The Partnership for Maternal, Newborn & Child Health

Invest, Deliver, Advance

BOARD MEETING, SEPTEMBER 13-14, GENEVA

NOTE FOR THE RECORD

Chair: Joy Phumaphi

Co-Chair: Ann Starrs, Dr. Tedros Adhanom

Facilitated by Keith Palmer, CEPA

DAY 1

Item 1 - Introduction (Plenary)

The aim of this session was to agree the proposed agenda for and purpose of the Retreat.

The Chair welcomed Board members and introduced Cambridge Economic Policy Associates (CEPA) - the Consultant team. Board members were reminded that the main purposes of the day were to agree:

- 4 - 5 MNCH priority outcomes in order to contribute to significant progress toward MDGs 4 and 5.
- Outputs and value-added activities that the partners could achieve more effectively working through PMNCH.

The basis of the discussions was the 'Issues Paper' circulated by CEPA to the Board members in advance of the Retreat.

CEPA presented:

- Proposed organisation of the two days of the Retreat.
- Key definitions to be used in Board deliberations and decisions. For example, partnership (small 'p') means partners working together via informal collaboration or through existing partnerships (not PMNCH), and that PMNCH refers to a formal partnership that is some version of the current PMNCH, with its precise governance, and role of Secretariat, if any, to be defined.
- Classification of types of Global Health Partnerships.
- Key issues/ factors necessary to be in place for a successful partnership.

Item 2 - Priority outcomes/outputs - "Top Down" approach

The aim of this session was to agree 4-5 MNCH priority outcomes.

CEPA presented the main findings of the priority outcomes survey conducted by the Retreat Planning Group[1], and related points arising from consultations with Board members. This was followed by Board discussion, at which key points raised included:

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[1] Retreat Planning Group members: Joy Phumaphi, Ann Starrs (Chair), Sadia Chowdhury, Liz Mason, Dan Kraushaar, Pascal Villeneuve, Al Bartlett, Purnima Mane, Helga Fogstad, Vinod Paul, Zulfiqar Bhutta

- The continuum of care concept should remain the cornerstone of the Partnership's work, and this needs to be advanced through partnership approaches. There was general agreement that the adoption and advancement of this concept makes the Partnership unique.
- Increased resource levels for MDGs 4 and 5 should be a primary outcome that the Partnership seeks to achieve. This needs to include mobilizing resources for MNCH from national and international budgets.
- Strengthening MNCH related technical and human resource capacity (trained and competent MNCH manpower) in countries was noted as an important requirement by countries.
- There is a need for dynamism and stronger leadership at all levels.
- Global coordination is helpful but country-level coordination is more important, and this must involve civil society actors: coordination at community, district and national level is critical.
- Introducing greater harmonisation in approaches and tools would be helpful to avoid duplication and confusion among different donor approaches. However, it is important not to stifle innovation.
- Introducing an accountability function would be helpful, through, for example, Countdown to 2015, but it should remain independent with clear authority lines.
- To be successful, PMNCH needs to engage with key executive level decision makers at country level, as well as within the international donor community and UN agencies.

Board members were then requested to consider the top 4-5 MNCH priority outcomes and illustrative partnership outputs.

Decision:

There was broad agreement on the following three MNCH priority outcomes:

1) MNCH profile raised and additional resources mobilised: to include financial and human resource mobilisation at global and national level, and improved linkages between 'internal' and 'external' resources.

2) Improved effectiveness of MNCH interventions/ consolidation (that address 'customer'/ client needs): to include coordination (national focus), harmonisation and alignment, and availability of robust information.

3) Higher accountability, including enhanced leadership and ownership and better governance of MNCH activities.

Item 3 - Partnership activities - "Bottom up" Approach

The aim of this session was to agree a list of potential activities and associated outputs that are best carried out in partnership and identify those activities where some version of PMNCH can add value.

CEPA presented four possible groupings of partnership activities based on its consultations with Board members: (a) advocacy; (b) learning, knowledge sharing and monitoring; (c) harmonisation; and (d) coordination, facilitation and brokerage.

The Board agreed that there is value-added to work in partnership when it can:

- achieve things that cannot be achieved by partners on their own; and/ or
- improve the outcomes/ effectiveness of partner activities.

Four breakout groups were then formed, each to discuss an activity grouping. Each group discussed the potential list of activities, value added through partnership, possible outputs, and whether there was a case for value added through PMNCH. Following the reporting back by the four groups, a short questionnaire was administered to all Board members to determine the extent of support for each of the activities (identified by the breakout groups), to be undertaken: (a) in partnership; and (b) specifically through some version of PMNCH.

The key points raised during the Board discussion of value added activities/ outputs were:

- In determining possible PMNCH activities and outputs, it is important to be realistic, and justify convincingly what can be achieved effectively outside PMNCH, and what should be done within.
- A number of operational issues also need to be kept in mind: (i) partnering vs Partnership approaches; (ii) role of Secretariat vs Partners; (iii) facilitating vs doing; (iv) global vs country; and (v) proactive vs reactive.
- Several partners emphasised that for the Partnership to retain interest of their organisation's executive leadership, it will be important to identify 3-4 bold, high-level outputs (deliverables) not currently implemented by any other entity, and for which there is a clear case as to the value added through PMNCH.

Decision:

There was agreement that PMNCH should focus on a list of value added activities, set out in Attachment 1 of this Note. For ease of reference, the agreed activities have been organised in four categories: (i) advocacy; (ii) learning/knowledge sharing; (iii) facilitating dialogue; and (iv) accountability.[2] (See Attachment 1).

Board members also saw value in a longer list of activities to be undertaken in partnership (not necessarily in PMNCH). These are also set out in Attachment 1 (please note that the PMNCH value-added activities in Attachment 1 are shaded in green and are a sub-set of partnership activities).

[2] Board members, however, recognised that activity categorisation could have been done in a number of other ways.

DAY 2

Item 4: Aims for the day

CEPA circulated a revised annotated agenda for the day and presented the day's aims as:

- To discuss and agree key issues to be resolved to improve PMNCH effectiveness.
- To agree the options for operationalising partnership activities (including whether through PMNCH; other partnerships; or partnering).
- To discuss and provide initial steer on the appropriate structure, given agreements on PMNCH activities (presuming that it continues to play a role).

Item 5: PMNCH guiding principles

The aim of this session was to agree the guiding principles that should define PMNCH operations and structure.

The donor and beneficiary country constituencies made brief presentations on their expectations from PMNCH. The Board then agreed to the following guiding principles of PMNCH:

- Tackle things that are beyond manageable interests of partners, rather than duplicate partners' activities.
- Concrete and time-bound activities, that require the specific and joint effort of partners.
- Clear and compelling theory of how to make change happen.
- Clear indicators of performance for all partners against actions – greater accountability.
- Align leadership of partner organisations for the agreed agenda, especially in high-burden countries.
- Country engagement to be country or demand led (responsive to country partner defined needs).
- Inclusiveness and transparency in decision making and information sharing, although the principle of inclusivity does not need to apply to activities themselves (i.e. not every member needs to be involved in every Partnership activity).

The *modus operandi* of executing these principles was suggested to include:

- Partners to own outcomes, execute work plans, and be aligned.
- Partnership holds them to account (through some form of an independent mechanisms) and acts as the 'glue' that binds partners together for a common program of work.
- Secretariat to play a facilitating, convening and brokering role, with partners implementing activities (i.e., neutral space for partners to work together on common interests and differences, and reach consensus).

Decision:

There was general agreement that these guiding principles should form the basis of PMNCH activities and outputs.

Item 6: PMNCH options
The aim of this session was to consider the possible structure options for PMNCH and agree the most suitable option, given its agreed value-added activities.

Based on the agreed list of PMNCH activities (Attachment 1), CEPA presented three structure options (each an increment of the previous). These options were:

- Option 1. Agreed activities include those under advocacy and learning and knowledge sharing.
- Option 2: Agreed activities include those under Option 1 as well as facilitation activities.
- Option 3. Agreed activities include those under Option 2 as well as the newly agreed activity on developing accountability mechanisms. Attachment 3 sets out at a high-level Structure Option 3.

Decision:

The Board expressed a clear preference for Option 3.

Item 7: Determining consolidated PMNCH outputs
The aim of this session was to develop a list of PMNCH outputs, based on the agreed list of its value added activities.

Given the need for further clarity on the key outputs/deliverables that will drive PMNCH activities, three breakout groups were asked to identify key outputs for the agreed list of PMNCH activities (Attachment 1). In order to guide the discussion, some examples of possible PMNCH activity were stated to be:

- Strengthening maternal health (with newborn care, the weakest link in the continuum of care).
- Align partners and their leadership for action in the highest-burden countries in South Asia and SSA.
- Execute the Asia investment case developed by multiple partners.
- Implement agreed Africa roadmap and Child Survival Framework, and the Maputo Framework.

Each of the three break-out groups therefore had the same discussion agenda, and presented back a possible list of PMNCH outputs. This was followed by Board discussion, key points of which were:

- There is a clear need for a focused agenda that leads to strong results. The PMNCH guiding principles adopted under Item 5 above should apply. In particular, it is important to recognise partners' mandates and avoid duplication.
- It was recognised that Board members had different levels of resources to support their participation in PMNCH activities. It is therefore important to ensure transparency and inclusion in Board discussions and decision making about what is to be done, but with an understanding that not all members will necessarily be involved/ work on all Partnership activities.

- A number of Board members proposed that a possible way of taking forward the agreed PMNCH activities/outputs, was to select a few high-burden countries where these activities could be implemented. It was emphasised that PMNCH would work within the agreed MNCH targets/ timelines in countries, and that pursuant to the Paris Declaration, country mandates would be responsive to country needs.

Tore Godal briefed the Board on the leadership that the Prime Minister of Norway is providing on the health-related MDGs, and the *1st year Report of the Global Campaign*. The report provides a useful information platform and will be distributed to Board members after the New York High-Level event on September 25. To develop the report a multi-agency group was established to estimate the cost of scaling up priority MNCH and family planning services for the 51 aid-dependent countries with greatest burden, and to assess health gains and deaths averted by scaling up services to 95% coverage. Norway offered to expand the group to include PMNCH Board constituencies not currently represented; those interested should contact Tore Godal directly.

Decision:

There was agreement on a list of PMNCH outputs, as set out in Attachment 2 of this Note. The Board also agreed that a task force would be constituted to develop in further detail the agreed PMNCH activities and outputs.

Item 8: Consideration of key structure/ implementation issues regarding the preferred option (Closed Board session)
The aim of this session was for the Board to decide on a number of issues related to governance, role of partners, role of the Secretariat, and funding

Decisions:

Structure: PMNCH will stay an alliance for now, and not become a legal entity.

Board: The question of opening up the PMNCH Board to additional constituency groups or sectors was raised, but not discussed at this meeting as it was seen as lower priority. The question will be taken up by the Task Force on Structure (see below). An executive committee of the Board is not felt to be needed at this time; instead, the Board will establish specific task forces to take on specific time-bound tasks. Each constituency group will define its means of internal information sharing and consultation. Processes for selecting representatives will also be decided by constituencies.

Hosting arrangement: The MOU with WHO will be renegotiated. A memo will be sent immediately to WHO authorities to signal this intention. Subsequently to the Board discussions, the Secretariat was asked to draft a list of issues that the Partnership would pursue during negotiations.

Working Groups: These are disbanded, except for the Advocacy Working Group which will continue until Deliver Now has completed the launch event in Latin America, scheduled for the week of 15th September 2008.

Deliver Now: This will be discontinued when the upcoming events in Latin America are completed. The Deliver Now activities, once launched, would be taken forward by the countries themselves.

External Evaluation: The revised executive summary will be posted to the PMNCH website. A statement will be posted with it, noting that the Board and secretariat do not endorse the full content of the report, and that the Board is taking action to address selected issues raised in the evaluation report.

Task Teams: these will not have independent authority. Membership does not need to include the Board Chair or Co-Chair, and will be on a volunteer basis (i.e., membership does not need to be balanced by constituency group). Decisions/ recommendations emerging from the task teams will be communicated to the Board Chair and Co-Chairs and then to the full Board for endorsement/adoption. Three new Task Teams will work from now to the November 2008 Board meeting, as follows:

a. **Outputs Task Team**[3] - Terms of reference will be developed by the Task Team Chair within the next ten days. The aim is to develop a three-year framework for delivery of Partnership outputs, also to further define the agreed outputs (see Attachment 2).
b. **Structure Task Team**[4] - Terms of reference will include providing further definition to a range of governance issues as well as functions of the Secretariat and Task Teams. CEPA will be asked to support and facilitate the work of this Task Team.
c. **Innovative High-Level Financing Task Team**[5] - The focus of discussion will include the setting up of a mechanism to finance MDGs 4 and 5.

Secretariat: To focus on providing a convening platform for consensus building and harmonization between partners, supporting the Board and its committees in their work, improving communication across the membership at large, and developing and facilitating the accountability framework of the PMNCH.

Item 9 - Next Board meeting

Date: November 10 and 11, 2008
Venue: to be determined, but preferably Europe.
Main items for discussion: reports from the three newly constituted Task Teams.

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[3] *Outputs Task Team*: Gary Darmstadt (Chair), Wendy Graham, Anne Tinker, Al Bartlett, André Lalonde, Sadia Chowdhury, Jane Schaller, Christine Reissmann, Medhin Zewdu (to be invited).
[4] *Structure Task Team*: Ann Starrs (Chair), Pius Okong, Purnima Mane, Pascal Villeneuve, Bridget Lynch, Daisy Mafubelu.
[5] *Innovative High-Level Financing Task Team*: Tore Godal, Pius Okong, Bridget Lynch, Dorothy Shaw, a representative from UNFPA, and Wendy Graham will join this Task Team, which pre-existed this Board Retreat.

RETREAT PARTICIPANTS

Representatives

Bill and Melinda Gates Foundation	Dan Kraushaar
CARE	Deborah Gordis (representing K. Togbey)
CIDA	Christine Reissmann
Family Care International	Ann Starrs
Government of Bolivia	Bertha Pooley (on behalf of W. Selem)
Government of Ethiopia	Medhin Zewdu (representing Dr. Tedros Adhanom)
Government of India	Sharat Chauhan (representing A. Ramadoss)
Government of Mali	Lassiné Konaté (representing O. Toure)
International Confederation of Midwives	Bridget Lynch
International Federation of Obs/ Gyn	André Lalonde
International Pediatric Association	Jane Schaller
Norway	Tore Godal
Save the Children	Anne Tinker
UNFPA	Purnima Mane
UNICEF	Pascal Villeneuve
World Bank	Sadia Chowdhury (representing J. Schweitzer)
USAID	Al Bartlett (representing R. Green)
WHO	Daisy Mafubelu
Expert, Maternal Health	Wendy Graham
Expert, Newborn	Zulfiqar Bhutta

Alternates and other participants

Bill + Melinda Gates Foundation	Gary Darmstadt
Government of Mali	Oumou Maïga Diakité
Government of Norway	Helga Fogstad
International Confederation of Midwives	Nester Moyo
International Federation of Obs/ Gyn	Pius Okong
UNFPA	Hedia Belhadj
WHO	Liz Mason, Monir Islam
Expert, Maternal Health	Julia Hussein

Consultants

Keith Palmer, Daniel Hulls, Pritha Venkatachalam, Nebojsa Novcic

Secretariat

Francisco Songane, Flavia Bustreo, Andres de Francisco, Sonya Rabeneck

ATTACHMENTS

Attachment 1 - PMNCH and partnership activities

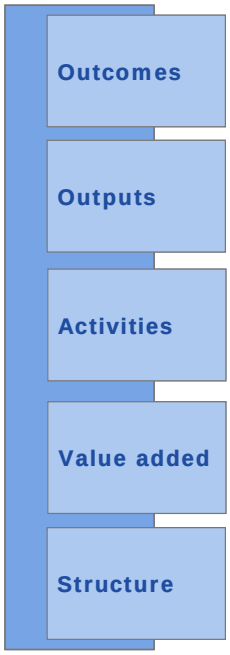
Activities	Value added in PMNCH	Value added in partnership
I. Advocacy:		
I1. Actively canvass members of G8 and other international groups (e.g. IMF) and at global events (e.g. High-Level Event in New York) to ensure inclusion of MNCH into health and development communiqués.	✓	✓
I2. Actively canvass relevant donors, stakeholders and other global funds at global, regional and national levels for a greater provision of financial resources to MNCH issues.	✓	✓
I3. Develop core MNCH messages (e.g. investment case, equity) and promote the adoption of and support with evidence, where possible, the continuum-of-care concept in global, regional and national health policies.	✓	✓
I4. Actively canvass key individuals and institutions in non-health sectors (e.g. labour, education, transport) and other development partners with a view to influence relevant policies to the benefit of MNCH.	✓	✓
I5. Increase outreach and communication to international, regional and national media and contribute to relevant MNCH focused fora.	**x**	✓
I6. Increase public awareness/ engagement at global, regional and national levels	**x**	✓
I7. Mobilise national champions/ stakeholders/ leaders for MNCH issues	**x**	✓
II. Learning and knowledge sharing[6]		
II1. Facilitate identification of gaps in MNCH information and knowledge, and encourage partners to fill these gaps	✓	✓
II2. Consolidate information on MNCH continuum of care	✓	✓
II3. Facilitate sharing of best practice in MNCH	✓	✓
III. Facilitation and coordination[7]		
III1. Convene and facilitate dialogue on specific technical and operational issues: new areas, areas of conflict (eg user fees, short term vs long term interventions on maternal health), and MNCH approaches / frameworks/ tools.	✓	✓
III2. Link (including on technical issues) with other initiatives (e.g. IHP, GAVI) to promote MNCH	✓	✓
III3. Proactively promote / support the development of functioning national level stakeholders	**x**	✓
IV. Introduce new independent accountability mechanism		
IV1. Agree what partners are doing alone or together with other partners for MNCH objectives	✓	✓
IV2. Define which areas of partner and Partnership activity will be subject to an accountability mechanism	✓	✓
IV3. Monitor performance against commitments	✓	✓
IV4. Develop an agreed mechanism to share findings publicly	✓	✓

[6] Monitoring, which was originally proposed as an activity under Learning category, has now been recast as a new PMNCH activity – accountability mechanisms.
[7] Facilitation and coordination, and harmonisation, which were originally two separate activity groupings, have now been merged into one value added activity group.

Attachment 2 - PMNCH outputs/ deliverables
(Source: CEPA slide)

- Costed strategy for ensuring supply of essential commodities and supplies for scaling-up effective interventions.
- Consolidated regional framework for achieving MDGs 4 and 5 in Asia, Africa and Latin America, with selected priority countries aligned to framework (e.g. Africa roadmap, Asia-Pacific investment case).
- Joint partner commitment to respond to countries' expressed needs in response to findings from Countdown to 2015.
- Increased funding (to be quantified) leveraged and mobilised for MNCH from G8, global funds (e.g. GAVI), other major funding agencies, and country government resources.
- Countries and partners using 'state of the art' tools, strategies, best practice through active implementation of a knowledge management repository actively facilitated through PMNCH.
- Agreed core package of interventions for implementation, subject to national plans (and country approval) of 4-5 high burden countries:
  a. Evidence-based core interventions incorporated in MNCH strategies and programs.
  b. Priority gaps in evidence identified and filled, e.g. skilled vs facility care.
  c. Indicators identified and accountability plans in place by end 2009.
  d. Civil society groups engaged in MNCH plans.
- Advocacy messages and plans for delivery of advocacy messages to high-level meetings:
  a. Ensure smooth bridge in emphasis in MNCH in G8 as shifts from Japan to Italy.
  b. MNCH plans/ MDGs 4 and 5 reflected in G8, OIC, and regional plans, e.g. SARC.
- Plan with near term actions to reduce maternal and newborn mortality, to be implemented at scale in limited number of countries.
- Strengthened human resource capacity to deliver quality MNCH care and promote investments behind it.
- Credible and effective accountability mechanism for all of the above agreed outputs to be developed within 6 months (using an external consultant).

Attachment 3 – Structure Option 3 (preferred option)



Profile raising/ resource mobilisation, improvement in effectiveness and accountability

- **Greater commitment from G8 to fund MNCH programmes**
- **Monitoring and hold partners to account resulting in increased accountability**

- **Advocacy: Activities agreed on Day 1**
- **Learning / knowledge sharing: Activities agreed on Day 1**
- **Facilitate dialogue on technical issues: Activities agreed on Day 1**
- **Introduce new independent accountability mechanism**

- **Unique for gathering all MNCH stakeholders around the table**
- **Easier access to best practice**
- **Partners held to account**

More formal governance; active involvement of members via task forces; possibly larger Secretariat (depending on nature of accountability mechanism)