and children. (ii) an in-depth review of PMNCH’s comparative advantage in tracking accountabilities (iii) a review of the options for interaction with the RMNCH Steering Committee and Trust Fund”	• The role of PMNCH at regional and country level, and especially the role in the post-2015 era. The Strategic Plan and the work since defined the role of PMNCH in post-2015 era, most recently in the PMNCH’s engagement to ensure that women’s, children’s and adolescents’ health is included in the UHC context. • An in-depth review of PMNCH’s comparative advantage in tracking accountabilities. Work on shaping and updating the role of the Partnership in the tracking accountabilities has been ongoing all the time. This has included the hosting of the IAP, reporting on commitments regularly (e.g. commitment reports, UNGA accountability breakfasts, etc.).

²⁰⁰ PwC (2014) External evaluation of the Partnership for Maternal, Newborn and Child Health

Recommendation	Actions taken – described by the Secretariat
	and playing a leading role in ensuring a consolidation of accountability reporting processes in 2019 and 2020. • A review of the options for interaction with the RMNCH Steering Committee and Trust Fund. This Steering Committee was very quickly dissolved after the evaluation and was external to PMNCH.
• “PMNCH board to take necessary action to improve its governance. It should consider the introduction of Programme and Governance board committees. Also it should seek to improve the effectiveness of the Executive Committee. It also needs to reconsider the composition of the board and generally align the board manual to a more mature PMNCH. This will allow the board to approve evidence-based recommendations to facilitate decision-making. The time saved can then be used for strategic discussions and oversight at board level. In addition, there is a need for the PMNCH board to play a stronger role in the performance evaluation of the ED. The PMNCH board can set performance objectives for the ED that are subsequently reviewed by both the WHO cluster leader and the PMNCH board. Finally, the working groups and governance manuals in general will need to be assessed and revised.”	• The PMNCH Board manual is the overall governance defining document, which has been improved and worked on over the years. • Please note The Governance and Nominations Committee during its meeting in Nairobi in Nov 2019 mandated a small sub-group of the Committee to review PMNCH's governance rules and procedures, to ensuring clarity and coherence. To this end, a full revision of the Board Manual will be undertaken in order to ensure relevance and consistency between documents.
• “Board to regularly assess the adequacy of the WHO hosting arrangement, including initiatives such as Countdown to 2015 or the Innovation Working Group that PMNCH is currently hosting. The board committees can identify key strengths and weaknesses of the hosting arrangements, taking into account the existing experience of other (de)hosted partnerships. Consideration should also be given to clarify the governance roles of the PMNCH board and of WHO, and to assess whether these roles are appropriately filled in practice.”	• PMNCH continues to be hosted by WHO and most Board members, to the best of our knowledge, approve of this arrangement. • PMNCH has since stopped hosting Countdown to 2015 (now to 2030) and the Innovation working group does not exist in that format any longer. PMNCH has been hosting the IAP since 2015. • The PMNCH's Governance and Nominations Committee is a well-functioning Committee, overseeing all aspects of PMNCH governance.
• “Secretariat to prepare, and the board to approve a theory of change and a performance and accountability framework for the secretariat and the partners. The starting point for introduction of a performance framework can be the definition of a theory of change and a results-chain. Focus should notably be on ensuring that outputs and deliverables consider the whole theory of change to achieve impact. Thorough work should be done to define key performance indicators, through defining specific impact indicators demonstrating the benefit of PMNCH's actions. Another important element of success for the accountability framework is the inclusion of the key stakeholders during the development process of such a framework, to ensure full buy-in. On this basis, the scheduling within the secretariat and the progressive benefit realisation of PMNCH projects and initiatives should be articulated and reprioritised. Such a shift would enable the board and secretariat leadership to hold partners accountable for progress towards outcomes and impact on prioritised and fewer projects. It will also enable them to clarify the roles of partners and of the secretariat. The partners will need to be further leveraged to implement projects and initiatives. This will reduce dependence on external consultants for implementation which will free secretariat budget to support critical core functions including governance and member engagement.”	• PMNCH's theory of change was updated for both the 2016 to 2020 Strategic Plan and subsequently, the 2018 to 2020 Business Plan. • The 2018 to 2020 Business Plan in sets out the latest performance framework for the Partnership, which the Board monitors regularly. • Roes and expectations of Partners and the Secretariat are delineated in the 2018 to 2020 Business Plan (e.g. see Annex 2).

Recommendation	Actions taken – described by the Secretariat
• “PMNCH secretariat to prepare and board to approve a tailored partner engagement strategy and approach. PMNCH needs to be clear about the desired balance between the depth (quality) and breadth (size) of its member base. There remains considerable work to be done with regard to the existing member base potential and engagement including a systematic way of engaging with and across constituencies. We recommend a short study to review members’ strategic alignment and potential support and interest in the PMNCH which will be critical for the next strategic framework. In particular, to leverage the large NGO membership and to unleash the potential of the partner country and private sector constituencies, PMNCH should focus on a specific NGO, partner country and private sector engagement approach.”	• PMNCH has continued to strengthen its partner base, growing it to more than 1,000 members in 2019. • Significant ongoing work is under way to further strengthen the way in which PMNCH interacts with its partners, through mapping and digitizing (more information on this has been shared with the evaluation team on a number of occasions to date).
• On Governance - the evaluation recommended “for the Board to revisit (i) its own composition; (ii) Its decision-making processes including the appropriate level of seniority and skills of board and Committee member; (iii) The appropriateness and number of board committees; (iv) the need for including external independent board members to increase the effectiveness of governing bodies and to provide oversight and guidance in the interest of PMNCH as a whole; (v) The possibility of increasing the role of the PMNCH board in the performance evaluation of the ED, (vi) The possibility of developing manuals for the committees and PMNCH working groups. Further, for (vii) the Board to assess the WHO hosting arrangements.”	• The PMNCH Board manual is the overall governance defining document, which has been improved and worked on over the years. See response to question 13 in relation to the PMNCH Board Manual.
• On operations, monitoring and delivery, the evaluation recommended: “(i) The secretariat to professionalise its work planning processes and strengthen its work plans for greater accountability; (ii) The board to consider an independent Secretariat HR review to ensure appropriate capacity and act upon it to ensure that the secretariat has the appropriate capacity and skill set to implement the work plan, (iii) The secretariat to define the appropriate monitoring framework to oversee the results achieved by the secretariat and the partners, (iv) The secretariat establishes a reporting system and clear reporting guidelines to hold partners accountable when they are engaged in PMNCH initiatives.”	• The secretariat to professionalise its work planning processes and strengthen its work plans for greater accountability. • The board to consider an independent Secretariat HR review to ensure appropriate capacity and act upon it to ensure that the secretariat has the appropriate capacity and skill set to implement the work plan • The secretariat to define the appropriate monitoring framework to oversee the results achieved by the secretariat and the partners, (iv) The secretariat establishes a reporting system and clear reporting guidelines to hold partners accountable when they are engaged in PMNCH initiatives.”
• On performance and impact, PWC recommended “(i) the secretariat to define a mechanism to review the use of its knowledge tools and summaries and for the board to regularly assess their impact; (ii) The board to review and decide on its future relationship with the RMNCH Steering Committee and Trust Fund; (iii) the board to reconsider the role of PMNCH in tracking accountabilities to RMNCH focusing on the add value and role that PMNCH can provide.”	• Knowledge tools. the Partnership recently established an Evidence and Knowledge working group, and has hired a new staff member at the Secretariat to support this workstream. • RMNCH Steering Committee and Trust Fund. This Steering Committee was very quickly dissolved after the evaluation and was external to PMNCH.
Evaluation of PMNCH commissioned by the Board in 2008 ²⁰¹	

²⁰¹ HLSP (2008) External Evaluation of the PMNCH. July 2008

Recommendation	Actions taken – described by the Secretariat
• Vision and mission: “PMNCH should consider focusing on a new limited “niche” role, initially in global advocacy with a focused and realistic costed work plan.”	• Board developed and approved strategy and work plan 2009-2011, agreeing a six-priority action area framework for the Partnership.
• Partnership engagement: “A marked difference in the level of involvement and engagement of different constituent groups.”	• A paper was discussed at the December 2009 board to improve engagement with existing and new members.
• Partnership engagement: “Essential that partner organisations are prepared to commit time to these groups for them to be effective, and that resources are found to support them where necessary.”	• The Partnership moved towards a partner centric approach where it relies on the work of partners to achieve its objectives.
• Governance: “Need to change board processes to increase its effectiveness and efficiency by: (i) Drawing up a schedule of meetings in advance. (ii) Agreeing on accountability/ monitoring schedule. (iii) Improving the availability of supporting information for decision making.”	• The board set up an Executive Committee to support the board with governance and monitoring issues in 2009.
• Governance: “With agreement on the future function of PMNCH, the board needs to confirm the functions it requires of the secretariat.”	• A new organogram for the secretariat was endorsed at the February 2009 board meeting.
Partners’ Forum evaluation (2019)²⁰²	
• Content: ○ Content was largely appreciated and three issues emerged: - Innovative content is highly valued - Unorganised speakers or those that go over time are irritating - Almost half of informants (46%) found not enough discussion to be the reason why a session is judged bad ○ A different format (previous recommendation) would solve these ○ Develop a Forum app	• Recommendations received at the beginning of 2019 and will be taken into account as PMNCH prepares for its next Forum in, provisionally, 2022. • Some recommendations already taken forward, such as creating a meeting’s app, which was tested for the PMNCH Nairobi Nov 2019 Board meeting.
• Logistics ○ Venue: Better wifi and signage; avoid the hierarchical lecture-type venue (sets up us-and-them) ○ Challenges in communication, registration, distribution of materials (69% satisfaction was the lowest score) ○ Start communication earlier ○ Conduct all registration online/ on the app ○ Post-Forum platform for presentations & discussions	• Recommendations received at the beginning of 2019 and will be taken into account as PMNCH prepares for its next Forum in, provisionally, 2022.
• General ○ A knowledge management (KM) strategy be developed for the Forum to:	• Recommendations received at the beginning of 2019 and will be taken into account as PMNCH prepares for its next Forum in, provisionally, 2022.

²⁰² Indigenous Peoples Knowledge (2019) PMNCH Partners’ Forum evaluation – Draft presentation

Recommendation	Actions taken – described by the Secretariat
○ Marry the aims of a forum – improving multisectoral action for results, sharing country solutions, and capturing best practices– with the type of event that will best allow that; ○ Use that to plan who should attend, how to structure sessions, and the role of the Virtual Forum and app	
Audit of PMNCH (2018)²⁰³	
• “formally document and maintain records, as Minutes documents, in addition to already keeping email exchanges and uploading of all relevant emails and documents for each donor to the WHO intranet site accessible to all WHO personnel, the internal consultations with WHO offices like the CRM and other stakeholders in planning and implementing its resource mobilization efforts for sharing of information as these would later provide valuable information for decision making, measuring progress and promoting accountability.”	• All relevant email exchanges – reflecting the notes of exchanges as well as any conversations – with CRE (central resource mobilization unit) are saved on the central / joint hard drive under the relevant donor’s folder.
• Programme management: Present existing data on baselines, targets and analysis of results into separate columns of any management monitoring tool to support work plan monitoring	• Completed. PMNCH has advanced substantial work on a comprehensive management monitoring tool that incorporates columns on baselines, targets and analysis of results. This tool was finalized by 30 April 2019 and is being regularly updated.
• Procurement: Clearly reflect in Adjudication Reports results of evaluation and scoring of losing candidates, to improve quality of ARs;	• Completed. PMNCH is now utilizing the official “adjudication report” (AR) template that WHO Procurement recommends. Its Section 5 (Evaluation) requests, among other things, that the contracting unit succinctly explains grounds and criteria for both the selected and the non-selected bidders. As the full-fledged explanation is provided in the signed comparison matrix that must always accompany such submissions in GSM.
• Travel: Adopt a strategy of enhancing approval workflow support when supervisors or other approvers are not available to manage TR approvals on;	• Completed. PMNCH distributed among all staff the attached email with clear instructions on approval workflow, including on travel, to ensure prompt approval of travel requests.
• Risk management: Consistently observe the CRE-set metrics in rating compliance with internal control activities for a more comparable and organisation-recognized platform of IC assessment; explain any differences in its rating of its compliance with internal controls and the self-calculating CRE-set metrics, to facilitate analysis of risks and internal control activities during self-assessment	• Completed. PMNCH liaised with CRE for consolidation of our 2018 ICS exercise with all other WHO departments, following the CRE-set metrics. See attached communication and details to this respect.
• Resource mobilisation: Consider further developing and combining all the existing documents detailing the specific activities, responsibilities and timelines for each donor into a single document to support implementing the RM strategy for a more focused and coordinated approach to resource partners;	• Completed. The relevant Committee of PMNCH's Board (i.e. the Strategy and Finance Committee) considered combining all existing resource mobilization documents into one at its meeting on its meeting of 26 April. 2019. A separate working group of this committee was set up to consider Resource Mobilisation efforts more broadly, as noted in the attached Note for the Record.

²⁰³ Commission on Audit (2018) Management Letter on audit of the Partnership for Maternal, Newborn and Child Health (PMNCH) as at 31 December 2018

Recommendation	Actions taken – described by the Secretariat
• Donor info and records: Formally document and maintain records, as Minutes documents, in addition to already keeping email exchanges and uploading of all relevant emails and documents for each donor to the WHO intranet site accessible to all WHO personnel, the internal consultations with WHO offices like the CRM and other stakeholders in planning and implementing its resource mobilization efforts for sharing of information as these would later provide valuable information for decision making, measuring progress and promoting accountability	• PMNCH SMT will consider this item and prepare an internal note to be followed by all staff on how to formalize and maintain records for all our exchanges with donors. We expect this note and its distribution to be completed by 30 June 2019.

Appendix L **SOCIAL NETWORK ANALYSIS OF ADOLESCENT ADVOCACY TOOLKIT**

L.1. INTRODUCTION

This Appendix presents a ‘deep dive’ social network analysis of the Advocating for Change for Adolescents! Toolkit in support of the External Evaluation of the Partnership for Maternal, Newborn and Child Health (PMNCH). The aim of the social network analysis (SNA) is to get a better understanding of how the organisations involved in this activity, have collaborated and how this has contributed to its success. Following a summary of the methodological approach (Section L.2), a brief overview of the workstream is provided. Social network analysis (SNA) is then applied to look at who are the main actors involved and how do they contribute (Section L.3.1), what results were achieved and what are the main contributing factors (Section L.3.2), how frequently did the network communicate (Section L.3.3) and what is the relative value of each actor in the network. Conclusions and lessons learned are presented at the start of each section. This case study is based on a review of key documentation, the Partnership e-based open enquiry and consultations with seven key informants from different PMNCH constituencies (government partners, youth organisations and NGOs) as well as the PMNCH Secretariat. Appendix A provides a list of references and documentation sources. Key informants consulted as part of the case study are included in the overall list of key informants (Appendix B).

L.2. METHODS

SNA is defined as a “distinctive set of methods used for mapping, measuring and analysing the social relationships between people, groups and organisations.”²⁰⁴ SNA helps characterise relationships between organisations – including relationships such as collaborations, resource exchange, information exchange, or memberships in a partnership. The nodes in the network are the organisations, while the links show relationships or flows between them. SNA provides both a visual and a mathematical analysis of organisational relationships. One of the core assumptions of SNA is that the patterns of these relationships can have important effects on individual and organisational behaviour, constraining or enabling access to resources and exposure to information and behaviour.

Data for the SNA were collected by asking nine key actors involved in the roll-out of the Adolescent Advocacy Toolkit to complete an online questionnaire estimating the number and type of communications with other actors. Seven key actors responded to the online survey. Missing information was collected during seven key informant interviews. Nine key network actors are included in the analysis:

- the youth organisations in five countries which received a grant for the roll-out of the toolkit (Cameroon Youth Network, The YP Foundation in India, the Organisation for African Youth (OAY) in Kenya, HeR Liberty in Malawi and Education as a Vaccine (EVA) in Nigeria);
- the PMNC Secretariat and a representative of the AYC constituency who oversaw the process; and
- Women Deliver and Girls’ Globe who coordinated the grant management in two distinct phases.

Each of these actors indicated other actors whom they engaged with actively during the project. These included:

- Global Financing Facility (GFF);
- UN agencies such as UNESCO and WHO;
- National non-governmental organisations (NGOs);
- National youth networks or councils;

²⁰⁴ Karl Blanchet, Philip James, How to do (or not to do) ... a social network analysis in health systems research, Health Policy and Planning, Volume 27, Issue 5, August 2012, Pages 438–446, <https://doi.org/10.1093/heapol/czr055>

- National partner governments (Ministry of Health, Ministry of Education, Ministry of Youth Affairs, adolescent technical working groups);
- Sub-national partner government (sub-national department of health); and
- National media.

Data collection was done using SurveyMonkey, while data analysis was done using Visible Network Labs' PARTNER software.

The table provides a glossary of terms used in SNA. In the application column, the meaning of the terms in the context of this analysis are summarised. They are presented in subsequent paragraphs and detailed values of the metrics are provided in Section L.4.

Table L.1: SNA glossary

Term	Meaning	Application
Network	The relationship that exists between actors.	All organisations and individuals involved in the roll out of the adolescent advocacy toolkit.
Actors	Network members that are distinct individuals, collective units or entities.	We identified 22 actors from 7 groups/constituencies
Nodes	The nodes in the network are the organisations while the links show relationships or flows between the nodes.	The size of the nodes is presented either by degree centrality or by value (see below).
Actor metrics		
Degree centrality	The degree centrality of an actor is a count of the number of actors that are connected to it.	The PMNCH Secretariat alongside Girls Globe and two youth organisations have the highest degree and therefore positions as central information hubs. There are, however, also several secondary hubs.
In-degree centrality	The in-degree centrality of an actor is a count of the number of actors from whom it is on the receiving end. If an actor is on the receiving end of many relationships, they are said to be prominent, or to have high prestige. That is, many other actors seek to direct ties to them, and this may indicate their importance.	The PMNCH Adolescents and Youth Constituency (AYC) member has the highest in-degree centrality confirming its role as a prominent partner in the network.
Out-degree centrality	The out-degree centrality of an actor is a count of the number of actors it relates to. Actors who have unusually high out-degree centrality are actors who are able to exchange with many others or make many others aware of their views. Actors who display high out-degree centrality are often said to be influential actors.	The PMNCH Secretariat but also Girls' Globe have the highest out-degree centrality confirming their role as prominent partners and influencers in the network. OAY Kenya and Cameroon Youth Network also have high out-degree centrality values because they identified a large number of key actors who they collaborate with.
Value metrics		
Power/Influence	Measures the level of power/influence an actor has in the network	Several organisations have a high level of influence in the project
Involvement	Measures the level of involvement an actor has in the network	Several organisations have a high level of involvement in the project

Term	Meaning	Application
Resource contribution	Measures the level of resources an actor contributes to the network (this includes funding, information, or other resources)	The PMNCH secretariat is the actor with the highest level of resource contribution

L.3. KEY FINDINGS

L.3.1. Advocating for Adolescent Change! Toolkit

In 2016, PMNCH started the development of an ‘Advocating for Change for Adolescents! Toolkit’ in collaboration with Women Deliver which was launched at the Global Adolescent Health conference in Ottawa in May 2017. During this process, PMNCH decided to pilot the toolkit at country level. A Request for Proposals (RfP) was launched and five youth organisations were selected from India, Cameroon, Nigeria, Malawi and Kenya.

In the first phase, between August 2017 and August 2018, the youth organisations received grants ranging between US\$10,000 to US\$15,000 to prepare a country-level adaptation of the global Advocating for Change for Adolescents! Toolkit as well as develop an “Advocacy Action Roadmap” to advocate for adolescent health and wellbeing in their countries. The grant management was overseen by Women Deliver who organised monthly technical assistance (TA) team calls with each of the grantees. The TA covered advice on building sustainable advocacy efforts through effective campaigning, youth mobilisation, engagement with decision-makers and partnerships with other networks and organisations. In addition, the TA also often included advice on grant management, including programme management, budgeting and monitoring and evaluation. Women Deliver helped to develop grant management tools and drafted an interim and final report. A technical support team made up by PMNCH Secretariat staff members and a representative of the AYC constituency participated in the monthly TA calls.

Lessons from the country adaptation processes were used to update the toolkit which was launched at the Partners’ Forum in New Delhi, India. The updated version includes illustrative case studies from the five youth-led organisations and highlights young people’s involvement in shaping national policies through processes such as the GFF.

In December 2018, a second grant was issued to the same five youth organisations to continue with the roll out of the Advocacy Roadmap and the dissemination of the toolkit, also at subnational level. In this second phase, which ran from December 2018 to December 2019, funds were transferred to the grantees via the WHO Country Office. The Regional Advisor for Southern Africa from Girls’ Globe provided TA to the grantees on a monthly basis. Group calls were organised for the grantees to share their experiences and learn from each other. They were supported by a technical support team made up of Secretariat staff members, an AYC board member as well as AYC members involved in the GFF civil society organisation (CSO) platform and investors group.

All countries developed a national version of the toolkit, in most instances adopted and branded by the national government. The youth organisations were creative and developed different formats of the toolkit. For example, in **Malawi** a short film and several music videos were developed to raise awareness of how policies affect young people’s Sexual and reproductive health and rights (SRHR) and how they can engage decision makers. The toolkit was also transformed in advocacy flashcard roadmaps to easily highlight key policies and avenues for communication in the Malawian context. In **India**, the toolkit was first transformed into an interactive web-version and, after many subnational youth consultations, converted into a workbook and facilitation guide for peer educators. The workbook is currently being piloted five districts in five different states. The aim is to include the workbook into the peer education component of the national adolescent health programme.

As part of their advocacy activities, adolescents and youth organisations in the five countries have represented and contributed meaningfully to national programmes and processes. For example, in **Cameroon** the toolkit has been combined with the Comprehensive Sexuality Education Manual and another toolkit to collect and analyse disaggregated data on adolescent health, into the Adolescent Health and Wellbeing Package which was launched in August 2018 and is now being rolled out. In **Kenya**, the focus has been on capacity building of youth advocates

across the country to use the toolkit and on dissemination of the toolkit to stakeholders in four counties. The youth organisation in Kenya is being engaged by the Ministry of Health to support the development of the 'Meaningful Youth Participation and Engagement Framework' and represents young people in the Adolescent SRHR Technical Working Group. In **Nigeria**, the youth organisation realised that while adolescent health is prioritised in the GFF investment case, it is not picked up in the Basic Health Care Provision Fund. Following concerted advocacy using policy briefs directed to relevant decision-makers, the National Assembly has now called for a review of the Fund.

According to the PMNCH briefing note for International Conference on Population and Development (ICPD), the project has exceeded the expected outcomes. Young people and youth-led organisations are being equipped with the advocacy skills, knowledge and resources they need to lead and organise action. They are forging stronger relationships with their governments and developing tight-knit networks of change-makers who are influencing policies, programmes, processes and decisions affecting adolescents' health and well-being.²⁰⁵

A third phase of the grant has been announced and will expand coverage to five other countries (Ghana, Liberia, Sierra Leone, Zambia and Zimbabwe).

L.3.2. Social network analysis

When reading the section below, the reader should take note of the fact that this analysis is based on information provided by seven main actors involved in the advocacy toolkit roll-out. Informants were asked to provide details about their interactions with the main partners for this activity. The analysis therefore presents a bird's-eye view of the network created by this activity and does not list all the actors that may have been engaged, especially at country level.

L.3.2.1. Main actors involved and their contributions

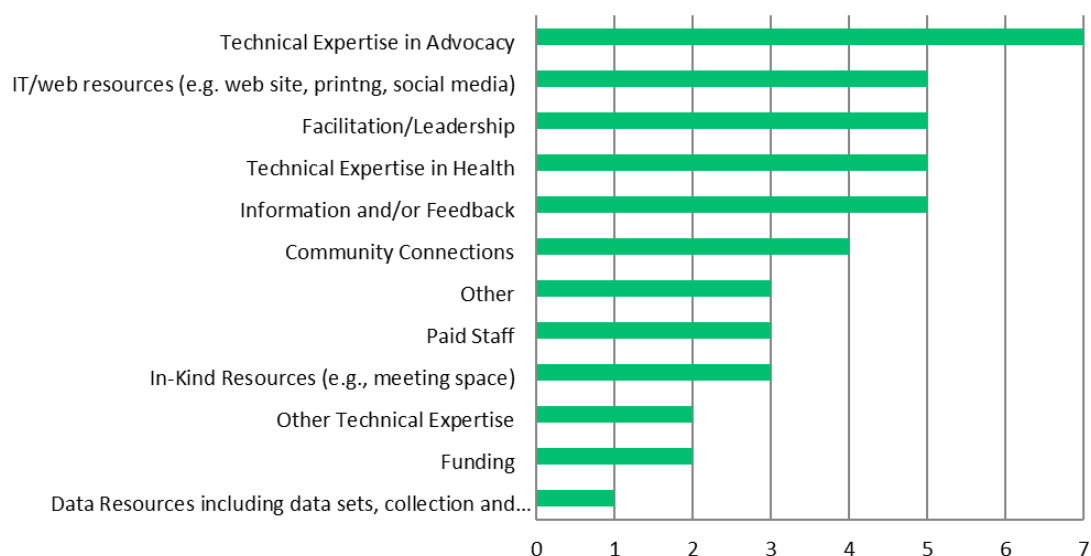
The organisations involved in the project were mostly advocacy organisations, both at global level (Women Deliver and Girls' Globe) but also at country level, the youth organisations were already conducting advocacy for adolescent health in their respective countries.

The nine main actors involved in the development and roll out of the advocacy toolkit were engaged from the beginning of the process. The representatives of the organisations that were interviewed or surveyed are either technical experts in advocacy and communication or senior managers. The majority have been in this position for more than three years.

The organisations have mostly contributed with technical expertise in advocacy, but also technical expertise in health, information and feedback, facilitation and leadership and IT and web resources (including website, social media and printing). Fewer organisations have contributed with financial or other resources, such as paid staff, in-kind resources or funding. When asked about the most important contribution, 5/7 participants chose 'technical expertise in advocacy' whereas 1/7 chose 'paid staff' and another 1/7 'facilitation/leadership'.

²⁰⁵ PMNCH (2019). Youth Advocacy Brief. Rolling out the Advocating for Change for Adolescents toolkit in five countries: highlights, challenges and lessons learned.

Figure L.1: Contribution of resources by main actors



Source: Hera

L.3.2.2. Main outcomes and contributing factors

The main outcome of the project is increased youth engagement. Political commitment is only mentioned by two informants, which is not surprising, as political commitment is dependent on several factors, not only advocacy. Interestingly, the two youth organisations that mentioned political commitment are also those that attributed a strong role to the PMNCH secretariat for brokering a dialogue with relevant government counterparts.

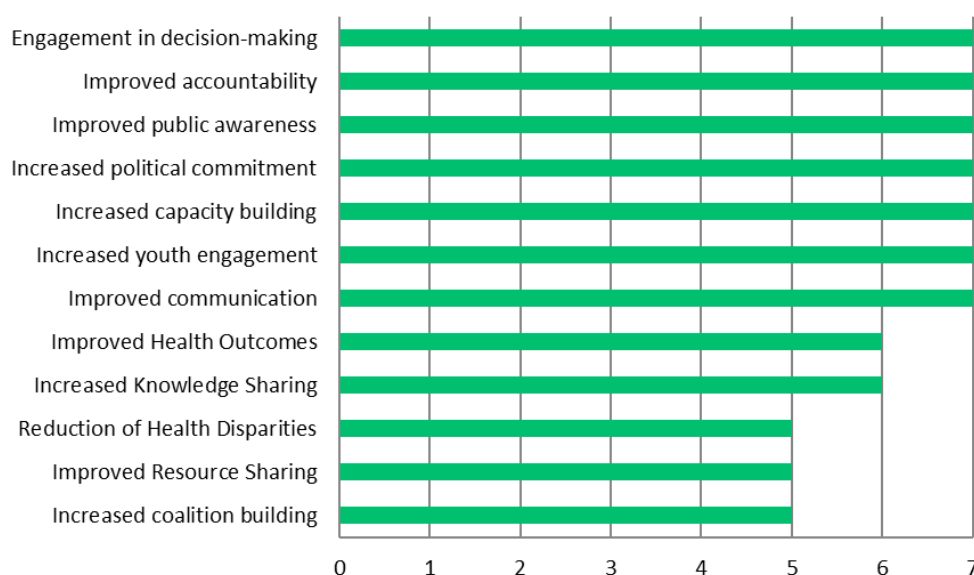
The factors that contributed most towards the success of this activity was the ability to bring together a diverse group of stakeholders. Having a shared mission and goals was also important, as well as the active exchange of information/knowledge and capacity building on advocacy. The key added value that PMNCH brought to the activity, according to the informants, was the active exchange of information/knowledge and their ability to bring together diverse stakeholders.

The informants overwhelmingly agreed that the project has contributed to engagement in decision-making, improved accountability, improved public awareness, increased political commitment, increased capacity building, increased youth engagement and improved communications (see Figure L.2 below). Not everyone agreed, however, on the project's contribution to increased coalition building, improved resource sharing and reduction of health disparities. When asked about what the main outcome was, 4/7 informants agreed this was increased youth engagement, 2/7 believe it was increased political engagement, while 1/7 highlighted increased capacity.

The interviews also confirm that increased youth engagement seems to be one of the major outcomes of the project. Key informants, including those that were not directly involved in the implementation, consistently referred to a wider number of young people being able to articulate their issues and to participate in dialogue and discussions on policies and issues that affect their SRHR. Political engagement was also highlighted in the survey and interviews and was attributed to PMNCH's support and facilitation. The PMNCH Secretariat facilitated a dialogue among the youth organisations and their respective government counterparts in the UN General Assembly in September 2017, which set the tone for constructive discussions in at least two of the countries. The fact that the toolkit was adapted from a global toolkit gives credibility to young people's engagement and has facilitated engagement with decision-makers.

The informants overall believe that the roll-out of the advocacy toolkit has been successful (3.43/5) in bringing about policy changes to improve the health and well-being of adolescents.

Figure L.2: Outcomes of the project



Source: Hera

The factors that contributed most towards the success of this activity was, according to most informants, the ability to bring together a diverse group of stakeholders. Having a shared mission and goals was also important, as well as the active exchange of information/knowledge and capacity building on advocacy. There was less agreement on whether collective decision-making, regular meeting or sharing of resources contributed to the success. When asked about what the key added value was that PMNCH brought to the activity, most informants agreed that this was the active exchange of information/knowledge and their ability to bring together diverse stakeholders.

Figure L.3: Factors that contribute to success



Source: Hera

L.3.2.3. Frequency and method of communication

The PMNCH Secretariat and AYC constituency member play a strong role in the network. The PMNCH Secretariat had weekly engagements with the youth organisations. This consists of monthly calls and emails about specific events or responding to needs from the country partners. This level of engagement may seem excessive, especially because there are other coordination mechanisms in place (Women Deliver in phase 1 and Girls' Globe in phase 2). Some youth organisations referred to conflicting messages from Girls' Globe and the Secretariat, which indicates that having two different coordination or management bodies may be a burden for the grantees (see Figures L.4 & L.6).

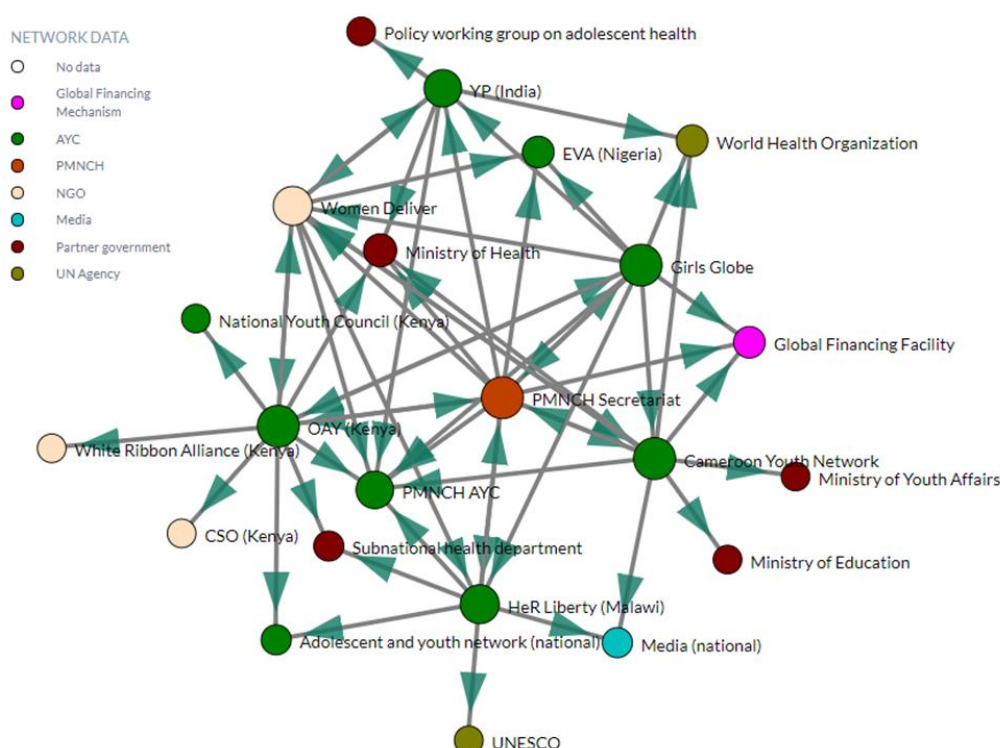
A great deal of communication is done by phone or through face-to-face interactions. Those that have a more coordinating role (PMNCH Secretariat, Women Deliver and Girls' Globe) mostly use the phone or email, while the youth organisations tend to prioritise face-to-face meetings, mostly with the government counter partners (Ministry of Education and Youth Affairs in the case of Cameroon and with the adolescent and youth networks in the case of

Kenya and Malawi). Having face-to-face interactions is relevant considering the advocacy activities they are conducting. Communication with the GFF, on the other hand, is mostly done via email even though the GFF has focal points at country level (see Figure L.5).

The group of actors that participated in the advocacy toolkit roll-out is a multipartite network including different types of actors with distinct roles. In the network analysis, the actors are colour-coded based on their respective PMNCH constituency.

The communication exchanges between the main partners (except the two actors that did not respond to the survey, i.e. AYC constituency and EVA in Nigeria) were bi-directional, indicating that both actors highlighted regular communication between them. Communication exchanges with external actors, mostly those at the country level, were one-directional because those actors did not participate in the survey. The PMNCH AYC constituency member received the highest number of communications, closely followed by Women Deliver, the Ministry of Health and the PMNCH Secretariat.

Figure L.4: Social network of directed communication exchanges²⁰⁶

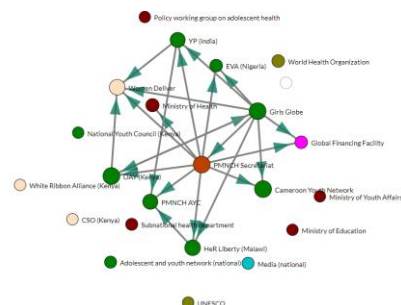


Source: Hera

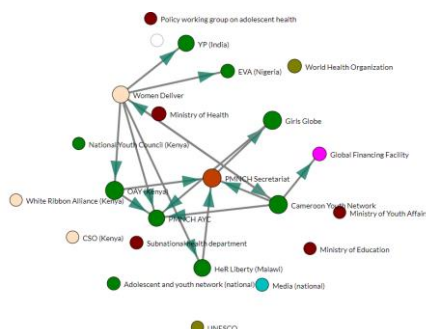
²⁰⁶ The size nodes in this figure are presented by degree-centrality (i.e. count of the number of actors that are connected to it)

Figure L.5: Type of communication

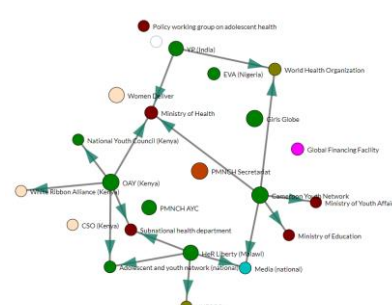
Communication by phone



Communication by email

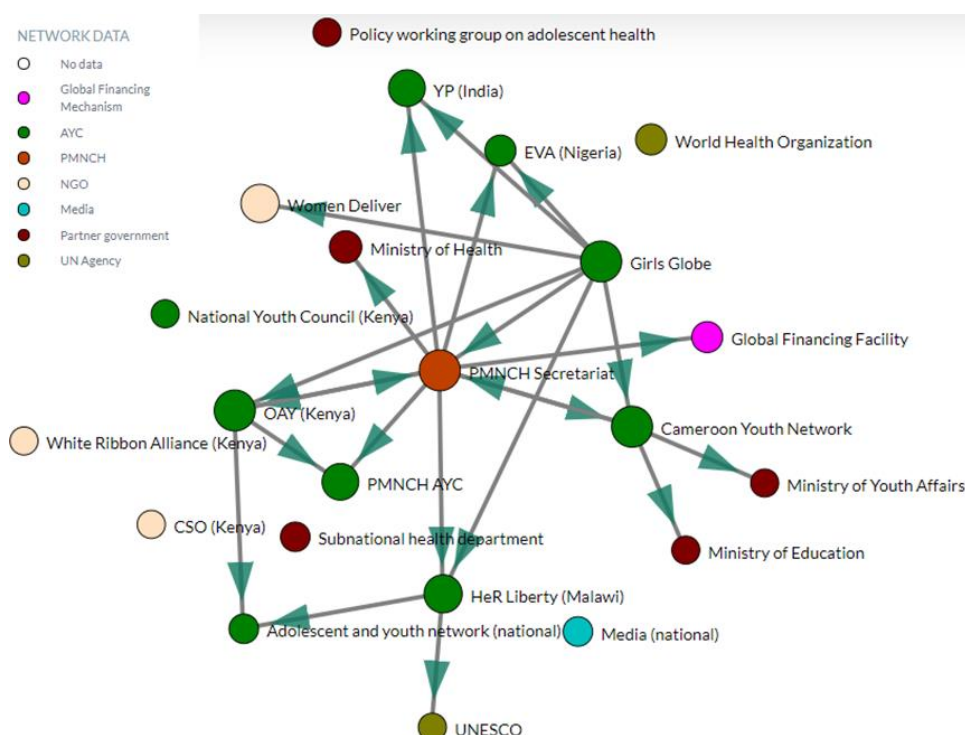


Communication in person



Source: Hera

Figure L.6: Frequency of communication (every week or every day)²⁰⁷



Source: Hera

L.3.2.4. Relative value of those contributing in the network

Youth organisations recognise that partner governments, but also UN organisations such as the WHO and UNESCO, and NGOs hold a great deal of influence on whether they achieve their objectives. However, while partner governments are to some extent involved in the activities, the UN agencies and NGOs identified in the network have much lower levels of engagement with the youth organisations. Many other important actors, for example other H6 agencies and large service delivery NGOs, are not included in the network of the youth organisations. There has been little involvement overall from the WHO Country Offices (except in Cameroon and India), while some youth organisations explicitly mentioned that stronger engagement from WHO at country level would be beneficial. Lack of a broader engagement with PMNCH members at country level is a missed opportunity.

²⁰⁷ The size nodes in this figure are presented by degree-centrality (i.e. count of the number of actors that are connected to it).

Linkages between the GFF CSO platform and the advocacy toolkit are actively pursued by the PMNCH Secretariat. However, only the Cameroon youth organisations identified the GFF as an important actor in their network. The media was identified as an important ally in both Malawi and Cameroon; however, this actor is not yet part of the PMNCH membership base.

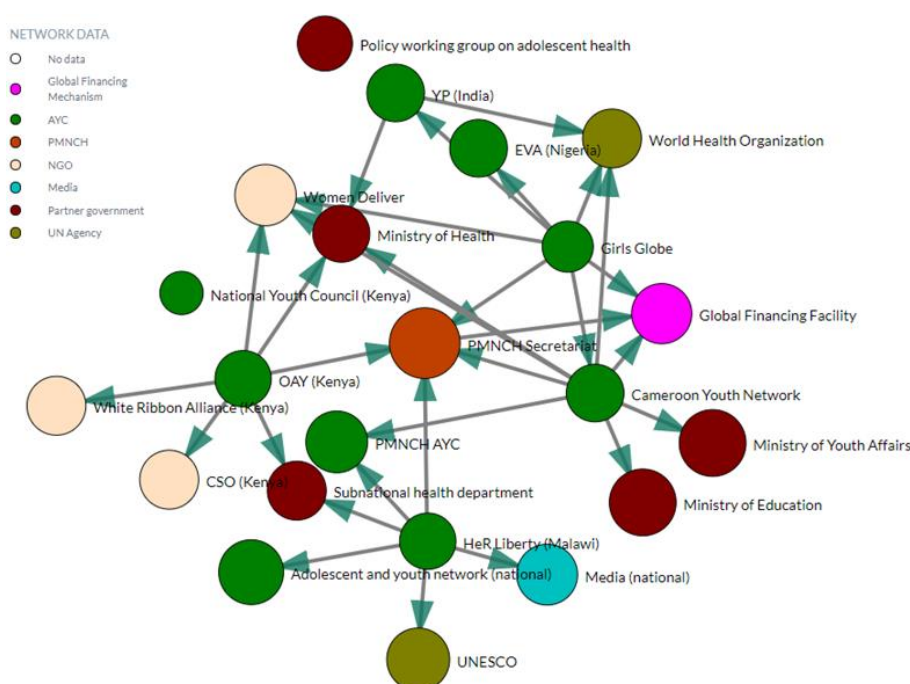
In terms of resource contribution, all youth organisations reported that both the PMNCH Secretariat and the PMNCH AYC constituency contributed a great deal of resources. The PMNCH Secretariat also pointed to the GFF for its contribution of resources. Youth organisations attributed some resource support to their national partners, in particular the partner governments, but also the adolescent and youth network and media.

The youth organisations mention that having a 'grant management' organisation is useful, because it helps build their capacity in terms of grant management.

The relative value of the actors was also analysed in terms of their 'power'²⁰⁸, 'level of involvement'²⁰⁹ and 'contribution of resources'²¹⁰.

The government partners were considered to have a powerful position for all the youth organisations. In addition, global partners with national reach such as the WHO, GFF and NGOs were also mentioned as important influencers. The PMNCH Secretariat only attributed 'a great deal' of power to the GFF (see Figure L.7).

Figure L.7: Actors with a great amount of power²¹¹



Source: Hera

In terms of involvement (Figure L.8), the PMNCH AYC constituency is the actor that received the highest score, followed by the PMNCH Secretariat and the different youth organisations. Global partners such as the WHO, GFF, UNESCO and NGO partners, on the other hand, were not as actively involved, compared to some of the government partners. The adolescent and youth networks in both Kenya and Malawi were also actively involved. Interestingly,

²⁰⁸ Power/Influence: The organisation or department holds a prominent position by being powerful, having influence, success as a change agent, and showing leadership on the overall goal of improving the health and well-being of adolescents.

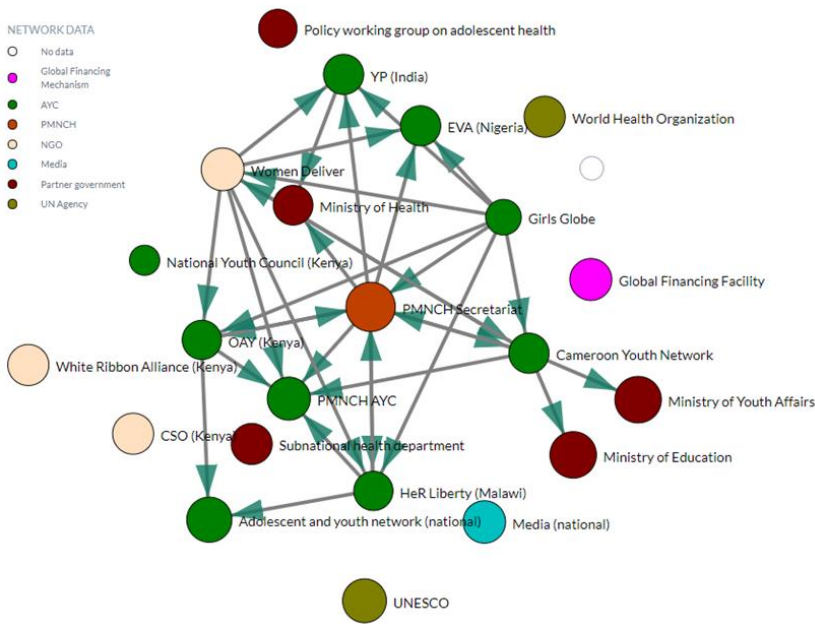
²⁰⁹ Level of Involvement: The organisation is strongly committed and active in the development and/or roll out of the advocacy toolkit and gets things done.

²¹⁰ Contributing Resources: The organisation brings resources to the activity like funding, information, or other resources.

²¹¹ The size nodes in this figure are presented by the overall value of the actors in terms of power, involvement and resource contribution.

Girls' Globe did not receive a high score in terms of its involvement, while Women Deliver received a slightly higher score.

Figure L.8: Active involvement by actors²¹²



Source: Hera

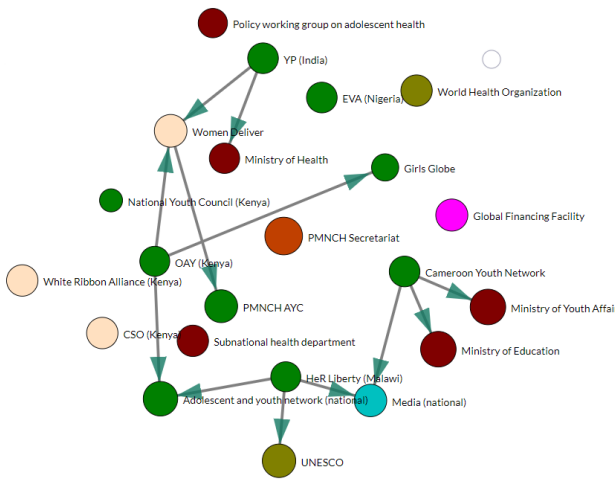
In terms of resource contribution, all youth organisations reported that both the PMNCH Secretariat and the PMNCH AYC constituency contributed a great deal of resources. The PMNCH Secretariat also pointed to the GFF for its contribution of resources. When looking at those that contributed a fair amount, the youth organisations attributed some resource support to their national partners, in particular the partner governments, but also the adolescent and youth network and media (in Malawi).

Figure L.9: Resource contribution

Great amount of resource contribution



Fair amount of resource contribution



Source: Hera

²¹² Idem

L.4. DETAILED VALUES OF SOCIAL NETWORK ANALYSIS

Table L.2: Detailed values of SNA

Organisation Name	Degree Centrality	In-Degree Centrality (Max 37)	Out-Degree Centrality (Max 37)	Total Value (1-4)	Power / Influence (1-4)	Level of Involvement (1-4)	Resource Contribution (1-4)
Cameroon Youth Network	27.03%	3	9	2.89	3.33	4	1.33
Girls Globe	27.03%	2	10	2.33	2.5	2.5	2
OAY (Kenya)	27.03%	3	10	2.78	3	4	1.33
PMNCH Secretariat	27.03%	4	10	4	4	4	4
HeR Liberty (Malawi)	21.62%	3	6	2.78	3	4	1.33
Women Deliver	21.62%	5	6	3.2	3.4	3.2	3
PMNCH AYC	18.92%	7	0	3.24	3.14	3.57	3
YP (India)	18.92%	3	5	2.89	3.33	4	1.33
Ministry of Health	10.81%	4	0	2.83	3.75	3	1.75
EVA (Nigeria)	8.11%	3	0	2.89	3.33	4	1.33
Global Financing Facility	8.11%	3	0	3.11	4	2.67	2.67
WHO	8.11%	3	0	3	4	2.33	2.67
Adolescent and youth network (national)	5.41%	2	0	3.5	3.5	4	3
Media (national)	5.41%	2	0	3.17	3.5	3	3
Subnational health department	5.41%	2	0	3	4	3	2
CSO (Kenya)	2.70%	1	0	3	4	3	2
Ministry of Education	2.70%	1	0	3.67	4	4	3
Ministry of Youth Affairs	2.70%	1	0	3.67	4	4	3
National Youth Council (Kenya)	2.70%	1	0	1.67	2	2	1
Policy working group on adolescent health	2.70%	1	0	2.67	3	3	2
UNESCO	2.70%	1	0	3.33	4	3	3
White Ribbon Alliance (Kenya)	2.70%	1	0	3	4	3	2

Calculated by PARTNER software from Visible Network Labs (<https://visiblenetworklabs.com/intro-to-partner/>)

Appendix M **SOCIAL NETWORK ANALYSIS OF PARTNERSHIP**

M.1. INTRODUCTION

This Appendix presents a partial social network analysis of the Partnership for Maternal, Newborn and Child Health (PMNCH). Social network analysis was used as a method to get a more nuanced understanding on the extent to which members of the Partnership are involved in the Partnership Governance mechanisms, how often they communicate with the PMNCH Secretariat and the scope of cross-constituency collaboration that exists. It is only a partial SNA, because the data collected does not allow analysis of relationships among all participating organisations. We therefore focused the analysis on how the organisations engage with the different Partnership governance structures and constituencies.

M.2. METHODS

This analysis is based on information provided by the Partnership's members through the e-based survey launched as part of the external evaluation in 2019 (see Appendix I). An average of 64 informants provided responses to the three questions used as a basis for the analysis:

- Please identify the governance structures in which your organisation was represented in the past year.
- In general, how often are you in contact with the PMNCH Secretariat?
- Did your organisation collaborate with members of other PMNCH's constituencies in the last year?

Data collection was done using SurveyMonkey, while Visible Network Labs's PARTNER software was used for data visualisation.

Limitations (also applied to the SNA described in Appendix L above)

The results from the e-based enquiry should not be considered representative of the overall partnership. The e-survey was only made available in English, which may have refrained members with other language skills to participate. A total of 87 organisations participated, which constitutes 8% of total PMNCH membership according to the PMNCH member database. Of these 87, an average of 64 informants completed the three questions used for the social network analysis.

There were no responses from either the Global Financing Mechanisms (GFMs) or United Nations Agencies (UNAs). Therefore, no mathematical calculations of the network's metrics were performed, as the sample was not sufficient to represent the whole Partnership. However, the results below present a snapshot of how members who contributed to the e-based survey participate and collaborate with the Partnership.

M.3. KEY FINDINGS

M.3.1. Participation in governance structures

Informants were asked if they participated in any of the following governance structures in the past year: PMNCH Partner's Forum, PMNCH Board, Strategy (previously Finance) Committee, Governance & Nomination Committee, Executive Committee, Thematic working group or Advocacy working group.

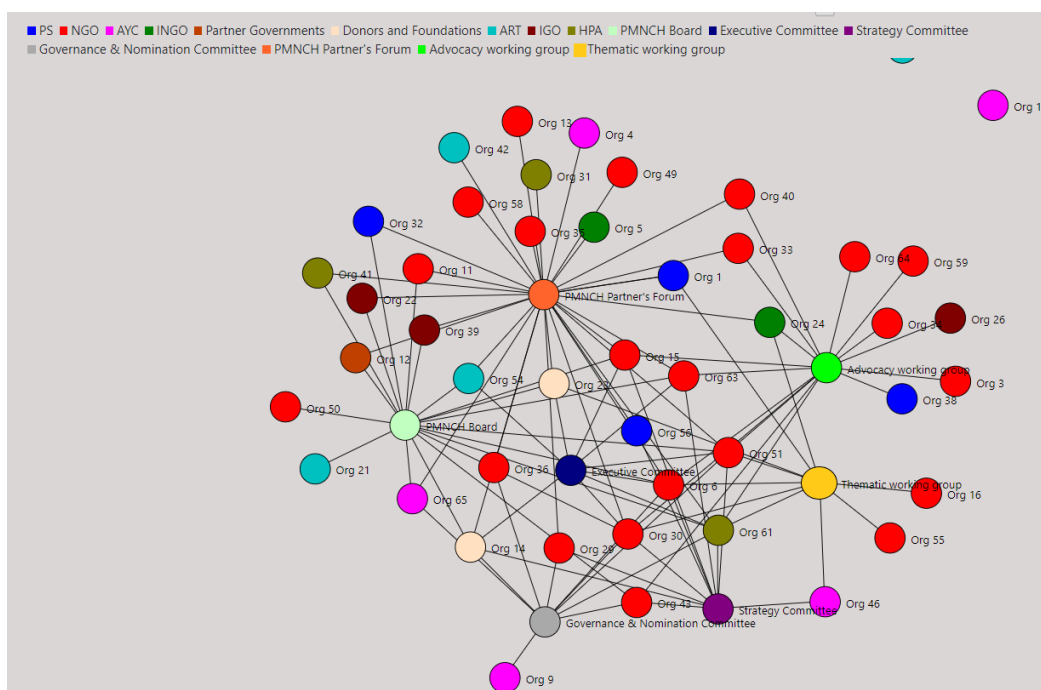
Among the participating organisations, two-thirds (42/63) have reportedly been involved with at least one of the PMNCH governance structures. Just under half of all informants (30/63) participated in the latest PMNCH Partnership Forum in 2018. Almost one third of the informants (19/63) also reportedly engage with the PMNCH Board. At least one representative from the participating constituencies was engaged with both the Partnership Forum and Board meetings. One third of informants (16/63) participated in the advocacy working group. While the sample includes organisations that are involved in the PMNCH Board, and also the standing committees (eleven participated in the Strategy Committee and ten in the Governance and Nomination Committee), only nine organisations indicated that

they have participated in the thematic working groups. This is a relatively small proportion, especially considering that the thematic working groups are supposed to drive the implementation of the Partnership's activities.

One third of the participants (21/63) have not been engaged in any of the PMNCH governance structures, not even in the PMNCH's Partnership Forum. Most of these organisations that have not been involved are national NGOs (12/21), international NGOs (3/21), academic institutions (2/21), one youth organisation, one partner government and one inter-governmental organisation. These informants mention that they are either not aware of how to engage in these structures or that they have tried but not succeeded to become involved. The interactions of the participating organisations across the different governance structures are visualised in Figure M.1 below.

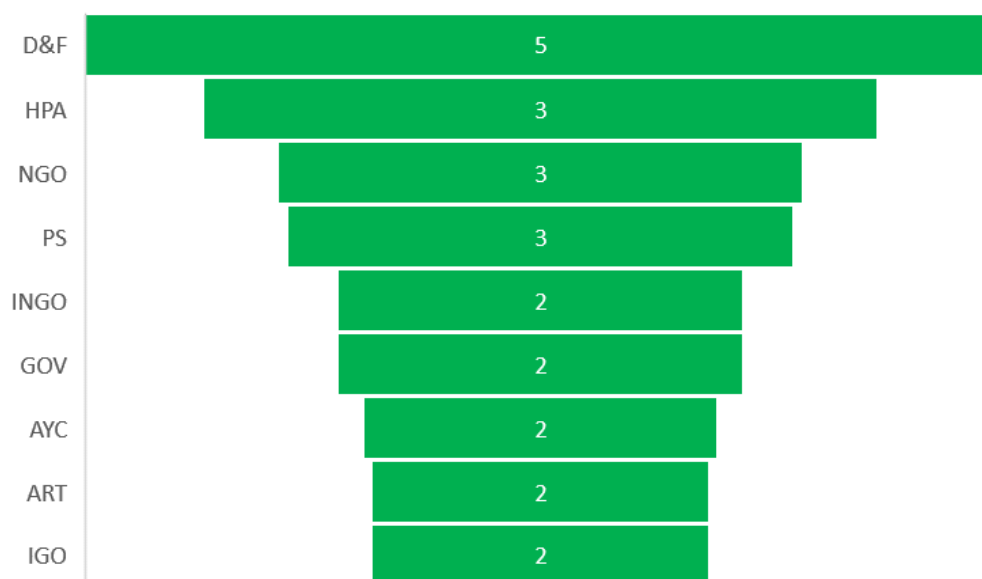
When looking at the average participation of each of the constituency groups across all governance structures, a strong variation is observed. The average number of engagements with different governance structures varies from five for the Donor and Foundations (DFs) to two for the International NGOs, Partner Governments (PGs), Adolescents and Youth Constituency (AYC), Academic, Research and Training Institutes (ART) and Inter-Governmental Organisations (IGO) members (see Figure M.2 below).

Figure M.1: Participation in governance structures



Source: Hera

Figure M.2: Average engagements in different governance structures by constituency



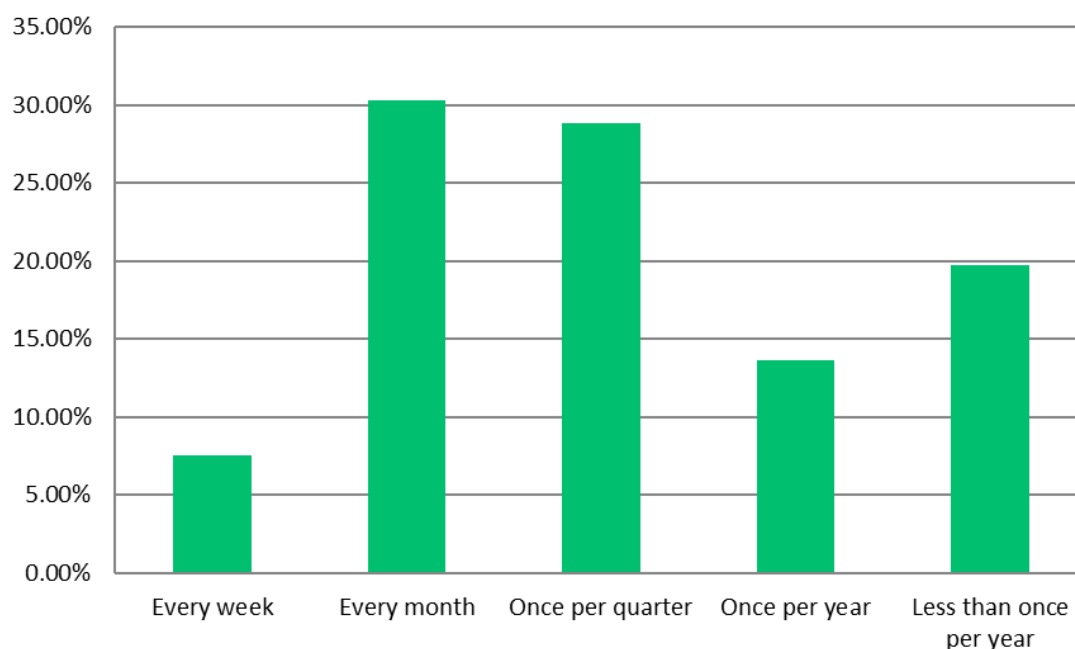
Source: Hera

M.3.2. Frequency of communication with the Secretariat

The Secretariat interacts on a regular basis with the participating organisations. More than 35% of organisations engage at least on a weekly or monthly basis with the Secretariat. Another 28% communicate at least once every quarter. While just under 20% communicate less than once per year.

This level of communication is very high and likely to be even much higher, given that the sample of organisations participating in the survey represent only a small proportion of the overall PMNCH membership base.

Figure M.3: Frequency of communication with Secretariat



Source: Hera

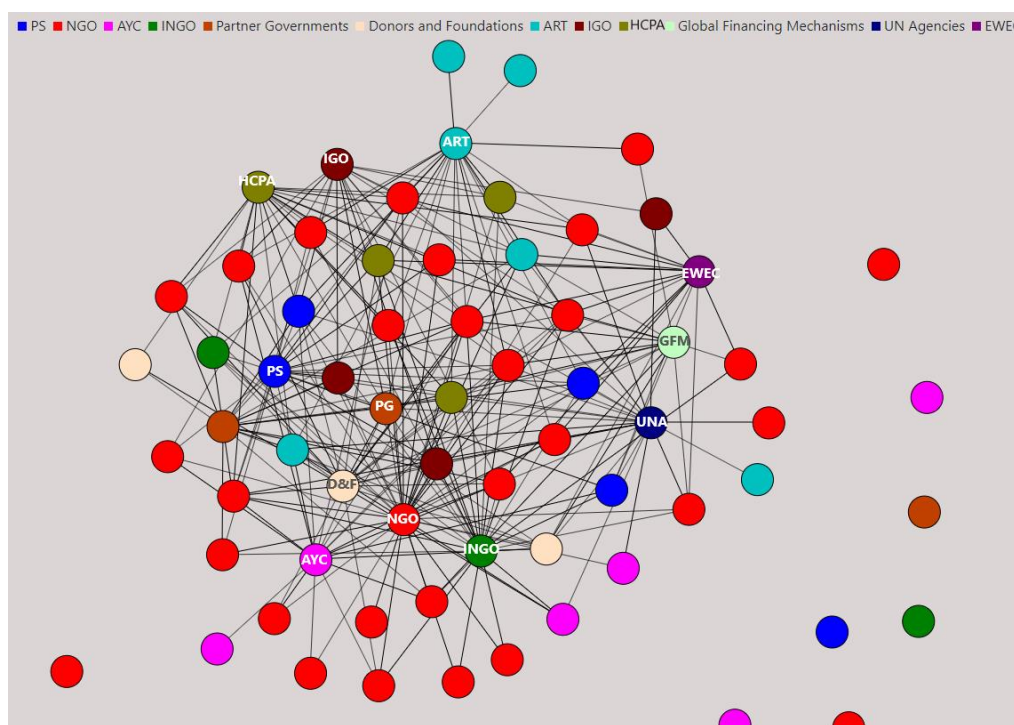
M.3.3. Cross-constituency collaboration

When asked about whether the organisations have collaborated with other PMNCH's members in the last year, the responses were to a large extent affirmative, however almost one third (18/62) responded that they have not collaborated with other partners outside their own constituency, or at least not owing to their PMNCH's membership. Several informants mentioned that they have not enough information of who the other members are or what they do and would appreciate more information on who is working on which topic and which project, as this could facilitate cross-constituency collaboration.

For those that have collaborated with other PMNCH members outside their constituency (44/62), there has been a dense web of collaborations across different constituencies (see Figure M.4). A total of 257 collaborations were mentioned, which is on average five interactions with other constituency members. A few examples mentioned include cross-constituency collaboration through the GFF Civil Society Coordination Group and Steering Committee where constituencies such as NGOs, AYC and Private Sector (PS) come together. Another example referred to is the domestication of the advocacy toolkit for adolescent change at country level where AYC members collaborated with NGOs and PG.

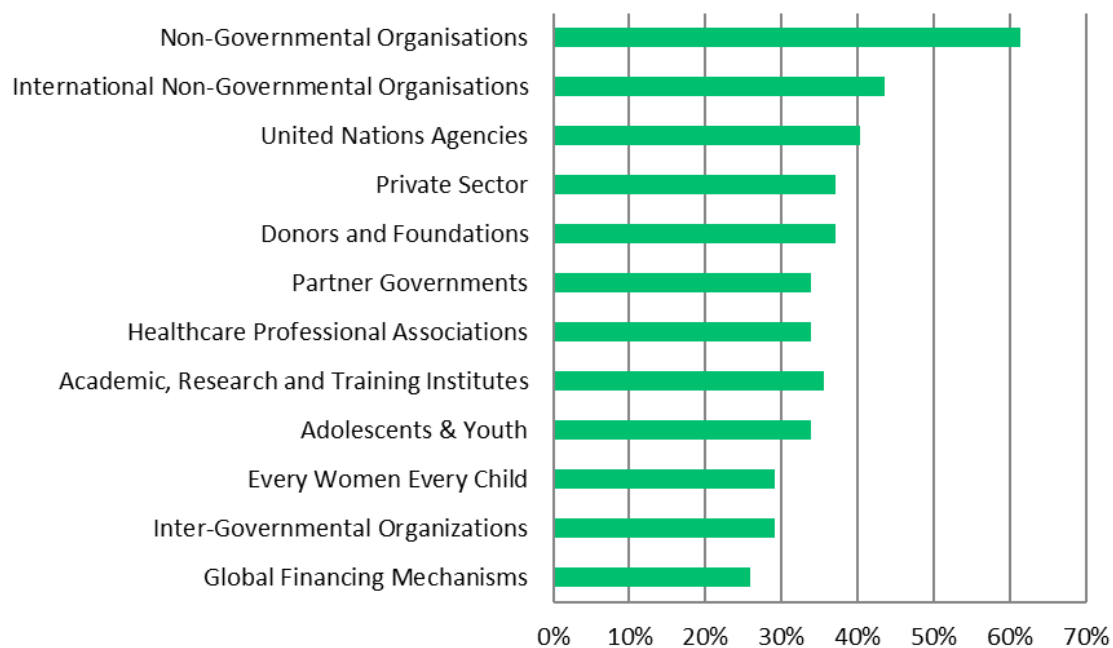
When looking at which constituencies the informants mostly engaged with, most interactions were with national NGOs (61%), followed by international NGOs (44%), and UNAs (40%). The informants interacted to a lesser extent with the Global Financing Mechanisms (GFM) (26%), the IGOs (29%) and Every Women Every Child (EWEC) (29%) (see Figure M.5).

Figure M.4: Cross-constituency collaboration



Source: Hera

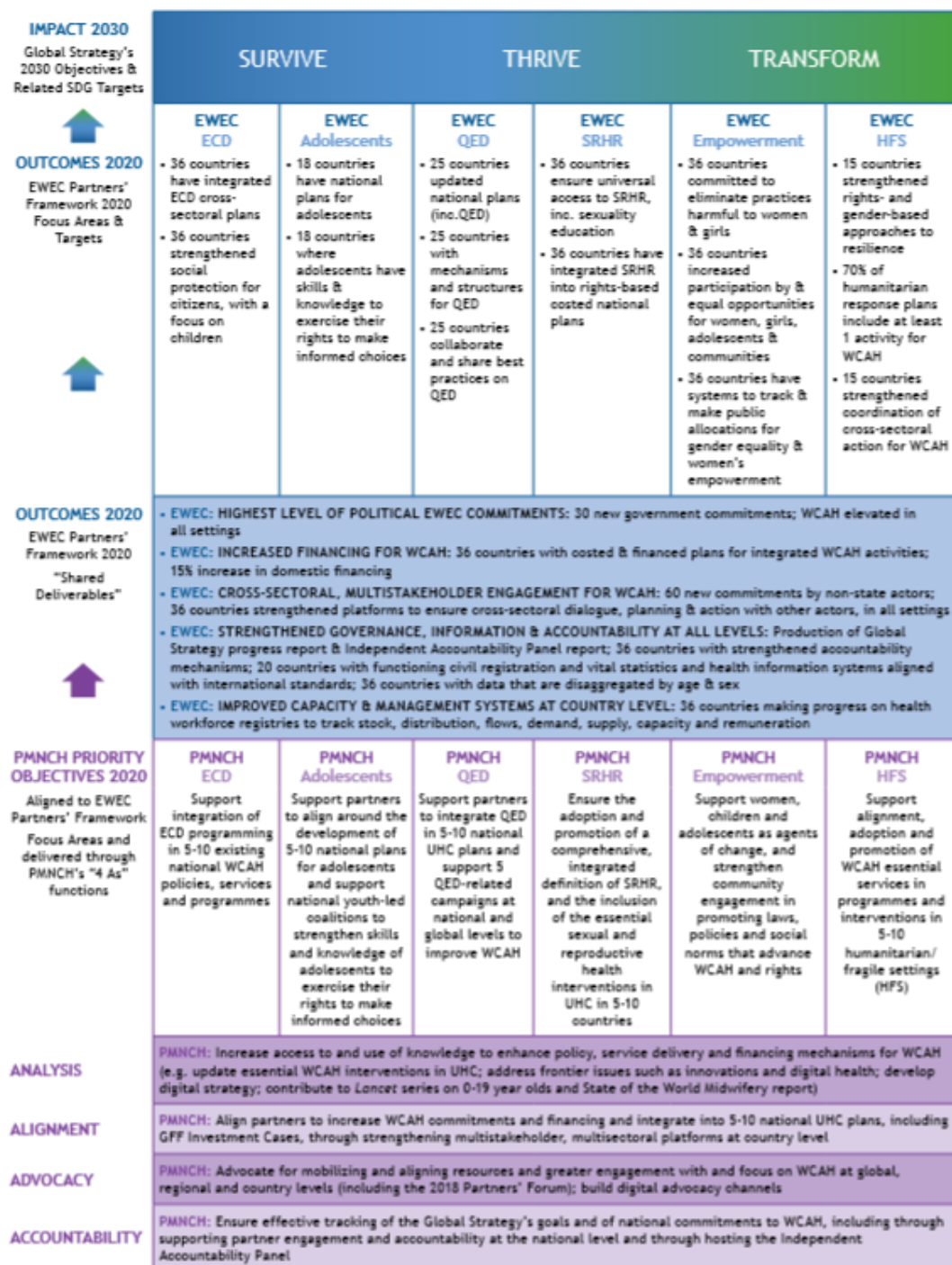
Figure M.5: Number of engagements with other constituencies (in %)



Source: Hera

Appendix N PMNCH'S THEORY OF CHANGE AND RESULTS FRAMEWORK

Figure N.1: The Partnership for Maternal, Newborn and Child Health's (PMNCH) Theory of Change and Results Framework for PMNCH Business Plan 2018-2020



Source: PMNCH 2018-20 Business Plan

Appendix O CASE STUDY CHARACTERISTICS FOR COUNTRY SELECTION

Three case studies for India, Kenya and Nigeria have been developed (see Appendices P, Q and R), to inform the overall findings and recommendations for the evaluation. This Appendix outlines the country case study selection process.

Initial criteria to select countries for the case studies included countries:

- (i) which are within the 75 highest-burden countries for MNCH challenges;
- (ii) across different geographic regions;
- (iii) with different population sizes;
- (iv) with high rates of under-5 mortality, maternal mortality and under-5 stunting;
- (v) with high/ low levels of immunisation coverage;
- (vi) defined as facing fragility;
- (vii) that are highly aid dependent, and;
- (viii) that have high/ low health systems barriers.

Qualitative factors were also considered including identifying countries that had received support from PMNCH between 2014-2019, for example through being selected for multi-stakeholder platform (MSP) support in 2019; through receiving support from PMNCH through Global Financing Facility (GFF) civil society organisation (CSO) grants; and through a small grant administered by PMNCH for adolescents and youth (AY) toolkit implementation.

Utilising the selection criteria, the evaluation team shortlisted a sub-set of 17 countries²¹³ which both met the criteria, and that were identified as (i) being useful to reflect a variety of the PMNCH's activities in the past; and (ii) needing additional support for Maternal, Newborn and Child Health (MNCH) in the PMNCH's next strategic period, to inform the prospective analysis. Some countries were excluded from the selection due to logistical and practical reasons including language constraints.

Based upon this list, the team chose three countries to include in the external evaluation, which took account of the PMNCH Nairobi Board meeting in November 2019 being held in Kenya, and a project team member being based in Nigeria. The three countries tentatively selected by CEPA were agreed upon by the External Evaluation Reference Group (EERG) in the Inception Phase. Table O.1 below presents the three finalised countries against this evaluation criteria.

Table O.1: The selected case study countries against the selection criteria.

Country	Region	Population	Under-5 mortality	Maternal mortality	Under-5 stunting	Immunisation coverage	Defined as facing fragility	Highly aid dependent	High health systems barriers
India	SEARO	1.3 b	36.6	145	38.4 (2015)	85%			✓
	Qualitative factors for consideration include: India is the only LMIC to have donated money to support the PMNCH (2015, 2016, 2018); India was selected for MSP support in 2019; India has a functional H6 platform (WHO) to improve implementation of MNCH project; India has received AY toolkit implementation support from PMNCH; India is a Partner Government; recent activities include the Government of India and key in-country partners, with support from PMNCH, reviving the reproductive, maternal, newborn, child and adolescent health (RMNCAH) Coalition (2018); Prime Minister Narendra Modi pledged US\$ 100 billion to improve women's, children's, and adolescents' health (WCAH) in India which could be followed up on; English documentation is likely.								
Kenya	AFRO	51.3 m	41.1	342	26 (2014)	81%		✓	
	Qualitative factors for consideration include: Nairobi Board meeting 2019 is an opportunity to interview country stakeholders; Kenya was selected for MSP support in 2019 based on principle of demand from in-country partners; Kenya has a functional H6 platform (UNFPA) to improve implementation of MNCH project; there have been various recent PMNCH activities including GFF CSO								

²¹³ Afghanistan, EMRO; Burkina Faso, AFRO; Burundi, AFRO; Cambodia, WPRO; Cameroon, AFRO; Ghana, AFRO; India, SEARO; Indonesia, SEARO; Kenya, AFRO; Liberia, AFRO; Madagascar, AFRO; Malawi, AFRO; Mauritania, AFRO; Nigeria, AFRO; Sierra Leone, AFRO; Zambia, AFRO; Zimbabwe, AFRO.

	catalytic grant, and support to the Kenyan branch of the Organisation of African Youth (OAY); Kenya has been selected as a country to roll out of the adolescent advocacy and accountability toolkit; English and Swahili documentation.								
Nigeria	AFRO	195 m	119.9	917	43.6 (2016)	58%	✓		✓
	Qualitative factors for consideration include: Nigeria has been selected for MSP support in 2019; Nigeria has a has functional H6 platform (UNICEF) to improve implementation of MNCH project; there have been various recent PMNCH activities including the CSO grant; Nigeria has been selected as a country to roll out of the adolescent advocacy and accountability toolkit; Nigeria is a Partner Government; CEPA team in-country presence; English documentation.								

Appendix P INDIA CASE STUDY: THE DELHI SUMMIT 2018 - A MULTI-STAKEHOLDER PLATFORM



P.1. INTRODUCTION

This Appendix presents the India country case study in support of the External Evaluation of the Partnership for Maternal, Newborn and Child Health (PMNCH). We have selected two examples of PMNCH's work in India: support to a multi-stakeholder platform (MSP) and the 2018 Delhi Partners' Forum. Following a summary of key background information (Section P.2), country-level findings on the Partners' Forum are presented (Section P.3). The conclusions are presented in Section P.4. This case study is based on a review of key documentation and key informant consultation. Appendix A provides a list of references and documentation sources. Key informants consulted as part of the case study are included in the overall list of key informants (in Appendix B). We are mindful of the size, and the socio-economic and cultural diversity of India making it difficult to draw generalised conclusions.²¹⁴

The 2018 Delhi Partners' Forum was a flagship event both for India and for PMNCH, involving significant time in preparation and financial commitment from the PMNCH and the Government of India. The Forum provides a good example of the PMNCH Secretariat's skills in planning and convening high profile global events.

P.2. BACKGROUND

P.2.1. SRMNCAH status in India

India's vast and diverse population of over 1.2 billion people is spread across 3.3 million square kilometres of land. Because of its sheer size, India ranks among the top five countries globally in terms of absolute numbers of maternal and child deaths. India has nevertheless made encouraging progress, with the under-five mortality rate (U5MR) declining from 115 per 1,000 live births in 1990 to 59 per 1,000 live births by 2010. Maternal mortality also declined dramatically during the same period, falling from 560 per 100,000 live births in 1990 to 190 by 2013.²¹⁵ However, progress on all indicators is uneven across states, and the 'low-income states' (LIS) – namely Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh – continue to lag behind the rest of the country.²¹⁶ This heterogeneity is reflected in - for example, uptake of modern contraception. While nationally, modern contraceptive prevalence (mCPR) in 2015 was 52.2%, sub-nationally, mCPR ranged from 14.7% for Manipur to 69.8% for Andhra Pradesh.²¹⁷ See Table P.1 and Figures P.1 and P.2 for key health indicators in India.

Table P.1: Key health indicators for India

Indicator	National Family Health Survey (NFHS) 2006	NFHS 2014
% Institutional deliveries	39	79
% Modern contraceptive use by currently married women	56 (CPR)	50 (mCPR)
% Unmet need for family planning	14	13

²¹⁴ The case study has deliberately avoided attributing comments to any individuals as a way of encouraging open and honest discussion. Comments come from a variety of sources across all constituencies both within India and globally.

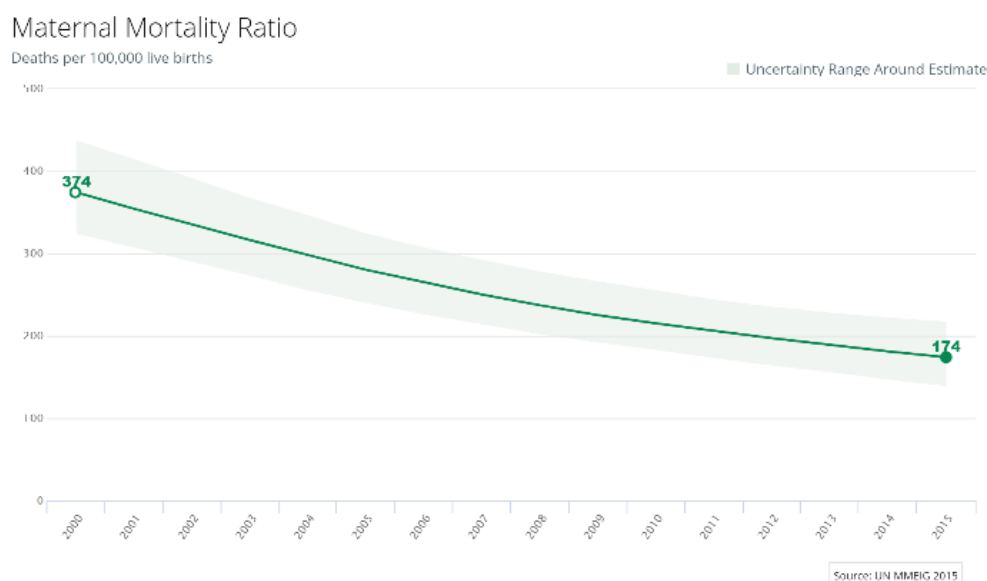
²¹⁵ Trends in maternal mortality: 2000 to 2017. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. 2019

²¹⁶ USAID. MCHIP. India's Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) Strategy

²¹⁷ New JR, Cahill N, Stover J, Pal Gupta Y, Alkema I. Levels and trends in contraceptive prevalence, unmet need, and demand for family planning for 29 states and union territories in India: a modelling study using the Family Planning Estimation Tool. *Lancet Glob Health* 2017; 5: 350–58.

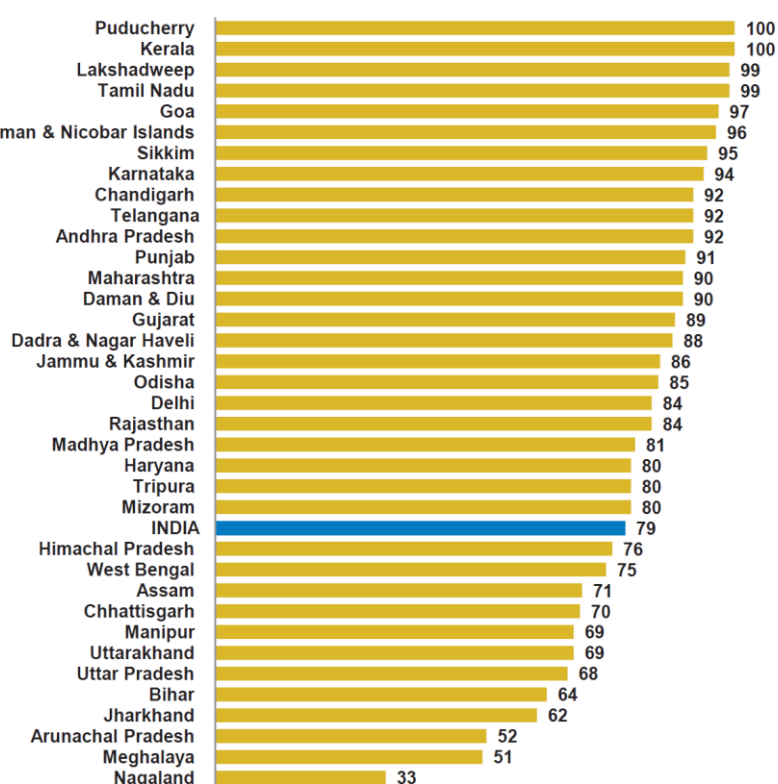
Indicator	National Family Health Survey (NFHS) 2006	NFHS 2014
Infant mortality rate per 1000 live births	79	41
Under-5 mortality rate per 1000 live births	109	50
Children under-five stunted (%)	48	38
Children (12-24 months) who had received all basic vaccines (%)	44	62

Figure P.1: Maternal mortality ratio in India between 2000 - 2015



Source: Countdown 2030

Figure P.2: Percentage of live births in the five years before the survey



SRMNCAH policy and strategy

Women, children and adolescents constitute 68% of India's population and India has the largest adolescent population in the world. To improve the availability of and access to quality health care, especially for poor women and children in rural areas, the Government of India launched the National Rural Health Mission for the 2005-2012 period. One of the important goals was to provide access to improved health care at the household level through female Accredited Social Health Activists (ASHAs), who act as an interface between the community and the public health system.

In June 2012, the governments of India, Ethiopia, and the United States and the United Nations International Children's Emergency Fund (UNICEF) convened the "Global Child Survival Call to Action: A Promise to Keep" summit in Washington DC to energise the global fight to end preventable child deaths through targeted investments in effective, life-saving interventions for children. More than 80 countries, including governments and partners from the private sector, civil society, and faith-based organisations, and many international agencies gathered at the Call to Action, where they challenged the world to reduce child mortality to 20 child deaths or fewer per 1,000 live births in every country by 2035. At the summit, India's Minister for Health and Family Welfare (MoHFW) Shri Ghulam Nabi Azad gave assurances that India would remain at the forefront of the global war against maternal and child mortality. Eight months after the event, the Government of India held its own historic Summit on the Call to Action for Child Survival. With over 250 participants present from approximately 40 countries and all 28 of India's states, the Government of India used the occasion to launch India's ambitious new Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) strategy, now known as RMNCAH, to accelerate mortality reduction amongst the country's most vulnerable women and children.²¹⁸ The Government of India established a secretariat for the activity with support from USAID's Maternal and Child Health Integrated Program (MCHIP), which coordinated activities with each of the subcommittees formed. The government also convened a steering committee and six subcommittees, each comprised of representatives from the MoHFW and development partners including the United States Agency for International Development (USAID), UNICEF, the United Nations Population Fund (UNFPA), and the Bill & Melinda Gates Foundation. The steering committee meetings provided a unique platform for collective decision making, shared responsibility by the MoHFW, development partners, media, private sector, and civil society organisations, and renewed commitment to child survival and a movement to improve reproductive, maternal, neonatal, child, and adolescent health.²¹⁹

India's National Health Policy was approved in 2017.

One informant noted:

"India's structure is very interesting – the state level is guided by national policies but translating this to states – the central government needs to give a lot of flexibility as the states are very diverse. Some states have already achieved the SDGs, but others are at the level of Sub-Saharan Africa. So, we can't have one strategy for all of India – flexibility, hand holding and accountability all need to be there."

P.2.2. PMNCH engagement in India

The World Health Organisation (WHO) commemorated World Health Day 2005 in New Delhi by launching *The World Health Report 2005 – Make every mother and child count*.²²⁰ Following the launch, in April 2005, PMNCH, with the Healthy Newborn Partnership, the Child Survival Partnership, and the Government of India, convened a global meeting "*Lives in the Balance: the Partnership Meeting on Maternal, Newborn and Child Health*". This was attended by representatives from nine countries (Bangladesh, Bolivia, Cambodia, Ethiopia, India, Nepal, Pakistan, Uganda and the United Republic of Tanzania), international agencies, development partners, and civil society groups to discuss the need for increasing the scale of interventions to prevent millions of deaths of mothers, newborns, and children.

²¹⁹ GoI. USAID. MCHIP. India's Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) Strategy. A Case of Extraordinary Government Leadership. July 2014

²²⁰ WHO (2005) The World Health Report 2005

At the close of the meeting, participants presented a statement of commitment called the *Delhi Declaration*, to Mrs. Sonia Gandhi, Chairperson of India's National Advisory Council.

India is one of PMNCH's priority countries and India is also a donor to PMNCH, donating just under US\$3.2m since 2016.²²¹ The Government of India and PMNCH engage at many levels: a representative of India was previously vice chair of PMNCH with roles on the Board, Executive Committee and the Governance and Nominations Committee (GNC). The Government of India was, and still is a co-chair of the writing committee of the Global Strategy as well as its operational framework. India has also been one of the countries that led the campaign for Women and Children's Health (WCAH) in Universal Health Coverage (UHC), co-hosting a ministerial reception to garner political support for the UHC resolutions. India featured as one of the British Medical Journal (BMJ) case studies released at the Partners' Forum and has co-authored editorials and papers with PMNCH. PMNCH has also supported India in championing midwifery, early childhood development (ECD) and the national MSP also known as the RMNCAH Coalition referred to below. It has been a mutually supportive relationship.

P.2.3. Partner coordination mechanisms in India

"The government is firmly in the driving seat and partners rally around national priorities."

On 1 May 2012, through an order from the Government of India, the MOHFW established the RMNCAH Coalition to be the country mechanism for coordination of partners. The first of its kind, the coalition - led by the Government of India with Save the Children acting as Secretariat - gave direction and led advocacy for RMNCH+A policy and programming and to work more effectively with stakeholders to enhance joint action and accountability, and to support the implementation of national commitments and policies. The Coalition had 134 representatives across central and state government agencies, academia, research and training institutes, health care professional associations, local bodies (Panchayats and Nagarpalikas), NGOs, civil-society organisations (CSOs), faith-based organisations (FBOs), media, corporate organisations, bilateral and multilateral donors and United Nations Agencies (UNAs). The coalition held its first and second meetings in November and December 2012 which identified programming, advocacy, strategy and capacity building priorities and agreed the roles of each member organisation and an immediate action plan.²²² The intention was for there to be synchronisation and alignment between the Coalition and PMNCH. The Chair and Coordinator of the India Coalition were both on the PMNCH Board. This was an opportunity for local to global alignment of accountability and advocacy. After the launch of the RMNCAH Strategy in early 2013 the Coalition ceased to exist.²²³

Call to Action India

As part of the RMNCH+A, a coalition of CSOs was formed in 2012. This group, including Save the Children and the White Ribbon Alliance India, has undertaken a mapping to identify CSOs working on RMNCH issues in India, particularly in districts with low density of civil society partners. Following the mapping, 673 NGOs and 147 faith-based organizations (FBOs) were identified as actively working on these issues.

Subsequently, 197 FBOs and NGOs signed the sub-group's declaration of commitment to the Call for Action for Child Survival. This declaration pledged their support to ending preventable child deaths and for reducing the infant mortality rate to 25/1000 live births, and the maternal mortality ratio to 100/100 000 live births by 2017. The sub-group continues to meet and advise the coalition on strategies for reducing mortality in India and it promises to drive advocacy, reach marginalized groups, promote integrated initiatives, support behaviour change communication strategies, promote gender equality and build accountability for women's and children's health across India. The

Declaration is available at:

http://www.unicef.org/india/3_Final_Mapping_CS0-FBO_Report_Jan_2013.pdf. The sub-group is currently drafting a framework on the potential role of CSOs and FBOs in supporting effective implementation of RMNCH+A strategy.

Responding directly to the recommendations of the Commission on Information and Accountability for Women's and Children's Health (CoIA), in late 2011 PMNCH began to provide catalytic financial and technical support for the development or strengthening of national civil society alliances for RMNCAH in ten countries including India. These funds were to be used to align priorities and activities in the context of existing national plans and processes. In India, the key challenge identified was the lack of opportunity for CSOs to participate in broad-based RMNCAH policy and planning, and hence focused on securing CSO participation within multi-stakeholder RMNCAH alliances, including government, donors, and the UN.²²⁴ Under the direction of the Adolescent and Youth Constituency (AYC), the

²²¹ Executive Director's report presented in Nairobi, November 2019.

²²² PMNCH. Strengthening National Advocacy Coalitions for Improved Women's and Children's Health. 2013.

²²³ Secretariat personal communication

Partnership supported an Indian Youth Organisation (the YP Foundation) with a grant of £35,000 for the development and roll out of a toolkit “*Advocating for change for adolescents.*”²²⁵ The Coalition Action Plan included:

- i) Mapping of donor partners;
- ii) Mapping of RMNCH+A projects at district and sub-district level, and the selection of interventions to scale up to impact outcomes;
- iii) Documenting global success stories of other countries in improving RMNCH+A outcomes;
- iv) Providing support to individual states to implement universal screening of neonates and childrens programme;
- v) Publicising coalition and its aims through a website, newsletter and other activities, and;
- vi) Disseminating the Book of Proceedings: a national consultation on the potential role of private sector providers in delivering essential neonatal care services and provisions in under-served urban and peri-urban settings.

In 2017, building upon the earlier Coalition, MoHFW (with PMNCH support) revived the Coalition and the PMNCH Secretariat issued a tender for technical support.²²⁶ The new Coalition developed a well-defined governance mechanism and a set of procedures and output indicators to track progress. Nine priority areas were identified: ECD; adolescent health and well-being; quality of care (quality assurance and quality improvement); urban areas; private sector (public–private partnerships); accountability mechanisms; equity (gender, geographic, economic); continuum of care; and violence against women. Working groups with representation from national, state and international partners, and clear terms of reference, were constituted for each priority area to carry out a situation analysis and develop actionable recommendations. Adolescent Health as a separate life stage was added and hence the inception of the RMNCAH Coalition for improved RMNCAH outcomes through alignment and partnership building.

More recently in 2018, PMNCH provided financial support of US\$75,000 for a period of 18 months. The MoHFW and partners used different agencies for different levels of support.²²⁷ Outputs included:

- i) Setting up of four working groups based on the national priorities identified by the Coalition i.e. Adolescent health, ECD, Quality assurance/Quality Equity Dignity. These working groups developed white papers for their respective priority areas;
- ii) Developing a coffee table book ‘Proven Paths’: The MSP/ Coalition guided the development of a coffee table book ‘Proven Paths’, which is a compendium of 36 best practices in maternal, child and adolescent health, which was released at the inaugural ceremony of the Partners’ Forum; and
- iii) Developing the India Strategy for Women’s, Children’s and Adolescents’ Health (I-WACH), 2018-30: This was developed under the guidance of the Coalition and launched at the Partners’ Forum.

P.3. THE 2018 PARTNERS’ FORUM

P.3.1. Genesis of the Partners’ Forum

The PMNCH Partners’ Forum provides a regular global platform for the renewal of commitments to the mission and purpose of the Partnership, for global high-level advocacy and for achieving broad consensus on the strategy and priorities of the Partnership. Members from all constituencies are invited to participate. There have been four Partners’ Forums to date: 2008 in Tanzania, 2010 in India, 2014 in South Africa and 2018 again in India to which this case study refers.

The November 2010 Delhi Partners’ Forum convened by PMNCH and hosted by the MOHFW was titled – “*From Pledges to Action*” – A Partners’ Forum on Women’s and Children’s Health. More than 1200 participants from 33 countries attended and it was inaugurated by the then President of India, Her Excellency Pratibha Devisingh Patil. Two months later in Delhi there was another Partners’ Forum on Women’s and Children’s Health to re-state commitments made during the year and provide a platform to promote action and accountability for the pledges. The MOHFW of India, health ministers from Africa and Asia and the Director-General of WHO were among the speakers at the Forum. The meeting in Delhi was considered significant as it was five years after the launch of PMNCH.

The Partners’ Forum 2018 (PF2018) resulted from a request from the Secretary of Health and PMNCH Board Vice-Chair, CK Mishra of the Government of India. The objective of PF2018 was to achieve greater consensus and

²²⁵ PMNCH. Women Deliver. *Advocating for Change for Adolescents! A practical toolkit for young people to advocate for improved adolescent health and well-being.* 2018.

²²⁶ <https://www.who.int/pmnch/getinvolved/rfps/support-for-rmncah-coalition.pdf>

²²⁷ Secretariat personal communication

alignment among PMNCH's 1,000+ partners on priorities, strategies and technical approaches to accelerate implementation of the Global Strategy and progress towards UHC and the Sustainable Development Goals (SDGs). PF2018 focused on improving multisectoral action for results, sharing country solutions, and capturing best practices and knowledge within both health and related sectors. It also emphasised the importance of people-centred accountability, bringing forward voices and lived realities. The Secretariat allocated US\$1.5m in the Business Plan, and subsequently US\$1.7m in the 2017 workplan and budget for the Partners' Forum.²²⁸

P.3.2. Planning and consultation

Planning the Forum required many months and a significant level of organisation both within India and globally. There were seven committees (including a youth engagement committee) and global and national organising committees with representatives from all partners including the H6. Different stakeholders were allocated tasks which played to their skills and strengths. There was significant NGO involvement and NGOs contributed *inter alia* to production of synthesis and accountability reports and the women's perspective - especially for respectful care, access to services, and protection from violence in the health system. NGOs reported that this all helped with the subsequent creation of an initiative for assured delivery.

Various events took place in the lead up to the conference. A global kick-off event was held before the Partners' Forum on 11 April in New Delhi which attracted more than 50 media organisations to a panel discussion attended by India's Minister of Health and Family Welfare, J.P. Nadda, incoming PMNCH board chair Michelle Bachelet and Bollywood star and UNICEF goodwill ambassador Priyanka Chopra. A common theme during the discussion was the need for cross-sectoral collaboration for action and results, as well as greater attention to improving gender equity and empowerment of women and girls. A panel discussion was followed by a visit to the residence of India's Prime Minister Modi, who received the Partners' Forum logo and agreed to become patron of the Forum.

Other pre forum events included a Webinar series with more than 300 participants from 80 or more countries.²²⁹ Also the launch of a new global campaign "What Women Want", piloted in 2017 in India to improve quality maternal & reproductive care for women and girls.

In the context of increasing evidence that more can be achieved when sectors like health, education, water, hygiene and sanitation, and labour work together, instead of in silos, it was agreed that a major focus of the 2018 Partners' Forum would be sharing stories of how countries are successfully collaborating across sectors and stakeholders to fast-track improvements in the health and well-being of women, children and adolescents.

The event

The Forum was convened by PMNCH and the Government of India in New Delhi on 12-13 December 2018 and led by Prime Minister Modi. Among the more than 1,600 participants from ten constituencies and 85 countries were 27 heads of country delegations, ministers and 23 parliamentarians. Participants also included more than 400 young people from all regions of the world, as part of the youth engagement strategy. It was only after the Government of India stepped in to provide support for local scholarships that about 40 Indian NGOs were able to participate.²³⁰ PMNCH in collaboration with the International Centre for Journalists also facilitated the participation of 50 journalists from around the world resulting in more than 85 published stories in 20 countries. Some informants referred to problems faced by the media, who had to be screened and selected by the Government.

The Summit provided a platform for the launch of various strategies and guidelines including *inter alia*: the India adaption of the Global Strategy, Guidelines on Midwifery Services in India and Indian Strategy for Women's, Children's and Adolescents' Health. Also announced was the newly approved PMNCH 2018-2020 Business Plan and 2017 Annual Report, Guide for Implementing the Global Strategy in Latin America & Caribbean, PMNCH – Women

²²⁸ PMNCH (2017) Partnership 2017 Budget: Complete and Essential.

²²⁹ <https://www.who.int/pmnch/media/news/2018/partners-forum-chair/en/>.

²³⁰ Anecdotal report from key informant.

Deliver Adolescent Toolkit version 2.0, Transforming Care for Small and Sick Newborns and Call for Action – Ministerial Conclave and Call for Action – Parliamentary Conclave.²³¹

The programme comprised four plenary sessions, 24 concurrent sessions and six official pre-Forum side events, and involved 195 speakers and moderators. It was shaped around the common deliverables specified in the Every Women Every Child (EWEC) Partners' Results Framework, including those relating to the cross-cutting themes of the Survive-Thrive-Transform agenda and the six priority focus areas: ECD; adolescent health and well-being; quality, equity and dignity in services; sexual and reproductive health and rights (SRHR); the empowerment of women, girls and communities; and humanitarian and fragile settings.

During the Forum there was considerable on-line participation and significant media coverage with 100 interviews conducted, including by popular outlets such as the Financial Times and CNN. It is difficult to estimate the actual numbers who connected with or benefited from the Forum because of the "Network/ Ripple effect".

In addition, a special edition of the BMJ was launched at the Forum, which featured twelve country case studies, including one from India on country-level collaboration across sectors. The India case study refers to collaboration between India's MOHFW and eleven other ministries to increase immunisation coverage among children and pregnant women to 90% by 2020. By the end of 2017, over 4.5m children and approximately one million pregnant women had been vaccinated. The strong partnerships built across government departments and the engagement of senior leaders at district, state and national levels are serving as a platform for strengthening the delivery of health services beyond immunisation.²³² Also included in the BMJ publication was a case study of a new global campaign supported by PMNCH to give women and girls an opportunity have their voice heard. Dr Aparajita Gogoi, National Coordinator, White Ribbon Alliance, told the audience that the "What Women Want" campaign, piloted in the previous year in India to improve quality maternal and reproductive care for women and girls, aimed to hear directly from one million women worldwide.²³³

Financial commitments

In September 2018, three months before the Partners' Forum, Prime Minister Modi had launched *Ayushman Bharat*, the world's largest government-funded health insurance scheme to provide health care to over 100 million families covering the urban and rural poor. All chief ministers subsequently launched the scheme from their respective states.^{234,235} The scheme is expected to cost the central and 29 state governments US\$1.6b per year. 70% of this is to be allocated to WCAH.²³⁶ This pledge for US\$100b was re-stated at the Partners' Forum.

The Forum also provided a highly visible space for 18 additional commitments including a World Vision International pledge to mobilise US\$7b for WCAH specifically, and a US\$65m additional funding pledge by Laerdal Medical Foundation.

Box P.1: Communique Delhi Forum 2018

During this Forum we have seen PMNCH in action as a model for the type of multi-stakeholder partnerships called for in the 2030 Agenda for Sustainable Development. **We call on governments, civil society organisations, the private sector, and all other partners, agencies and individuals** to invest and work comprehensively toward the goals of the Global Strategy, and to collaborate with organisations and sectors outside their standard partners. Only by doing so can we ensure that women, children and adolescents – and their families and communities – will survive and thrive, that gains will be sustained and equitable, and that societies will be transformed, for the better.

Source: PMNCH (2018) *Communique Delhi Forum 2018*

²³¹ Presentation at the post Forum Board meeting by Executive Director.

²³² MoHFW, GoI, PMNCH Country case studies on collaboration across sectors for women's, children's and adolescents' health.

²³³ Making Multisectoral Collaboration Work. Improving vaccination coverage in India: lessons from Intensified Mission Indradhanush, a cross-sectoral systems strengthening strategy. BMJ 2018;363:k4782

²³⁴ Economic Times. 18 September 2018.

²³⁵ <https://www.theguardian.com/world/2018/sep/24/modicare-indias-pm-promises-free-health-care-for-half-a-billion-people>

²³⁶ Anecdotal report by key informant

P.3.3. Evaluation of the Forum

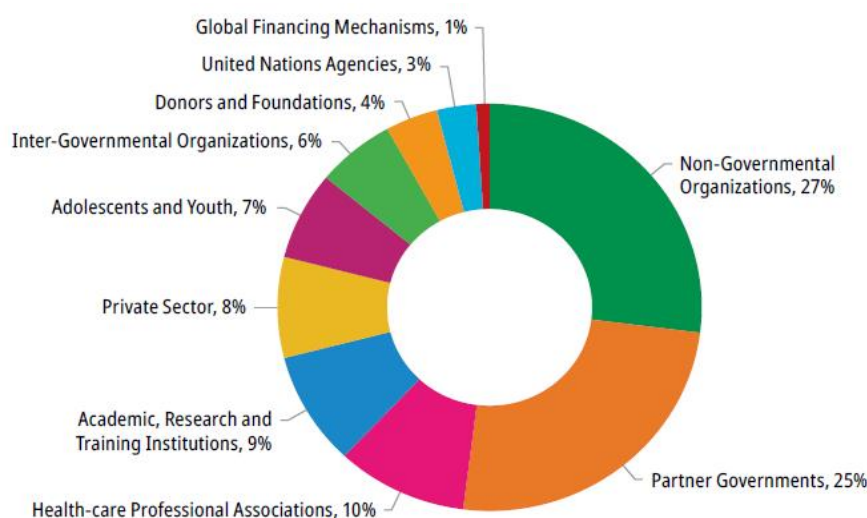
The PMNCH Secretariat has generated a vast body of information about the Forum which is still accessible on their website. It is evident from this that publicity and communication were done very effectively across the membership and beyond, with members such as Gavi referring to the Forum on their website as a “*key moment to galvanise global efforts to deliver on the EWEK Global Strategy - a roadmap for ending all preventable maternal, newborn and child deaths by 2030.*”²³⁷

In March 2019, Indigenous Peoples Knowledge (I-P-K) was commissioned to conduct a survey to elicit feedback from participants on PF2018’s programme, content and logistics. The survey was emailed to 1,782 Forum participants by Survey Monkey.²³⁸ 141 responses were received – a low response rate of 8%, though the analysis of responses in Figures P.3 and P.4 are made on 138 and 97 respectively. The largest responses by constituency were from partner governments (25 responses) and NGOs (27 responses). More than two-thirds (69%) of informants reported that PF2018 had a positive impact on their work practice, and over half (56%) reported making new contacts and forging potential collaborations as the key change (Figure P.4). The Forum was a public relations success for India though its timing (in its proximity to the national elections) was questioned through key informant interviews, both at the global and national level.

²³⁷ Gavi (2018) Harnessing the power of partnerships to benefit maternal, newborn & child health

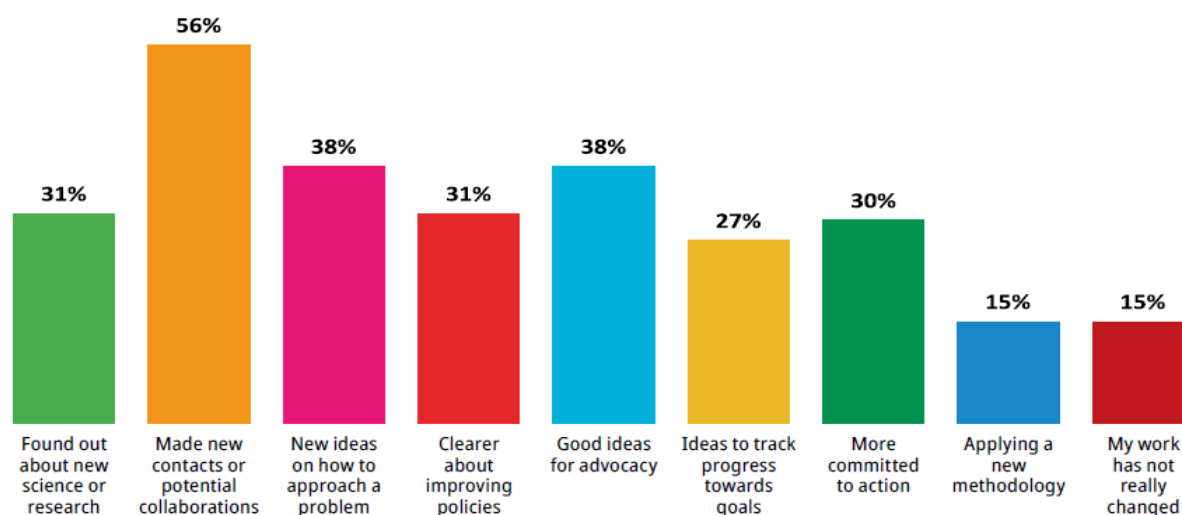
²³⁸ Indigenous Peoples Knowledge (2019) PMNCH Partners’ Forum evaluation – Draft presentation

Figure P.3: Distribution of informants by occupation, according to PMNCH constituency, N=138



Source: Indigenous Peoples Knowledge (2019) PMNCH Partners' Forum evaluation – Draft presentation

Figure P.4: Reported enhancement of work practices following the Forum, N=97



Source: Indigenous Peoples Knowledge (IPK) (2019) PMNCH Partners' Forum evaluation – Draft presentation

The Government of India informants considered the Forum to have been a very successful platform by providing the opportunity to launch many products such as the Forum Communique, Ministerial Forum and Success Factor case studies. As one informant noted:

“India as a country benefitted immensely from this entire collective advocacy and developed an India adaptation of the Global Strategy and also announced the inclusion of midwifery nurse practitioner cadre. Helping India convene a global expert group on Early Childhood Development that paved the way for the development of initiatives around ECD in India and their incorporation into the existing programme activities.”

And another explained,

“As a partner country, India values the contribution of PMNCH in bringing one of the key governance mechanisms of the Partners' Forum to India for the second time in 2018. This provided us not only an opportunity to learn from global best practices and experience but also to renew the commitment of the Government of India to the WCAH agenda.”

It was also felt by some informants that the Forum rejuvenated the RMNCAH coalition. As one informant explained, *“we have kept the foot on the accelerator and reinforced the need for continued and sustained investment in WCAH”.*

Also, it has helped to revive and strengthen CSO engagement and, together with other support, to mainstream adolescent and youth engagement. The launch of the Adolescent Toolkit was a feature of this.

Concerning the Forum's impact on their work, 69% of IPK respondents reported a positive change in the months following the event. While all informants across constituencies interviewed for this evaluation agreed it was a very good networking opportunity, not all the NGOs felt that their voice was heard – including some international NGOs.

"I attended the Forum in Delhi but was disappointed at the lack of opportunities for discussions and always being on the receiving end."

P.4. CONCLUSIONS

PMNCH support to the MSP in India – is it still needed?

It has been challenging to set out a coherent and consistent narrative on the evolution of the MSP in India. It would seem from the informants that national stewardship and alignment of partners is not an embedded and routine process in the health sector or one which would normally be inclusive of non-state actors.

Informants provided opposing views on whether PMNCH and/or the Secretariat support is needed for a functioning MSP in India. Whilst some stated that the PMNCH can continue to play a catalytic role in India, bringing fresh ideas of what is happening globally in various areas using a focused approach on priority issues, others suggested PMNCH's engagement in India does not add particular value given that there are already platforms and strong mechanisms at the country level.

In the context of numerous global health meetings, strong contribution of Indian experts to global knowledge and effective and sophisticated social media in India, the need for PMNCH support to a national MSP to keep India informed of global developments in health is unclear. However, the vast variation in key indicators between Indian states suggests that strengthening capacity of MSPs in low performing states is a priority, which was articulated by various respondents at the national level.²³⁹

The 2018 Partners Forum – did it provide value for money?

The 2014 evaluation of PMNCH noted that the Forum mechanism can convene many high level delegates which speaks for the high regard in which partners hold PMNCH.²⁴⁰ The majority of PF2018 survey informants cited that the greatest value of the forum was the opportunity provided for professional networking, advocacy and interaction with policy-makers - a view supported by many informants in this evaluation. However, our KIs found that various informants at the global levels, including in the PMNCH Board, members and other external stakeholders, think the outcomes of the Forum make it difficult to justify the financial spend and carbon costs incurred, and that some of these informants would not support the event in the future.

Some informants, including at the global level, suggested that there could be a risk that events such as this can be politicised and that the choice of country venue for the Forum can influence which other countries are able to attend or what examples of programmes and activities are showcased.

In the context of climate change, diminishing donor funds for such events and the increased sophistication in virtual communication, there is an urgency to review the value for money of the PMNCH Partners' Forum. The proposal in the Forum evaluation for alternative conferencing arrangements that allow for e.g. Open Space Technology is one that could contribute to future planning.²⁴¹ Paying for the carbon footprint of such events will also be an important consideration in going forward.

²³⁹ PMNCH communication.

²⁴⁰ Price Waterhouse Coopers. PMNCH External evaluation. July 2014.

²⁴¹ Marc Steinlin and Margaret Jack. Ingenious Peoples' Knowledge. PMNCH Partners' Forum Evaluation. April 2019

Appendix Q KENYA CASE STUDY: “GIVING A VOICE TO YOUTH AND CIVIL SOCIETY ORGANISATION”

This Appendix presents the Kenya country case study in support of the External Evaluation of the Partnership for Maternal, Newborn and Child Health (PMNCH). The case study looks at how PMNCH has engaged with constituencies in Kenya, in particular the Adolescent Youth Constituency (AYC) and non-governmental organisation (NGO) constituencies. Following a summary of the Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) context in Kenya (Section Q.1), country-level findings are presented (Section Q.2) looking at the rationale for engagement (Section Q.2.1), what activities were supported and how (Section Q.2.2), what results were achieved (Section Q.2.3) and what are the lessons learned (Section Q.2.4).

This case study is based on a review of key documentation and consultations with ten key informants from different PMNCH constituencies in Kenya (government partners, youth organisations, NGOs and representatives of multilateral and academic institutions) as well as the PMNCH Secretariat. Appendix A provides a list of references and documentation sources. Key informants consulted as part of the case study are included in the overall list of key informants (see Appendix B). We note the socio-economic and cultural diversity of Kenya and that stewardship of the health sector is provided at the sub-national level. Owing to limitations of time and budget, we have conducted consultations only at the central level.

Q.1. THE SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH CONTEXT IN KENYA

Kenya has experienced strong economic growth of around 5.7% p.a. on average in the last five years. This economic growth, however, has not been inclusive. High levels of poverty, as well as regional and economic disparities, continue to exist. Poverty levels vary widely among counties and between rural and urban areas.²⁴² According to the 2019 Multi-dimensional Poverty Index, 39% of Kenya's population is considered poor as they are deprived of essential access to either health, education or standard of living.²⁴³

The Kenyan government has made a commitment to achieve UHC by 2022. The country's political commitment to Universal Health Coverage (UHC) is embodied in the government's big 4 agenda which includes healthcare for all as a key development priority. The pilot roll-out of UHC in four counties²⁴⁴ is a progressive move. The government's commitment to UHC is also visible in the allocation of KES 2.5 billion (US\$24m) for health in the 2018/19 budget, an increase from KES 1.1 billion (US\$10.7m) compared to 2017-2018.²⁴⁵

According to the 2014 Kenya Demographic Health Survey, the country made progress in most SRMNCAH indicators (see Table Q.1). Under-five mortality and infant mortality rates were halved between 2003 and 2014 due to increased use of essential health services such as immunisation, vitamin A supplementation, and use of insecticide treated nets. However, progress was not enough to reach the Millennium Development Goals' (MDGs) targets in 2015. Neonatal mortality experienced a much slower rate of decline in the last decade. Despite improvements in nutrition status, more than one in four children under five were stunted. Moreover, the maternal mortality ratio remained high, and adolescent pregnancy rates barely decreased. Considerable differences by geographic and socio-economic factors remain an important concern. For example, skilled birth attendance was 22% in Wajir county compared to 93% in Kiambu county, and 31% among the poorest wealth quintile compared to 93% among the richest. Infant and child mortality rates have remained lowest in the Central and Nairobi regions, but they are persistently higher than the national average in the Nyanza, Western and Coast regions.²⁴⁶

²⁴² Development Initiatives (March 2017), Analysis of Kenya's budget 2017/18, what's in it for the poorest people?

²⁴³ <http://hdr.undp.org/en/2019-MPI>. Accessed on 22 November 2019.

²⁴⁴ Isiolo, Kisumu, Machakos and Nyeri counties

²⁴⁵ Price Waterhouse Coopers (2018), Reimagine the possible Budget 2018/2019

²⁴⁶ National Council for Population and Development, 2015. Kenya Demographic and Health Survey 2014. Rockville, Maryland: Macro International Inc.

Table Q.1: Key SRMNCAH indicators for Kenya

Key indicators	Kenya Demographic health Survey (KDHS) 2008/2009 ²⁴⁷	KDHS 2014 ²⁴⁸
Neonatal mortality rate (per 1,000 live births)	31	22
Infant mortality rate (per 1,000 live births)	52	39
Under-five mortality rate (per 1,000 live births)	74	52
Maternal mortality ratio (per 100,000 live births)	488	360
Total fertility rate (per women)	4.6	3.9
Adolescent (15-19) fertility rate (per 1,000 girls)	103	96
Children under-five stunted (%)	35	26
Deliveries attended by a skilled provider (%)	43	62
Women who had 4+ antenatal visits during their last pregnancy (%)	47	58
Children (12-24 months) who had received all basic vaccines (%)	65	71
Children under 6 months exclusively breastfed (%)	32	61
Contraceptive prevalence rate (any modern method) among currently married women (%)	39	53
Unmet need for family planning (%)	25	18

In 2013, Kenya embarked on a devolution process, bringing resources and government functions closer to the people. While this presents opportunities to improve health services and can contribute to greater equity, it also poses challenges, as the capacity at county level both in terms of human resources and infrastructure needs to be strengthened for implementation of the new mandate. An analysis of the national health budget reveals that there is wide variation among counties in allocation of resources as well as fluctuations in the overall public financing for the health sector. However, since 2014/15, the government allocation for health has remained stable at roughly 7.5% of the total government budget.²⁴⁹ Based on the Gross Domestic Product growth rate, Kenya was re-classified as a lower-middle income country in 2014 and this has affected the volume of development assistance. Donor contributions have decreased from 32% of the total health expenditure in 2009/10 to 26% in 2012/13,²⁵⁰ 23.4% in 2015/16,²⁵¹ and 19.5% in 2016/17.²⁵²

As a front-runner country for the Global Financing Facility (GFF), Kenya developed a Reproductive, Maternal, Newborn, Child, and Adolescent Health + Nutrition (RMNCAH(+N)) investment framework to scale up a set of effective, efficient, and equitable interventions. The GFF combines external support, domestic financing and innovative sources for resource mobilisation and delivery, including the private sector. Specific targets are set to be achieved by 2020, such as increasing skilled birth attendance to 87%, four plus antenatal care visits to 69%, full immunisation to 76%, reducing stunting among children under five to 19% and contributing to a decrease in neonatal mortality to 18%.²⁵³ Up to June 2019, 30% of the total budget (US\$191m) had been disbursed. All counties receive

²⁴⁷ National Council for Population and Development (2009). Kenya Demographic and Health Survey 2008-2009. Calverton, Maryland: Macro International Inc

²⁴⁸ National Council for Population and Development (2015). Kenya Demographic and Health Survey 2014. Rockville, Maryland: Macro International Inc.

²⁴⁹ MoH. 2017. National and County Health Budget Analysis Report, FY 2016/17.

²⁵⁰ MoH. Kenya National Health Account 2012-13

²⁵¹ MoH. Kenya National Health Accounts 2015-16

²⁵² WHO, Kenya Health accounts, downloaded 24 November 2019

²⁵³ Ministry of Health, Government of Kenya, 2016. Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment framework.

funding to support the implementation of their annual workplans which is integrated in an overarching national Investment Framework. Counties receive the GFF resources as separate funding flows. Their absorption capacity is reported to be low, partly due to weak coordination, and late disbursement is also a challenge.²⁵⁴

In addition to the GFF project, Danida, DFID, and Gavi established a multi-donor trust fund to align investments in capacity building to provide additional technical assistance and support the implementation of the Investment Framework. The UN Joint Programme on RMNACH (2016-2020), for example, is funded through this trust fund and aligned to the Investment Framework. This programme is implemented by the H6 in six high-burden counties.²⁵⁵

The main coordination mechanism on SRMNCAH in Kenya is the recently reformed Reproductive Health Technical Working Group (RH TWG), which is made up of sub-committees for the different sub-programmes, such as Maternal and Newborn Health, Adolescent sexual and reproductive health and rights (SRHR), Gender and Rights, Family Planning and Monitoring & Evaluation. These committees are led by the Ministry of Health and members from H6, international NGOs and local NGOs including youth-focused NGOs. In addition, the GFF also has a separate coordination mechanism in which both CSO and youth will be represented. This mechanism was planned to start in 2018 but is not yet up and running. As health is now a devolved function, the TWGs at national level are mostly concerned with policy setting and capacity building and less so with actual implementation. The Reproductive Health TWGs at county level are where most SRMNCAH discussion now takes place.

Almost 80% of Kenyans are aged 35 years or younger according to the 2009 census.²⁵⁶ This group faces barriers that affect their health seeking behaviours, such as stigma and poor healthcare provider attitudes. Their main health concerns include teenage pregnancy, harmful practices, sexual and gender-based violence, drug abuse, road accidents and injuries and mental health problems. Non-communicable diseases are also on the rise among young people, as are new HIV infections among adolescent girls.²⁵⁷

Q.2. PMNCH'S ENGAGEMENT IN KENYA

Up to mid-2019, PMNCH's engagement with Kenya has been mainly through the small grant mechanism. PMNCH has provided two grants to the Organisation for African Youth (OAY) to build capacity for adolescent advocacy using the global Advocating for Change for Adolescents! Toolkit. HENNET, an umbrella organisation of health NGOs in Kenya received a grant in 2018 to strengthen the national CSO platform for engagement with the GFF processes. In September 2019, HENNET received a second grant to further their work of strengthening the capacity of civil society to support advocacy and accountability at national, sub-national, and community levels for increased access to and use of quality family planning services among women, adolescents, and young people. PMNCH is also in discussions with the Ministry of Health in Kenya to explore how it can provide support to the existing national coordination mechanisms. This case study focuses on the engagement of PMNCH with OAY and HENNET between 2017 and mid-2019.

Q.2.1. Strengthening advocacy capacity of young people

Why did PMNCH engage with young people and what has been done?

PMNCH engagement with youth in Kenya started in 2017 although no specific reference can be found in the 2017 workplan. In the 2016 workplan,²⁵⁸ the activity of 'coordinating a youth-led advocacy campaign to scale up national action on adolescent health and to increase meaningful engagement of youth and adolescents' was planned under Strategic Objective 3 (focus on results). In the 2017 workplan,²⁵⁹ it featured under Strategic Objective 1 (prioritise

²⁵⁴ Waci Health, Wemos (2019). The Global Financing Facility in Kenya: a brief summary. September 2019

²⁵⁵ Mandera, Marsabit, Wajir, Isiolo, Lamu, Migori

²⁵⁶ Source: https://knbs.or.ke/visualizations/?page_id=3126 (NB. the most recent census does not (yet) provide details on the proportion of young people in Kenya).

²⁵⁷ KDHS, 2014; Mumah J, Kabiru CW, Mukiira C et al. Unintended Pregnancies in Kenya: A Country Profile. STEP UP Research Report. Nairobi: African Population and Health Research Center, 2014.

²⁵⁸ PMNCH (2016). PMNCH 2016 Annual Workplan.

²⁵⁹ PMNCH (2017). PMNCH 2017 Workplan and Budget.

engagement in countries) as ‘comprehensive adolescent health and well-being advancing policies included in the national plans and implemented in three priority geographies (Malawi, India, Nigeria)’. In the 2018²⁶⁰ and 2019²⁶¹ workplans, the activity related to the adolescent advocacy toolkit and capacity strengthening through small grants is reflected both in the workstream on ‘meaningful country engagement’ and ‘adolescent health and well-being’.

In 2016, PMNCH started the development of an ‘Advocating for Change for Adolescents! Toolkit’ in collaboration with Women Deliver which was launched at the Global Adolescent Health conference in Ottawa in May 2017.²⁶² During this process, PMNCH asked the AYC members if they could pre-test some of the tools on a voluntary basis. The OAY in Kenya had become a PMNCH member in 2016 and took up this challenge by conducting a consultative youth platform and providing feedback. Following this exercise an official Request for Proposals (RfP) was launched and five youth organisations were selected from India, Cameroon, Nigeria, Malawi and Kenya.

OAY was the organisation selected in Kenya. The purpose of the grant was to adapt the toolkit to the local context and to develop a national advocacy action roadmap. The first grant for a total amount of USD 10,000 ran from August 2017 to August 2018. Grant management was overseen by Women Deliver in collaboration with a technical support team made up of a Secretariat staff member, an Adolescent Youth Constituency (AYC) member and an expert from Women Deliver.²⁶³ The second grant from January 2019 to December 2019 totalled US\$15,000. In the second phase, grants were disbursed through the WHO Country Office and coordination was provided by the regional representative for Southern Africa of Girls’ Globe, supported by a technical team made up of Secretariat staff members, an AYC board member as well as AYC members involved in the GFF CSO platform and investors group²⁶⁴. A third phase of the grants has been announced which will be a continuation of their advocacy toolkit roll-out aiming to strengthen coalitions, build capacities, implement their advocacy roadmaps, etc.

The overall purpose of both grants was to ensure young people are meaningfully engaged in relevant decision-making processes to increase their access to health information and services. To achieve this, OAY worked collaboratively with the government to promote meaningful adolescent and youth participation. While the first grant focused on building the capacity of youth organisations to advocate for increased access to health services and information, as well as increasing the dialogue between adolescents and the government, the second grant focused on the dissemination of the toolkit to four counties as well as collecting and amplifying grassroots adolescents’ voices in their dialogue with the government.

To kick-start the work, PMNCH facilitated a conversation on the status of adolescent SRHR between the representatives of the youth organisations and their respective government counterparts during the UN General Assembly in September 2017. This dialogue was much appreciated by both parties and set the tone for a constructive collaboration. The adaptation of the global Advocating for Change for Adolescents! Toolkit was done through a working group in which 15 organisations were represented. The Ministry of Health (MoH) facilitated this work, in collaboration with the National Youth Council. The toolkit was successfully domesticated and approved by the MoH. The Deputy Head for the Adolescent Sexual and Reproductive Health Programme wrote the foreword and chaired the official launch in March 2018.

The MoH, through the Department for Adolescent Health, was also involved in the training of trainers. In the first year, OAY trained over 200 youth advocates from 40 youth-led and youth-serving organisations across ten counties. With the support of the National Youth Council, which printed some of the toolkits, OAY was able to disseminate the national toolkit across four counties and to other youth networks such as KAYSRRH network and Jiactivate Youth Network. The toolkit is currently being used as an advocacy training manual for youth advocates in three counties to ensure youth activism generates demand for adolescent SRH services and education. It is estimated that a total of

²⁶⁰ PMNCH (2018). 2018 Workplan and Budget.

²⁶¹ PMNCH (2019). Progress Report as of 1 January - 30 June 2019 - PMNCH 2018 to 2020 Business Plan Deliverables.

²⁶² Women Deliver and PMNCH (2017). Advocating for Change for Adolescents! A Practical Toolkit for Young People to Advocate for Improved Adolescent Health and Well-being. May 2017.

²⁶³ Women Deliver & PMNCH (2018). Adolescent Health and Wellbeing Advocacy Toolkit Country Roll-out. Final Grant Report. October 2018.

²⁶⁴ Girls Globe & PMNCH (2019). Advocating for change for adolescents! Toolkit adolescent health and wellbeing advocacy toolkit country roll-out. Progress report. June 2019.

345 young people were trained on the toolkit by December 2019. A shorter version of the toolkit was also produced in 2019 to facilitate printing and dissemination.

OAY has used the toolkit to design advocacy strategies, such as engagement in the 6th Devolution Conference in 2019, which resulted in a commitment by the Council of Governors to prioritise responsive interventions towards adolescent and teenage health needs and gender-based violence in the next budget cycle. In February 2019, OAY collaborated with other youth networks to advocate for increased budget allocation for youth-friendly services during the validation of the Nairobi draft county fiscal strategy paper. This joint advocacy resulted in an increased allocation of KES 300 million specifically for the implementation of youth-friendly services in the county.

In 2019, OAY partnered with the KAYSRRH network to collect data from young people on their meaningful engagement during the Devolution Caravan. Data from over 200 young people were collected and are being used to inform the Meaningful Youth Participation Framework, which is being developed by the Government of Kenya. Further, OAY has also developed a strategy for engagement with the GFF and facilitated a workshop for young people on the GFF together with HENNET.

Currently OAY actively participates in the sub-committee on Adolescent SRHR and has been allocated a seat on the GFF platform.

What are the main results and lessons learned?

There is general agreement among the stakeholders consulted that young people who have been trained by OAY have increased their capacity to advocate for adolescent health issues. While there is a lot of advocacy being done, this has not always been driven by young people due to lack of capacity. Their involvement is crucial to ensure programmes are responsive and address barriers faced by adolescents. The toolkit clearly explains how young people can participate in policy dialogues and equips them with the necessary tools to articulate their concerns. The dissemination of the toolkit to the counties is important and informants mentioned they have received feedback that in those counties young people are more meaningfully engaged in council technical working groups.

For OAY, there are also clear advantages in having led this project. They have improved their relationship with the government and are being recognised as the ‘youth voice on adolescent SRHR’. They have established stronger relationships with other youth networks, participate in key policy debates (such as for the review of the national youth policy), and are invited to international conferences. The PMNCH grant has given them more credibility and they are gradually being supported by other national and international organisations in the country, for example, the Children’s Investment Fund Foundation (CIFF) Kenya, the Bill and Melinda Gates Foundation (BMGF), DAVOS and the National Campaign on Drug Abuse.

Several organisations, mostly NGOs and youth-led organisations but also government agencies, contributed to the success of this project, often on a voluntary basis. Active linkages were sought with HENNET which also received a grant from PMNCH (see below) to strengthen young people’s understanding and capacity to engage with the GFF.

While all stakeholders interviewed are satisfied with the results achieved, they also indicate that much more remains to be done, for example, to reach young people in the remaining 43 counties as well as to ensure that the results of dissemination and further training on the toolkit are adequately documented. The MoH also believes that more can be done together with young people, such as finalising the Meaningful Engagement Framework and developing the Adolescent Health Guidelines. However, OAY does not have enough core funding to allow the organisation to contribute more actively in these discussions. Finally, some informants believe that there could have been a stronger collaboration with other PMNCH constituencies based in Kenya. For example, there has reportedly been no collaboration with the WHO Country Office, which leads the H6 in the country, despite attempts from OAY to engage. Also, little engagement was observed with large international NGOs, particularly those working on service delivery for adolescent health.

Q.2.2. Strengthening the national CSO platform

Why did PMNCH engage with HENNET and what has been done?

In the 2018 PMNCH workplan, the workstream on meaningful engagement of multi-stakeholder actors in national policy platforms stipulates a clear deliverable on improving the capacity of national CSOs to partner effectively with each other in the delivery of joint advocacy and accountability outputs. As part of this CSO coalition-building objective, PMNCH had budgeted US\$70,000 in small grants to support CSO coalition development and advocacy and accountability efforts, as well as to support the implementation of GFF investment cases and improve the quality and coherence of CSO participation in national multi-stakeholder policy dialogue platforms.²⁶⁵

This activity was linked to the GFF Civil Society Engagement Strategy²⁶⁶ which aims to strengthen civil society engagement in GFF processes at the global and national levels. Following the approval by the GFF Investors Group in 2017, PMNCH and the GFF Secretariat jointly committed US\$800,000 to implement this strategy. The small grants mechanism was announced in November 2018 and the grant application process began in February 2019 and was concluded in September 2019. The grants were to be distributed to CSOs in nine countries²⁶⁷ in the last quarter of 2019 and will be managed by Management Sciences for Health (MSH). During this process PMNCH, in collaboration with the GFF CSO Coordination Group, decided to issue 'catalytic' pilot grants to CSOs in four countries²⁶⁸ to stimulate CSO engagement with the GFF and demonstrate potential contributions by CSOs. Kenya was one of the countries selected, based on the existence of a CSO coalition, existence of a GFF investment case and ongoing processes.

HENNET, the Health NGOs Network in Kenya, was established in 2005 as an entity to convene NGOs working in the health sector to have a joint position and voice in order to influence health policies and hold the government to account. HENNET provides a forum for local and international NGOs to come together, discuss positions, share and learn from each other. It is also the liaison agency with the government as it represents the CSOs in relevant TWGs. Members pay a membership fee to HENNET and some members also provide small grants and in-kind contributions. According to key informants, the organisation has not always been very strong, but it is considered a useful vehicle for joint advocacy and accountability.

In 2017, through one of its member organisations (Evidence for Action (E4A)-MamaYe), HENNET was involved in the development of a GFF accountability scorecard to track progress on the GFF process. The scorecard tracks progress in terms of establishment and functionality of the GFF country platform, CSOs' engagement in drafting key documents, and implementation of the investment case. One of the gaps highlighted in the scorecard was funding for family planning, which was rectified in 2018 with the GFF now providing 25% of funding for family planning commodities. Because of this engagement and its convening power for national and international NGOs, HENNET was identified as a recipient of the catalytic grant²⁶⁹ in 2018. The grant was managed directly by the PMNCH Secretariat.

The objectives were to (i) develop and implement an advocacy strategy to strengthen the GFF platform and engage CSOs; (ii) strengthen HENNET's capacity to mobilise resources and advocate for policy change and increased multi-stakeholder representation; (iii) continue with the GFF accountability scorecard, using its results to track progress and financing, and support advocacy on GFF commitments; (iv) map CSOs working on women, children and adolescents' health with a view to increase HENNET's membership; and (v) build the capacity of CSOs, including youth-led organisations, through training and workshops on GFF processes. The objectives were largely achieved²⁷⁰:

- HENNET provided support to the Department of Family Health to develop the terms of reference (ToRs) for the GFF country platform and developed a CSO engagement strategy to meaningfully engage CSOs in the GFF at national and sub-national levels. According to the ToRs, the GFF platform will bring together the MoH, CSOs (including a youth-led organisation, a religious CSO and two technical implementing partners)

²⁶⁵ PMNCH (2018). 2018 Workplan and Budget.

²⁶⁶ Global Financing Facility (GFF). 2017. Civil Society Engagement Strategy. Fifth Investors Group Meeting. April 2017.

²⁶⁷ Burkina Faso, Cambodia, Cameroon, Kenya, Malawi, Mozambique, Nigeria, Rwanda, and Uganda.

²⁶⁸ Cameroon, Kenya, Nigeria and Sierra Leone.

²⁶⁹ No information could be found on how much the grant was for exactly, but it should have been either USD 15,000 or USD 20,000.

²⁷⁰ Global Civil Society Coordination Group for the GFF and PMNCH (n.d). Catalytic pilot grants to strengthen civil society engagement in national Global Financing Facility processes: Implementation report.

alongside the H6 and private sector. Discussions are still ongoing, however, on whether the platform should be a sub-committee under the RH TWG or a stand-alone forum.

- HENNET has, supported by E4A-MamaYe, publish the second version of the GFF accountability scorecard in 2018. The scorecard showed that the design of key documents was fully accomplished and that some progress was made in terms of establishing the country platform and facilitating CSO engagement. In terms of implementation, good progress was observed for the timely release of funding in 2018.
- HENNET also started a mapping exercise and expansion of its member base with a focus on involving NGOs at the county levels through the establishment of county chapters.
- In terms of capacity building, HENNET collaborated with OAY in a two-day workshop for 50 young people to build their understanding of the GFF process and how they can be engaged. The workshop started with a session on health literacy and how it affects young people's sexual and reproductive health, followed by extensive information on the GFF, the Investment Framework in Kenya and how it supports interventions for young people. The workshop then focused on what role young people can play in advocacy and monitoring and evaluation. Finally, participants were asked to develop an advocacy action roadmap on three thematic areas: (i) advocacy for use of GFF resources to enhance information access on reproductive health education for all adolescents; (ii) advocacy for use of GFF resources to address drug abuse and gender-based violence among adolescents; and (iii) increasing literacy and awareness on GFF within Nairobi City County. HENNET has also convened several meetings for CSOs to explain the GFF process and make sure CSOs are equipped to get involved. This is particularly important at the county level, given that most of SRMNCAH decisions are being made at county level.

HENNET also learns from its member organisations and can take advantage of their knowledge and tools to further their objectives. For example, AMREF Health Africa is currently training health NGOs on the Motion Tracker tool which is a civil society-led approach for strengthening accountability and driving action to achieve FP2020 commitments. HENNET staff have been trained on the tool and see opportunities for using a similar tool for monitoring the GFF processes in Kenya.

In the next grant, HENNET will strengthen capacity building for domestic resource mobilisation and social accountability for family planning through budget and SMART advocacy approaches. In addition, the network will provide technical support to Malawi and Tanzania on how to build a national CSO coalition²⁷¹.

What are the main results and lessons learned?

According to the stakeholders interviewed, the small grant received from PMNCH has strengthened the independence of the organisation to convene health NGOs and push a common health agenda. It has given the network stronger credibility – not only among its existing and potential members but also among government partners.

Due to the shrinking external funding available for the health sector, NGOs are also suffering financially, and this has an impact on an umbrella organisation such as HENNET. The grant is therefore considered an 'investment' which has helped to strengthen the network's ability to do further business development in addition to advocacy and accountability. Several informants from different constituencies confirmed that HENNET is re-emerging as a strong convener and refer to the recently published position paper on UHC²⁷², as an example of how it can provide a strong CSO voice.

The follow-up grant is seen as an excellent opportunity for promoting the vision of a people-driven movement including representation from the counties that can articulate a joint position on key health issues, influence policies and hold the government to account.

²⁷¹ https://www.who.int/pmnch/media/news/2019/small_grants_announced/en/

²⁷² The Health NGOs Network (HENNET) Position on Universal Health Coverage for Kenya. Available here: <https://amref.org/kenya/download/hennet-position-paper-uhc/>

Q.2.3. Overall lessons learned FROM PMNCH's engagement in Kenya

Through the small grants to OAY, PMNCH has strengthened the capacity and voice of youth and civil society organisations on adolescent health issues and their ability to engage more meaningfully with the GFF process in Kenya. OAY has also increased its engagement with the MoH, and this has been facilitated directly by PMNCH. HENNET is seen as a stronger convener for health NGOs, again due to support from PMNCH.

The support received is deemed relevant by all stakeholders involved at country level as it is seen to fill a gap. However, it is not clear whether the identification of these activities in country is strategic or opportunistic. For the adolescent advocacy toolkit, an RfP was issued and OAY responded, while the selection of HENNET for the first grant did not go through an open call for proposals. Some informants reportedly questioned whether these grants should be designed at the global level (by PMNCH) or at the country level (by the constituency members themselves). Informants also noted that the funds mobilised for the grants are too low to support any meaningful institutional capacity building.

Opportunities for cross-constituency learning and collaboration were encouraged across the two grants. However, other PMNCH constituency members in country were not aware of the support provided and this was a missed opportunity. For example, a stronger engagement with H6 partners, and with other PMNCH constituencies, could have been facilitated and may have contributed to further amplify the position and voice of youth and CSOs in the country.

The management of grants also differed. While the first grant to OAY was administered by Women Deliver, the second grant was processed through WHO with overall support from a Girls' Globe representative. Women Deliver helped to develop grant management tools that are still being used. These are useful tools for both the youth organisations and the Secretariat. The grant to HENNET was managed directly by the PMNCH Secretariat, but will for the next phase be managed by MSH. The sub-contracting of management of small grants is the desired option for both the PMNCH Secretariat and the grantees, because it reduces the workload of the Secretariat, facilitates learning in terms of grant management by grantees, and promotes inter- and cross-constituency collaboration. Using a sub-contractor is, however, more expensive.

Both organisations largely achieved their objectives but also believe that more time and support are needed to continue the work. The already committed follow-up grants are therefore appreciated. In terms of sustainability, both organisations claim that this is achieved through capacity building of other young people or CSOs to conduct advocacy or hold the government to account. While this is plausible, there is, however, no mechanism in place for those that were trained to report back on what it is they have done. In terms of organisational sustainability, the OAY has been able to secure funding from other partners, which they attribute to the work on the toolkit.

Appendix R **NIGERIA CASE STUDY**

This Appendix presents the Nigeria country case study in support of the External Evaluation of the Partnership for Maternal, Newborn and Child Health (PMNCH). The case study looks at how PMNCH has engaged with stakeholders in the RMNCAH+N field in Nigeria. Following a summary of key background information (Section R.1); country-level findings are presented (Section R.2) looking at the rationale for engagement (Section O.2.1); what activities are supported and how (Section R.2.2); what results have been achieved (Section R.2.3); the lessons learned (Section R.2.4); and key conclusions (Section R.2.5).

This case study is based on a review of key documentation and key informant interviews. Appendix A provides a list of references and documentation sources. Key informants consulted as part of the case study are included in the overall list of key informants (see Appendix B).²⁷³ We note the socio-economic and cultural diversity and complexity of Nigeria and that stewardship of the health sector is provided at all operational levels of the national health system. Owing to limitations of both time and budget, our approach has been to conduct consultations at the central level only while anticipating that key informants and available data will also reflect attitudes, experience and performance at sub-national levels.

R.1. BACKGROUND

Health outcomes in Nigeria are sub-optimal and its indicators remain well below regional averages. McKinsey and Company in its most recent assessment of growth and development in Nigeria²⁷⁴ highlighted the wealth of opportunities to reverse a seemingly unabated report of limited progress across all sectors. The report highlights that human capital development including health, education, poverty and sustainable livelihoods with particular emphasis on young persons and women remain priority issues. The McKinsey report affirms that Nigeria has everything it takes to be a leading economy (young growing labour force, high adoption of technology, abundant natural resources), a transformative economic trajectory over the past 20 years, a nominal GDP of US\$397b, and remains the largest economy in Africa with a 50 year annual growth rate of 4.2% and a 20 year growth rate of 6.5%. However, growth has been volatile, with a recorded decline from 6.6% in 2014 to its current low of 2%, leading to poor economic performance and negative social impact. These challenges have led to high rates of poverty, with over 50% of its population living in extreme poverty (less than US\$1.90 a day)²⁷⁵, particularly impacting woman, young persons and children.^{276,277}

The 2018 Demographic and Health Survey affirms the stagnation in indicators of health and wellbeing, along with chronic health systems insufficiency adversely affecting women, children and young people. Levels of stunting remain high (36.8%). The maternal mortality ratio is 512 per 100,000 live births, with only 43.2% of births attended by skilled health personnel, 36.7% with access to a modern method of family planning and high levels of adolescent birth.^{278,279}

²⁷³ In-country interviewees were provisionally based off an indicative list provided by PMNCH Secretariat in the Inception Phase of the evaluation, which was later expanded upon. Whilst our evaluation team reached out to other in-country stakeholders such as NAYA, however were unable to organise an interview.

²⁷⁴ McKinsey and Company (2019) Nigeria at a crossroads: Getting Nigeria where it belongs. December 2019

²⁷⁵ WB (2019) Poverty & Equity Brief Nigeria. April 2019 https://databank.worldbank.org/data/download/poverty/33EF03BB-9722-4AE2-ABC7-AA2972D68AFE/Archives-2019/Global_POVEQ_NGA.pdf

²⁷⁶ McKinsey and Company (2019) Nigeria at a crossroads: Getting Nigeria where it belongs. December 2019

²⁷⁷ CSIS (2016) *Using incentives to reduce maternal mortality in Nigeria: Lessons from Ondo state* <https://www.csis.org/blogs/smart-global-health/using-incentives-reduce-maternal-mortality-nigeria-lessons-ondo-state>

²⁷⁸ Nigerian Demographic Health Survey (2018) <https://www.dhsprogram.com/pubs/pdf/FR359/FR359.pdf>

²⁷⁹ National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF). 2017 Multiple Indicator Cluster Survey 2016-17, Survey Findings Report. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund. <https://www.unicef.org/nigeria/sites/unicef.org.nigeria/files/2018-09/Nigeria-MICS-2016-17.pdf>

Table R.1: Key health indicators for Nigeria

Indicator	Value	Source
Select health impact and disease burden indicators		
Maternal mortality rate per 100 000 live births (modelled estimate)	512	Demographic Health Survey (DHS) 2018
Infant mortality rate per 1000 live births	65	UN Inter-agency Group for Child Mortality Estimation (IGME) 2018
Under-5 mortality rate per 1000 live births	132	DHS 2018
Neonatal Mortality Rate	39	DHS 2018
Prevalence of malnutrition among children under 5 years of age		
Prevalence of stunting among children under 5 years of age	36.8	DHS 2018
Prevalence of wasting among children under 5 years of age	6.8	DHS 2018
Prevalence of overweight among children under 5 years of age	2.1	DHS 2018
Adolescent birth rate over 1,000 women		
Girls aged 10-14 years	2	DHS 2018
Women aged 15-19 years	106	DHS 2018
Health systems performance, including key barriers		
Proportion of Children (12-24 months) who had received all basic vaccines (%) in their national programme		
Coverage of diphtheria, pertussis, and tetanus (DPT) containing vaccine (3 doses)	50.1	DHS 2018
Coverage of measles containing vaccine (2 nd dose)	15.6	DHS 2018
Coverage of pneumococcal conjugate vaccine (last dose on the schedule)	47.3	DHS 2018
Proportion of births attended by skilled health practitioner	43.2	DHS 2018
Proportion of women of reproductive (15-49 years) who have their need for family planning satisfied by modern contraception	35.7	DHS 2018
Select points on the health sector structure and development		
Proportion of ever partnered women and girls aged over 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months	29.5	DHS 2018
Physical Violence	11.8	DHS 2018
Sexual Violence	4.7	DHS 2018
Psychological Violence	26.7	DHS 2018
Proportion of women aged 20-24 years who are married or in a union before age 15 and before age 18 years		
Before age 15 years	15.7	DHS 2018
Before age 18 years	43.4	DHS 2018
Proportion of women aged 15-49 years who make their own decisions regarding sexual relations, contraceptive use and reproductive health care	28.6	DHS 2018

Indicator	Value	Source
Proportion of children under 5 years of age whose births have been registered with a civil authority	42.6	DHS 2018

Nigeria is committed to the attainment of Universal Health Coverage (UHC) and achievement of other health Sustainable Development Goals (SDGs) at its highest political, legislative and technical levels. Such commitment is reflected in the Nigerian Health Act which provides for improved management of the national health care system, positioning the National Council of Health (NCH) and its state variants as the highest health policy making body.²⁸⁰ The Act further makes provisions to pool 1% of Nigeria's consolidated revenue into a Basic Health Care Provision Fund (BHCPF) to improve access of vulnerable populations, especially women and children to primary care services through national and sub-national structures of the National Primary Health Care Development Agency (NPHCDA) and to financial risk protection through the National Health Insurance Scheme (NHIS).²⁸¹ These positions, along with other national initiatives in the context of the National Health Strategic Development Plan II 2017 – 2022 (NHSDP II)²⁸² and more recently the next level ministerial agenda (2019 – 2023) provide focused accountability of the Federal Ministry of Health (FMOH) to shared objectives for human capital development presented by the Buhari-led administration in its second term.²⁸³

Nigeria is one of the focal countries for the Global Financing Facility (GFF). Working with other partners and with the leadership of the FMOH, and support from the World Bank, the Nigerian investment case for reproductive, maternal, newborn, child and adolescent health plus nutrition (RMNCAH+N) has been developed.²⁸⁴ The investment case among other things, calls for increased partnership and alignment, not only within existing programmes but across external and internal resource flows for RMNCAH+N. This effort is preceded by the Saving One Million Lives by 2015 initiative launched by the Nigerian President to expand access to basic primary health care services for women and children. During its launch, it was acclaimed that Saving One Million Lives will serve as a new yardstick for measuring health sector performance in Nigeria,²⁸⁵ and will enhance Nigeria's chances to grow and become one of the 20 biggest economies in the world'.²⁸⁶ Oversight for these activities rests with a core technical team (CTT) on RMNCAH+N led by the FMOH and co-chaired by the departments of Family Health, and Planning, Research and Statistics.

Many other initiatives and programmes contribute to the RMNCAH+N landscape. Notable among these are Gavi and the Global Fund as well as initiatives supported by bilateral funding. The Saving One Million Lives Programme for Results initiative is implemented at the national level and across all 36 states through a credit facility of US\$500m provided by the World Bank. The World Bank further supports the NSHIP programme across a few states to promote performance and accountability. State governments provide leadership at sub-national levels, both directly and through stand-alone programme initiatives led by the First ladies of the states as an indication of their own commitment and leadership roles for women, children and young people.

²⁸⁰ Federal Republic of Nigeria (2014) Official Gazette of the National Health Act. October 2014. FGP156/122015/1.200. https://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/2018/07/01_-Official-Gazette-of-the-National-Health-Act-FGN.pdf

²⁸¹ Federal Ministry of Health. National Primary Health Care Development Agency, National Health Insurance Scheme (2016) Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund. August 2016 <https://www.health.gov.ng/doc/BHCPFG.pdf>

²⁸² Federal Ministry of Health (2017) Second National Health Sector Development Plan Development II 2018-2022 (NHSDP II) <https://www.health.gov.ng/doc/NSHDP%20II%20Final.pdf>

²⁸³ Federal Ministry of Health (2019) Agenda for the Health Sector (2019-2023) Next Level Agenda for the Health Sector (2019-2023)

²⁸⁴ Nigeria Global Financing Facility Investment Case https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Nigeria-Investment-Case.pdf

²⁸⁵ WHO (2012) Nigeria launches 'Saving One Million Lives' by 2015 Initiative <https://www.who.int/workforcealliance/media/news/2012/1mlives/en/>

²⁸⁶ Federal Ministry of Health (2016) Saving One Million Lives Programme for Results: Programme Implementation Manual (PIM), Abuja, Nigeria. August 2016. <http://somlppforr.org.ng/wp-content/uploads/2017/02/SOML-PIM.pdf>

Significant resources at national and sub-national levels are provided by foundations, including Dangote Foundation, Bill and Melinda Gates Foundation, Ford Foundation as well as the McArthur Foundation. Programme implementation in the RMNCAH+N space also comes through a myriad of global and national civil society and private sector led initiatives including investments from Johnson & Johnson and from Merck for Mothers. This is in addition to other national and regional programmes including the activities of civil society organisations (CSOs), social enterprises and private sector actors. The PMNCH is positioned in this mosaic landscape of implementing partners. Nigeria is a member of the PMNCH Board. PMNCH also hosts CSO members on its Board as well as on the GFF CSO Coordinating Committee.

R.2. PMNCH ENGAGEMENT IN NIGERIA

R.2.1. Rationale for engagement

PMNCH identifies Nigeria as one of its priority countries for engagement. PMNCH also seeks to improve access for adolescents to advocacy training, through which adolescents can demand RMNCAH services that they require. Further, through the GFF CSO platform PMNCH hosts at the global level, it aims to contribute to demand for increased domestic resources for RMNCAH, increased coordination and alignment across all partners and inclusive mechanisms for accountability for RMNCAH+N outcomes delivered by resilient and equitable national health systems.

Much of the leadership and coordination efforts for RMNCAH+N are jointly vested in the FMOH and the CTT on RMNCAH+N co-chaired by the Departments of Family Health and Planning Research and Statistics. The goal is to improve functional linkages between investments in health systems strengthening as well as strengthen service delivery capacities to achieve national, regional and global targets in RMNCAH. A CTT for RMNCAH+N is further hosted in every state including the Federal Capital Territory providing sub-national linkages for planning, implementation and evaluation.

However, several other coordinating, technical and implementing platforms have emerged over the past decade. These are often in response to diverse mandates of funding partners and currently include the Immunization Coordinating Committee (Gavi), Country Coordinating Committee (Global Fund), the Saving One Million Lives (SOML) initiative Technical Committee, GFF Technical Committee, implementing committees of programmes supported by BMGF and for nutrition the Dangote Foundation amongst many others. These are often paralleled by CSO implementing, advocacy and accountability platforms. A direct consequence of this is a large overlap in mandate and implementation. Significant among these include the African Health Budget Network (AHBN), Health Sector Reform Foundation of Nigeria (HERFON), Health Sector Reform Coalition (HSRC), CSO Working Group on the GFF, Education as a Vaccine, National Advocates for Health and many others. Accountability lines are driven by programme or mandate based key performance indicators and deliverables.

Although the CTT-RMNCAH+N is established to coordinate and lead both policy and implementation in Nigeria, overlapping mandates and fragmented fund flow limit its effectiveness. The results are a complex situation with many actors that blurs lines of performance and accountability with a negative impact on results and outcomes.

R.2.2. What has been done?

Aside from the membership of the Government of Nigeria on the Board of PMNCH, and leadership of Dr. Aminu Magashi on its workstream on accountability, specific investment in Nigeria is only evidenced in PMNCH's 2017 work plan^{287,288, 289}. PMNCH's support of US\$20,000 was provided to Education as a Vaccine (EVA) to (a) National/State Adolescent Health advancing policies developed and implemented in one state in Nigeria; and (b) rollout of the

²⁸⁷ PMNCH (2016). PMNCH 2016 Annual Workplan https://www.who.int/pmnch/about/strategy/workplan_2016.pdf?ua=1

²⁸⁸ PMNCH (2017). PMNCH 2017 Workplan and Budget.

https://www.who.int/pmnch/about/strategy/pmnch_workplan_2017.pdf?ua=1

²⁸⁹ Advocating for Change for Adolescents! Toolkit. Adolescent health and wellbeing toolkit country roll-out. Progress Report, June 2019 (document from Marieke, authors and citation unstated)

Adolescent Health Advocacy toolkit.²⁹⁰ EVA has adapted the PMNCH adolescent toolkit, creating a country toolkit sensitive to the local context. In collaboration with the National Population Commission the toolkit was launched as a part of the 2018 celebration of the World Population Day in Abuja, Nigeria.²⁹¹ The adapted toolkit and factsheets have been used as key training materials across eleven states (Ondo Cross Rivers, Kaduna, Akwa Ibom, Taraba, Zamfara, Yobe, Kano, Adamawa, Niger and the Federal Capital Territory) and provided capacity building on advocacy skills to nearly 400 adolescents over two years (2018-2019).²⁹²

In addition, the grantee has undertaken several advocacy visits to public sector leaders, the National Population Commission, BHCPF, NPHCDA including state primary health care development agencies, the Federal Ministry of Education and a broad range of community level stakeholders. EVA has further reached out to collaborate with eight other organisations (HERFON, HSRC who have now created a youth seat under the Voice and Accountability Committee, White Ribbon Alliance (WRA), Nigeria, Nigerian Health Watch, Association for Reproductive and Family Health (ARFH), Challenge Initiative (TCI), Youth Hub Africa, Connected Development (CODE)). EVA has also succeeded in engaging UNFPA and UNESCO country offices in this effort.

PMNCH through its CSO GFF coordinating hub has also been actively supporting work in the context of the GFF in Nigeria. Much of this effort has been led by the African Health Budget Network (AHBN) with the production of various accountability score cards. These score cards have had regional and global appeal but are yet to have significant traction at the country level. The GFF CSO coordinating hub has also supported participation in CSO meetings as well as in meetings of the GFF investor group as might be relevant.²⁹³

More recently, MaMaYe, a DFID-funded campaign group for the reduction of maternal mortality has been elected into the steering committee of the GFF CSO hub, expanding participation in the global discussion beyond AHBN. However, country engagement in the context of the GFF has reportedly been fraught with challenges across the board, more so as it relates to CSO engagement. For example, many CSOs complain of the lack of inclusiveness and internal democracy of the ²⁹⁴AHBN led process. PMNCH Secretariat also participated in a conference on RMNCAH+N meeting hosted by partners in February 2016. At this event, PMNCH Secretariat presented its framework on accountability to national stakeholders. No specific output or follow on programme was identified following this meeting.²⁹⁵

It is also reported that PMNCH has provided non-financial technical assistance to the Department of Family Health of the FMOH in its efforts to improve coordination and alignment across fragmented resource flows across donors, foundations, implementing partners and CSOs. There is now increased agreement to align within the context of the GFF investment case on RMNCAH+N bringing on board investments from the BHCPF, SOML, GFF, Gavi, Global Fund and the many streams of advocacy and accountability platforms/processes on RMNCAH. However, many country actors are not aware of any support or contribution by the Secretariat to this effort, neither are they aware of its vision, mission or work. Informants had greater recognition in the Nigeria RMNCAH+N space of development partners, global programmes and foundations with much larger funding streams and country presence including the World Bank, UNICEF, Gavi, Global Fund, BHCPF, SOML and NHSDPIL than PMNCH.

²⁹⁰ PMNCH (2018) *Advocating Change for Adolescent. A Practical Toolkit for Young People to Advocate for Improved Adolescent Health and Well-being* https://www.who.int/pmnch/knowledge/publications/advocacy_toolkit.pdf

²⁹¹ *Education as a Vaccine (2018) Education as a Vaccine in collaboration with National Population Commission launches Advocating for Change for Adolescents! –Nigeria Toolkit. Press Release, 10th July 2018, Abuja, Nigeria*

²⁹² *Education as a Vaccine (2019) Programmatic milestone for 2018-2019 (Personal Communication and report provided by Olubukonla Williams, Executive Director, Education as a Vaccine)*

²⁹³ Nigerian Advocates for Health, Nigerian Civil Society Working Group for the GFF, Nigeria Youth Champions for Universal Health Coverage (2018) *Review of the Nigerian RMNCAH+N (GFF) Investment Case.* <https://arfh-ng.org/wp-content/uploads/2018/10/Review-of-the-Nigeria-RMNCAHN-GFF-Investment-Case-Sept-2018.pdf>

²⁹⁴ AHBN declined interview on country processes of the PMNCH

²⁹⁵ PMNCH (2016) *Nigerian stakeholder accountability in RMNCAH, 16th February 2016, Abuja, Nigeria* <https://www.who.int/pmnch/media/events/2016/nigeria/en/>

R.2.3. What are the results?

The output from the investment in youth advocacy through EVA was described by informants as - at best - a qualified success. Nearly 400 advocates have been trained but they still require further support to translate the training into action and impact. In addition, given the size of this demographic group in Nigeria, informants noted that there is a lot more to be done for broader relevance and impact, and to ensure that the 'A' in the RMNCAH+N in Nigeria is not overlooked. EVA has however been more successful in its stakeholder advocacy efforts, which were referred to by all persons interviewed for the evaluation. EVA has successfully leveraged the HSRC hosted by HERFON, amplifying issues related to adolescent reproductive health to a wider audience, and has effectively linked this amplification of issues to actions by Women Deliver and the Civil Society Engagement Mechanism on UHC (CSEM-UHC). Even though the adolescent advocacy toolkit is yet to attract wide attention and relevance, organisations exposed to it have expressed its value to their own work.

Success around CSOs in GFF remains varied across all organisations. Some factors adduced for this include limited internal democracy and lack of inclusiveness in the GFF-CSO leadership at the country level. Global and country action will be required to improve collaboration among development and funding partners on RMNCAH in Nigeria. It will also require greater efforts at harmonising national investments across the RMNCAH+N, primary health care (PHC), UHC and other health systems investments.

EVA noted that different youth groups do not understand the GFF process in-country and there is a need to break it down for young people to actively engage them in both advocacy and accountability. This will require more investment of time and resources to achieve than is currently available through the PMNCH as it is only able to provide small funds and is thus an insignificant player at the country level.

Perhaps the most notable efforts can be identified around health budgets advocacy, financing and RMNCAH score cards, and other efforts by CSOs to improve coordination around accountability frameworks for health systems (in this case the BHCPF), UHC and RMNCAH. HERFON, as hosts of the HSRC, has also taken steps to integrate RMNCAH+N accountability measures into the accountability framework it implements for the BHCPF. This is without the support or contribution of PMNCH. More recently MaMaye/Options Nigeria has become more active, promoting integration with the BHCPF²⁹⁶ as well as collective efforts to integrate accountability mechanisms into the GFF investment case.²⁹⁷ At the sub-national level i.e. states, progress has been consequent on the SMOL Program-for-Results Financing (PforR) initiative. Leadership of the initiative has had no interaction with PMNCH Secretariat and members, and the leadership are unaware of both global and country level efforts of the Partnership.

Within this context, it would be inappropriate to seek to track either attribution or contribution of activities supported by PMNCH to strengthen country engagement around RMNCAH+N activities in Nigeria. While appreciated, the resources provided can neither achieve scale nor widespread impact. This will require greater partnerships within key funded initiatives on RMNCAH+N and health systems, notably the GFF, BHCPF and SOML PforR.

R.2.4. Lessons learned

Many opportunities abound to allow Nigeria - the largest performing economy in Africa – to support a healthy productive population for sustained growth. Its large and youthful population remain an inadequately tapped target to unleash the country's high levels of technology adoption for productivity and to optimise its resources for impact. The McKinsey report²⁹⁸ identifies eight big bets towards increasing productivity with sustainable social and economic impact. Central amongst this is investment in human capital (health, education, poverty reduction and sustainable livelihood).

²⁹⁶ MaMaye (2019) Nigeria RMNCH+N GFF Investment Case

<https://mamaye.org/index.php/resources/toolkits/nigeria-rmncahn-gff-investment-case-brief>

²⁹⁷ MaMaye (2019) Supporting CSO implementing the GFF in Nigeria. <https://mamaye.org/blog/supporting-civil-society-implementing-gff-nigeria>

²⁹⁸ McKinsey and Company (2019) Nigeria at a crossroads: Getting Nigeria where it belongs. December 2019

It is clear that PMNCH has not had significant country level engagement impact, as PMNCH's own resources are limited. In addition, there is reportedly poor coordination and fragmented resource flows with huge transaction costs for PMNCH to navigate. It is evident that this not only limits the impact of PMNCH but also of every initiative and programme, domestic and international. Informants noted that multiple organisations are serving overlapping purposes, each sub-optimally funded by large vertically implemented global programmes and initiatives.

Informants pointed to a failure of coordination, first of the programmes driven by large global resources, and the multiple platforms that exist for national initiatives and programmes as the key barriers to engagement and the evolution of a strong country coordinating platform. There is competition for the limited resources available amongst CSOs. CSO platforms are numerous, they follow the lines of financing through fragmented programmes and reportedly lack internal democracy that provides for inclusion within a shared mandate. Power dominates the political economy of this space, further making it difficult to achieve cohesive purpose around a shared agenda. Clarity of roles and strong leadership to drive improved coordination of all duty bearers and stakeholders, and harmonisation of resource flows from all sources are needed.

Despite its leadership and coordination challenges, many opportunities were identified by informants: There is an evolving consensus to position the GFF investment case as the country RMNCAH+N plan, building it amongst a more inclusive and democratic process than before. The investment in the SOML PforR initiative encompasses all states and is also active at the federal level. This initiative has focused on results driven by performance across all 36 states, using regularly collected data to incentivise performance to improve access to basic health care and improve health outcomes for women and children. Several states are responding to this incentive, providing an evidence driven learning portal for action. National commitment to the BHCPF further provides opportunities to deepen engagement, more so around UHC. Leadership commitment through the next level agenda of the health ministers, implemented within the overall framework of NHSDPII also provide opportunities for PMNCH engagement.

Informants described how the GFF, Global Action Plan (GAP) and UHC2030 provide opportunities to improve the workings of CSO platforms in Nigeria, however strong leadership is also required to improve the internal democracy across all CSO stakeholders, many of whom are reportedly institutionally weak and lacking resources.

R.2.5. Looking forward

While advocacy action remains critical, it is important for these to translate into service delivery at both federal and state levels, and go much further to be inclusive of adolescents, empowering of communities and assuring citizens' engagement. Success using combined approaches linked to advocacy and accountability is reported in the SOML PforR initiative, even if much is required to validate the results, and ensure it is used by CSOs to drive their accountability function. It is also noteworthy that the link between effective health systems delivery, and service coverage for women and children has been demonstrated in Ondo state (2004-2016), especially through the states Abiye project.²⁹⁹ These composite models of advocacy, effective data use, policy engagement and service delivery are worthy of deeper review and amplification.

Lack of coordination and fragmentation across duty bearers and stakeholders was seen to be the key challenge constraining successful implementation and sustainable impact of a huge volume of financial resources available for RMNCAH+N activities in Nigeria. The FMoH proposes to strengthen its coordination capacity around the GFF investment case, adopting it as the national implementation plan for RMNCAH+N. This suggestion is welcome by many of the key stakeholders and provides a window of engagement for PMNCH to not only play a brokering role across powerful players and stakeholders, but also support the FMoH in its efforts. Informants however described uncertainty that PMNCH is best placed to engage in this depth of country engagement, as it has not been recognised by local stakeholders in this capacity.

²⁹⁹ (2016) *Using incentives to reduce maternal mortality in Nigeria: Lessons from Ondo state* <https://www.csis.org/blogs/smart-global-health/using-incentives-reduce-maternal-mortality-nigeria-lessons-ondo-state>

It is further proposed to transition and expand the CTT-RMNCAH+N into a national partnership and multi-stakeholder platform for RMNCAH+N. The initial thought is to make this an open membership-based platform with constituencies managed in inclusive and open democratic processes such as is the case in the global PMNCH body. This platform is proposed to be jointly hosted by the Department of Family Health and the Department of Planning, Research and Statistics. This proposal for the national partnership and multi-stakeholder platform also seems to find traction among public sector stakeholders in hopes it will improve coordination, promote harmonisation, reduce transaction costs, promote joint evaluation and learning and permit joint identification of gaps at the sub-national level. However, there are concerns on leadership capacity in the FMOH to negotiate and realign development assistance and its diverse flows, as well as the appetite to meaningfully institutionalise, resource and track the engagement of non-state actors including the private sector, social enterprises and other not-for-profit organisations.

National engagement in UHC and commitment to the BHCPF, as well as the key lessons learned from SOML PforR, and the process of stakeholder engagement in the development of the GFF investment case provide areas for potential PMNCH engagement.