PMNCH Task Force on Outputs
19th & 20th November 2008

The Partnership for Maternal, Newborn & Child Health

Board Paper – Three-Year Strategic Framework for Action and Commitment by Partners with Work Plan Elements for Year One

19th & 20th February, 2009

CONTENTS

RECOMMENDATIONS ON PRIORITY ACTION AREAS

The task force on outputs recommends that, subject to the Board discussions (and any related amendments) that the Board:

Recommendation 1 : Agrees the proposed outcomes, and outputs of the seven proposed Priority and next steps for either refinement or implementation.

Recommendation 2 : Agrees the proposed phasing for the Priority Action Areas

Recommendation 3 : Notes the initial estimates of additional expenditure (referred to as 'PMNCH Programme Expenditure') attached to the Priority Action Areas; and agrees in principle (subject to further work as may be deemed necessary) that these be incorporated in a draft PMNCH budget.

1. INTRODUCTION

1.1. Aim

The focus of this paper is the seven actions (referred to as priority action areas) agreed by the Board in November. It aims to:

- Put the proposed Priority Action Areas into the context of the mission and modus operandi of PMNCH as a "partner centric" global health partnership.
- Summarise the outcomes and the outputs that the Partnership expects to achieve through the Priority Action Areas and the proposed phasing
- Present initial estimates of the additional resources required to cover the activity over and above Partner's contributions in kind and the cost of the Secretariat – referred to as the PMNCH 'Programme Expenditure'.

1.2. Methodology

This paper is the result of the work of the Task Force on Outputs. It draws on the considerable work carried out by lead Partners on several 'priority action areas'. This work has included planning, drafting and participation in more than thirty meetings since the November Board Meeting, which the PMNCH Secretariat has facilitated and summarized. In the "partner centric" modality of work, it therefore represents the synthesis of what the PMNCH partners defined as value added for the Partnership.

As far as possible the Output Taskforce, with Secretariat support has sought to ensure a degree of consistency of methodology and approach across each of the initiatives. The intention has been that work on each priority action area as a minimum:

- assigns responsibilities to partners for work to be undertaken in 2009, and if possible beyond;
- sets out achievable outputs that will contribute to defined outcomes and the mission of PMNCH; and
- defines the expected role of the Secretariat and an estimate of the PMNCH programme expenditure in 2009; and if possible beyond.

However, Board Members should note that the stage of development varies across priority areas, which is relevant to Board discussion of prioritisation and related budget consequences. Board Members should also note that the numbering of the initiatives has changed slightly since the November Board meeting, but this does not affect the substance.

1.3. Structure of paper

The structure of the paper is as follows:

- Section 2 provides the wider context
- Section 3 summarises the strategic framework for PMNCH operation and activities as agreed by the Board at the September and November 2008 Board Meetings.
- Section 4 provides a summary of the full list of priority action areas and a summary of outcomes, outputs, indicators and budget for 2009, and for 2010-2011. It also shows the proposed phasing.
- Section 5 provides additional summary information on the proposed PMNCH Programme expenditure that relates to each Priority Action Area. More detail is provided in the Budget Board Paper.

2. CONTEXT

The wider context of this report is that the health community has seven years before reaching the deadline for the Millennium Development Goals. With this short time to go, it is already evident that MDG 4 will be reached only by a few countries and that MDG5 is lagging further behind. Achieving MDG 4 &5 requires as a minimum:

- more and better use of resources;
- increase knowledge and use of the services by the communities who will benefit from them; and
- recommendation and uptake of authoritative, harmonized, high-impact, effective interventions to be undertaken by/in countries.

Part of the challenge is that the field of Maternal, Newborn and Child Health involves many local actors working across the continuum of care. Interventions to improve health of mothers, newborn and their children:

- are required at global, regional and national levels;
- need to engage with the full range of stakeholders including members of governments, international development partners, international organizations, members of civil society organizations, academics, health care professionals, and the communities using the services.
- work across several disciplines, which include biomedical scientists, policy makers, academics, social scientists, health workers, community development specialists, and the private sector.

It is therefore essential that partners and countries work together to achieve galvanize action, to bring coherence to the multiple existing activities undertaken and to take account of respective comparative advantage.

3. STRATEGIC FRAMEWORK

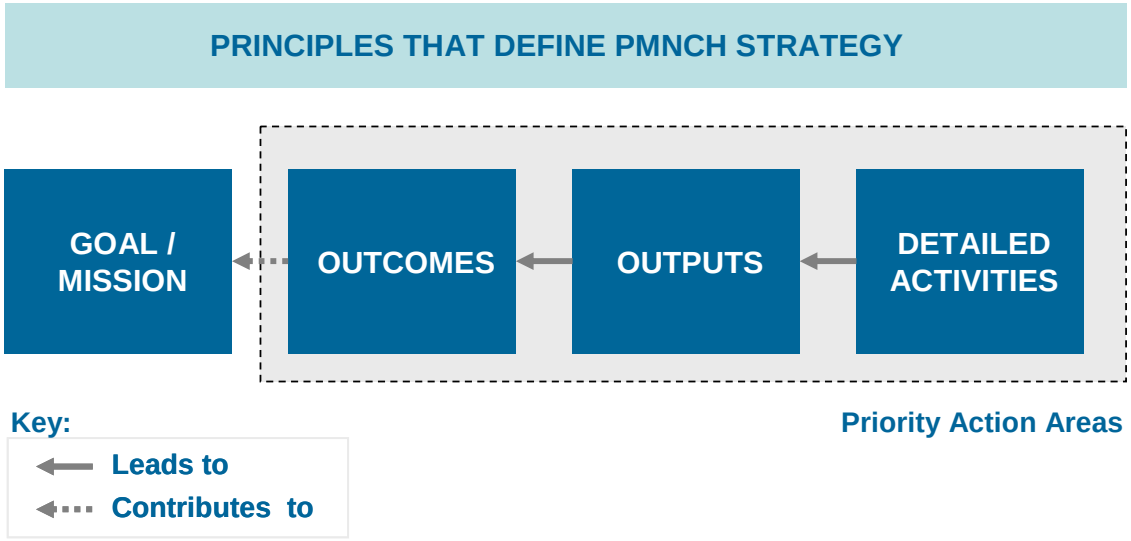
3.1. Logical framework

Figure 3.1 below defines the logical framework and definitions that has been used to structure this paper. We recognise that there are many different ways of defining such logical frameworks and alternative terminology. However, Board Members are asked to focus on the substance primarily.

Key points to note are as follows:

- The starting point for PMNCH are the principles that define its strategy, structure and operations. These were agreed at the September Board Meeting and are set out in Section 3.2 below
- The Goal of the Partnership is the ultimate objective of PMNCH. All of the priority action areas as agreed by the Board are expected to contribute to the achievement of this ultimate goal or mission. The Goal as agreed in principle in the November Board Meeting is set out in Section 3.3.
- The Goal will be reached by working in three areas (raising funds/promoting an evidence base / track partners commitments) as depicted in figure 3.2 below.
- The priority action areas are organised around **seven outcomes** that the Partnership is expecting to work towards. Within each there are detailed activities that are expected to lead to defined, and achievable outputs. Responsibility for the detailed activities are allocated by partner (including the expected role to be played by the Secretariat in supporting the partners) and there are indicative budgets. See Section 4 for the detail on this.

Figure 3.1: Logical framework

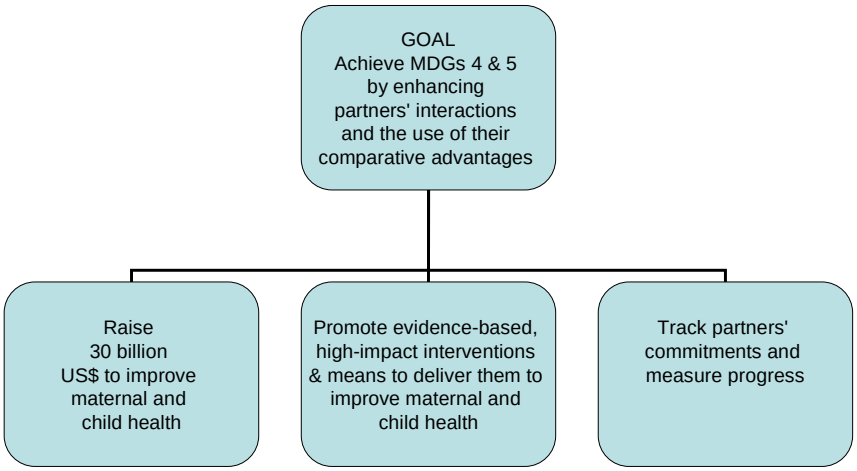


3.2. PMNCH's Goal

As depicted in figure 3.2, the PMNCH Goal is to achieve MDGs 4 and 5 by enhancing partners' interactions and the use of their comparative advantages to:

- raise of 30 billion USD to improve maternal and child health through advocacy
- promote evidence-based high-impact interventions and means to deliver them through harmonization
- track of partner's commitments and measurement of progress for accountability.

Figure 3.2: Goal and focus of action



3.3. Principles that define PMNCH structure and operations

During 2008 the Board indicated its desire that PMNCH change the way that it operates to become more 'partner-centric' global health partnership. It therefore agreed in September 2008 a series of principles that should define the structure and operations of the Partnership as follows:

- The Partnership will tackle things that are beyond manageable limits of partners, rather than duplicate partners activities
- The Partnership's activities will be concrete and time bound, requiring specific and joint effort of partners.
- The Priority Action or initiatives will have a clear and compelling concept of how to achieve specific outputs; and will have clear indicators of performance for all partners – greater accountability.
- The Partnership should (through its members) seek to align leadership of partner organisations for the agreed agenda, especially in high burden countries.
- Country engagement should be country/ demand led (responsive to country partner defined needs)

- There should be inclusiveness and transparency in decision making and information sharing – but clear understanding that 'not everyone does everything'.

In this context the Board envisaged that the Secretariat would play an important role in supporting, facilitating and contributing to the Partnership's activities. In what follows we set out the specific role of the Secretariat by priority action area. A more detailed discussion of the proposed structure and roles of the Secretariat (including its core functions) is provided in the separate paper presented for the Board's attention..

As part of the Board's discussion of the strategic principles it agreed that the types of activity that PMNCH were likely to be engaged broadly fall into three categories: advocacy; harmonisation of activities; and promoting accountability. We do not however use this broad categories of activity to organise the priority action areas – since many of them involve aspects of all three.

4. PRIORITY ACTION AREAS / WORK PLANS

4.1. Summary of priority action areas

The November Board established seven 'priority action' areas which will be pursued jointly by partners. In these priority action areas each participating partner will bring its comparative advantages to bear in delivering the envisaged outputs.

Table 4.1 below seeks to summarise the seven priority action areas and attempts to present briefly what the Partnership will achieve in 2009 and subsequent two years. Annex A provides short descriptions of each priority action areas. Annex B contains a list of the Lead and Contributing Partners responsible for each Priority Action. It has seven detailed Priority Action tables which were developed by Lead Partners in discussion and agreement with Contributing Partners.

4.2. Phasing of the Priority Actions

Figure 4.2 shows the sequence of actions towards the outputs in relation to quarters – based on the work plan information developed by the Partners in the detailed tables. The important point to note is that activities to be implemented towards achieving the outputs for priority actions are not all starting at the same time. Some activities start at various points in 2009 and 2010. The Board is requested to consider whether it regards the proposed phasing as reasonable and if not to indicate possible amendments.

Table 4.1: Summary of Priority Action Areas

Priority Action -Title	**Outputs** (What Partners will deliver)	**Objectively Verifiable Indicators** (2009)	**Objectively Verifiable Indicators** (2010-2011)	Indicative Budget ($000)		
				2009	**2010**	**2011**
1. Advocacy for increased funding and for better positioning MNCH in Health Systems initiatives	1.1 Consensus on critical MNCH Health Systems indicators 1.2 Effective channels for funding MNCH 1.3 Advocacy to high level actors (G8, HLTF) 1.4 Partner mobilization	- Establish interagency working group on costing. -Paper with 'price tag' for priority countries & on effective channelling of funds - G8 events	- Critical HS indicators identified and disseminated - Constraints to scale up identified - Inputs to joint UN costing tool development - Inputs provided for national health plans (incl.IHP compacts) include a long term financial plan. - Advocacy deliverables ready for 2009 and used in 2010/2011.	**100**	**246**	**100**
2. Develop costed national strategies for advocacy and community outreach for increased availability and use of MNCH services	2.1 Civil Society (CS) alliances to generate community pressure for funding 2.2 Costed strategies to request, access and use quality HS 2.3 Enhance M&E for demand creation (5 countries)	- Strategies developed on health-seeking behaviour -CS networks developed -80% countries abolished user fees - Advocacy campaigns to raise national funding, improve the use quality health services	1- 5 countries with MNCH national policies and able to incorporate demand outputs and impact data into a database	**450**	**150**	**150**

Priority Action -Title	**Outputs** What Partners will deliver	**Objectively Verifiable Indicators** (2009)	**Objectively Verifiable Indicators** (2010-2011)	Indicative Budget ($000)		
				2009	**2010**	**2011**
3. Identify gaps in delivery of existing MNCH Core Package of interventions and prioritize implementation research	3.1 Dissemination of current package of interventions across the continuum 3.2 Mapping of ongoing research into delivery of MNCH interventions 3.3 Identification of gaps in evidence and agreement on research needed resources mobilised for identified r&d 3.4 Consensus by partners on new evidence 3.5 Advocacy for implementation at scale of delivery strategies for agreed interventions.	- Up-to-date report on key MNCH interventions and level of delivery - Mapping of research and gaps in research identified to complete evidence	1-Advocacy implemented	**200**	**65**	**165**
4. Supplies and commodities needs met in selected MNCH priority countries	4.1 Develop basket of essential commodities 4.2 Review costing tools supply elements 4.3 Promote commodity security for national plan 4.4. Assess global availability of commodities & options	- List of commodities - Expert meeting held - Costing tool defined - Strategic plan developed (5 countries) - Mapping PPPs	- Strategic plan implemented in 5 countries	**185**	**700**	**655**
5. National plans including human resources requirements	5.1 Strategy to include Health Care Providers (HCP) in national planning 5.2 Scale-up integration of HCP in 17 countries 5.3 Costing strategies	- Situation analysis & follow up plan done for 17 countries - M&E process developed - Annual global HCP, UN Agencies and Donors meeting - Two HCP workshops	- Strategy for inclusion of HCP developed - HR policies in countries	**605**	**235**	**140**

Priority Action -Title	**Outputs** (What Partners will deliver)	**Objectively Verifiable Indicators** (2009)	**Objectively Verifiable Indicators** (2010-2011)	Indicative Budget ($000)		
				2009	**2010**	**2011**
6. Robust knowledge resources on MNCH readily available through managed portal	6.1 "Map" existing knowledge resources 6.2 Create knowledge portal 6.3 Maintain portal 6.4 Identify status of knowledge on critical issues for MNCH and flag gaps to PMNCH Board	- "Map" available - Portal designed - Guidelines available on knowledge status reports - First knowledge status report available.	- Fully operational portal available & sustained - Knowledge products from other Priority Action areas available through portal - Knowledge status known for prioritised issues in MNCH and gap resolution decisions made by Board.	**325**	**225**	**225**
7. Accountable partners for MNCH	7.1 *OTHER accountability tasks (to be defined)* *7.2* CD advocacy 7.3 CD meeting 7.4 Support CD-WGs	- Accountability outputs defined - Advocacy activities progress report	- Advanced preparations for CD mtg and document launch.	**650**	**1,450**	**250**

Table 4.2: Sequence of Outputs

Priority Actions	2009				2010				2011			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
PA1: Advocacy for increased funding and for better positioning MNCH in Health Systems initiatives	Output 1: Identify Health System Investments that need to be made to achieve MDGs 4 and 5 related outcomes											
	Output 2: Effective channels for funding of MNCH and ways to increase financing identified											
		Outputs 3-4:Mobilization & partner coordination, advocacy on key MNCH messages for G8 and other partners, help HLTF to raise the additional US$ 30 bn										
PA 2: Develop costed national strategies for advocacy and community outreach for increased availability and use of MNCH services			Output 1: Civil society to generate com. pressure for policies, funding for MNCH programs									
			Output 2: Support costed strategies for the health-seeking behavior by communities									
					Output 3: Enhance country's capacity for monitoring & evaluation of impact of demand creation strategies							
PA3: Identify gaps in delivery of existing MNCH Core Package of interventions and prioritize implementation research		Output 1: Disseminate MNCH delivery int. packages										
		Output 2: Mapping and gap identification										
					Outputs 3-4-5: Funds mobilized for research/consensus building and agreement/advocacy for implementation							
PA4: Supplies and commodities needs met in selected MNCH priority countries		Output 1: Supply component of MNCH interventions										
					Outputs 2-3:Supply components of costing tools/MNCH commodity security as a critical element of plans and budgets							
					Output 4: Assess global availability of commodities							

Cont. . . . .

Priority Actions	2009				2010				2011			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
PA5: National plans including human resources requirements		Ouput 1: Strategy for HCPs to increase their contribution to MNCHplans										
			Output 2: Scaling-up HR strategies and integration into National Health Care Planning in 17 countries									
			Output 3: Costing strategies for scaling-up HR for health (Drs, Nurses, MWs, other MNCH health care providers, other Civil Society actors).									
PA6: Robust knowledge resources on MNCH readily available through managed portal		Output 1: Mapping										
				Outputs 2-3: Proactive managed portal created, Strategies and mechanisms implemented for maintaining portal								
				Output 4: Knowledge on critical issues identified through portal and key "gaps" flagged back to the PMNCH for "resolution"								
PA7: Accountable partners for MNCH			Output 4: Define the Outputs for Accountability Action									
					Outputs 1-2-3: Countdown work							

5. PMNCH PROGRAMME EXPENDITURE

Details on the budget required to implement activities included in Table 4.1 are spelt out in the accompanying 'Budget Paper', which will be presented at the Board meeting. The Budget Paper sets out the cost of the Secretariat and PMNCH core functions, as well as the anticipated expenditure associated with the fulfilment of PMNCH Programme activities or Priority Action Areas. The latter of these, i.e. PMNCH Programme Expenditure, are assumed to be the additional resources required to cover the activity over and above Partner's contributions in kind and the cost of the Secretariat and PMNCH core function cost. While the costs presented here have been largely extracted from estimates submitted by partners in the tables, they are understood to be estimates. These estimates will be reviewed by the Finance Committee in due course.

In the final section of this paper we summarise the PMNCH Programme Expenditure element of the Budget Paper. It is important to note that these expenditure assumptions are still under development. However, it was felt important that the available information is shared with the Board members to inform their deliberation on the Priority Action Areas.

A summary of PMNCH Programme Expenditure is shown in Table 5.1 below. The key points to note from this table are:

- The overall budget for the three year period is currently estimated to be around US$ 7.2m. The expenditure in year 2009 is expected to be around US$ 2.5m, rising to around US$ 3m in 2010. The final year of the projected budget is expected to have a somewhat lower expenditure level of around US$ 1.6m.
- Priority Action Area 7 is currently assumed to be most costly at an estimated US$ 2.4m over the three year period, primarily due to the expenditure associated with the next Countdown meeting, currently planned for 2010. Priority Action Area 4 is the next most costly at US$ 1.5m.
- It is important to note that these expenditure levels are likely to be an underestimate, primarily because the expenditure for:
    - Priority 1 currently excludes any cost estimates for outputs 3 and 4 under this area;
    - Priority 3 does not include any costs for output 3 in 2010; and
    - Priority 5 currently only assumes that relevant meetings will only be taking place in 2009 and not in later years.

Table 5.1: Summary of PMNCH Programme Expenditure

Category	2009	2010	2011	Total
Priority Action 1: MNCH Advocacy and HS positioning	50	246	50	**346**
Priority Action 2: Advocacy and community outreach for MNCH services	450	150	150	**750**
Priority Action 3: Gaps in MNCH Core Packages	200	65	165	**430**
Priority Action 4: Develop costed strategies to scale up commodity supplies	185	700	655	**1,540**
Priority Action 5: Human resources for MNCH	605	235	140	**980**
Priority Action 6: MNCH knowledge management portal	325	225	225	**775**
Priority Action 7: Accountability and the use of Countdown	650	1,450	250	**2,350**
TOTAL	**2,465**	**3,071**	**1,635**	**7,171**

Table 5.2 below sets out the details of the same proposed expenditure from the perspective of functions that would be required to achieve the work plans of individual Priorities. Similar caveats will need to borne in mind about the possibility that this expenditure information is an underestimate at this point. Nevertheless, key points to note at this stage are:

- Expenditure associated with **meetings and travel** are currently estimated to be in the region of US$ 2.9m. As their title suggests, these are likely to include expenditure on flights and accommodation as well as any other costs associated with organising the meetings in question (e.g. conference facilities).
- **Consultant** expenditure is assumed to cover the costs of outsourcing any specialist work that will be required to support activities under the different priorities. This expenditure is expected to be in the region of US$ 2.3m over the three year period, with the bulk of it (US$ 1.2m) being projected to happen in year 2009.
- **Other outsourcing** refers to additional costs that may be associated with specialist IT/ web support as linked to specific Priorities as well as any coordination/ advocacy support. This expenditure is expected to be around US$1.4m over the period.
- The final category of cost relates to additional expenditure expected to be incurred by the **Secretariat** in their agreed role in the Priority Action Areas. These costs include, for example, Secretariat travel costs, editorial and publication costs, additional logistics costs (e.g. For the Countdown Meeting, and HCPA workshops). This is estimated to be around US$ 0.7m for the period.

Table 5.2: Summary of functional PMNCH Programme Expenditure

Category	2009	2010	2011	Total
Meetings and travel	735	1,460	685	**2,880**
Consultants	1,200	680	390	**2,270**
Other outsourcing	330	616	420	**1,366**
Other Secretariat	200	315	140	**655**
Total	**2,465**	**3,071**	**1,635**	**7,171**

ANNEX A: NARRATIVES OF PRIORITY ACTION PLANS

Task teams from the Task Team on Outputs have been working developing ideas and plans for each on since the initiatives were proposed at the September Board retreat. Lead partners volunteered to develop and take on this work, and were confirmed. They contributed, with the help of the Secretariat, to develop the seven priority actions proposed.

This Annex provides a work plan for the year 2009, and projects the priority actions into the 3-year Strategic Framework. It describes the overall consensus reached for each priority action group, and defines responsible partners for specific actions.

Priority action 1. Advocacy for increased funding and for better positioning MNCH in Health Systems initiatives.

During the Board meeting in November 2008, partners stressed the importance for PMNCH to focus on advocacy. . Priority Action 1 intends to mobilize MNCH partners to actively and strategically advocate at various levels so as to increase the effects on raising focus on and resources for MDGs 4 and 5. Focus will be emphasized on efforts surrounding the G8 (Italy president in 2009) and G20, as well as take advantage of the Health Financing Task Force for Innovative Financing of Health Systems.

Outcomes: Profile raised and resources mobilized (additional US$ 30 billion) from G8 and other partners at global and country level to save 3 million mothers and 7 million children by 2015.

Main outputs:
1. MNCH profile highlighted and the health systems investments needed to achieve MDG4&5 identified in the HLTF and other fora.
2. Innovative ways to increase resources and effective funding channels identified and promoted.
3. Development of messages and advocacy strategies targeting both high level actors (G8,HLTF, etc) and community level actors, using very different media and advocates to raise commitment and resources for MNCH (incl. assisting HLTF to raise the additional US$ 30 billion). It is acknowledged that messages may need to be updated as this work progresses.
4. Mobilization and coordination of partners around MNCH

Expected deliverables:
2009:

1. HLTF recommendations influenced to adequately reflect MNCH prioritization.
2. HLTF recommendations used strategically to raise profile and funding for MNCH at G20, WHA, G8, UNGA, etc.
3. Studies that address health systems obstacles for MNCH scale up conducted and findings made available to improve planning at national and global level.
4. Paper on innovative financing and effective mechanisms to channel funds developed and provided to HLTF work.
5. Core advocacy messages developed, materials produced and strategically disseminated to raise resources.
6. Target audiences identified and cross-linking to other health initiatives and advocates established.
7. Coordinated media strategy and events calendar related to MNCH advocacy developed.
8. G8 country specific strategies developed for engagement with parliamentarian alliances and others (e.g. G8 health experts, etc).
9. Partner plans, capacity to engage and activities mapped.

2010-2011:

1. Critical health system elements and related indicators to achieve MDG 4&5 identified and disseminated strategically (to targeted audiences e.g. like the "Investment Case" audience).
2. Priority health systems constraints that prevent scaling up identified and guidance on this disseminated on PMNCH and partners' websites.
3. Inputs provided to the joint UN costing tool development and made available on PMNCH website.
4. Inputs provided to work on ensuring that national health plans (incl.IHP compacts) include a long term financial plan with focus on MDG4&5.
5. All advocacy deliverables will expand to at least 2010, recognizing that momentum built for 2009 G-8 will contribute and directly shape opportunities in 2010 G-8.

Leader partners: Norway, Canadian CIDA and FCI are the lead partners responsible for this Priority Action.

Interactions with other Priority Actions: PA1 will have close interaction with PA 3 (gaps), PA 4 (costing scaling up), PA5 (human resources), PA6 (portal).

Support from the Secretariat:
1. Participate in HLTF WG1; Contribute to paper development; and facilitate dissemination of results on PMNCH website
2. Contribute to the harmonization and development of the joint UN costing tool and make links available on PMNCH website.
3. Participate in interagency working group on costing; disseminate results on PMNCH website
4. Conduct analysis through Working Group on Financing; manage contracts of partners; ; disseminate results on PMNCH website
5. Facilitate incorporation of findings in Countdown 2010; disseminate results on PMNCH website
6. Co-prepare mapping and analysis, as well as strategies and plans to improve positioning of MDG4&5

Transition activities from 2008
- Work with lead NGO in Italy towards G8 summit 2009, in collaboration with lead partners/task force established for G8 advocacy in 2009.
- Coordinate with partners to mobilize leaders and champions for MNCH.
- Develop a coordinated media and events calendar including planned events related to MNCH advocacy.
- Monitor public statements, high-level meetings, signed commitments for MNCH.
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Priority Action 2. Develop costed national strategies for advocacy and community outreach for increased availability and use of MNCH services

Outcomes: Increased availability and utilization of key MNCH services at national and community level

Main outputs:
1. Support local and national civil society alliances for generating community pressure for the adoption for appropriate policies and for funding for MNCH programs / services in 5 countries.
2. Support costed strategies for the health-seeking behavior by communities, women and children to request, access, and use quality MNCH services
3. Enhance country's capacity for monitoring & evaluation of impact of demand creation strategies

Expected deliverables:
1. All targeted recipient countries developed MNCH national policies
2. Five strategies developed on health-seeking behaviour by communities to request, access and use MNCH services
3. At least 50% of targeted countries established mechanisms for incorporating demand-side outputs and impact data into local and national database.

Timelines for 2009: June 2009 review of evidence completed. Five strategies completed by en 2009. Civil society alliances, and advocacy campaigns developed by end 2009.

Leaders/Potential support: CARE, FCI, UNFPA, USAID, Norway, CIDA.

Interactions with other Initiatives: Interactions in particular with PA5 (human resources) and PA4 (costed supplies) and Initiative 4a on scaling-up supplies.

Support from the Secretariat:
1. Review of literature on civil society alliances and support for its dissemination
2. Support for alliance creation.
3. Follow the development of national policies and demand creation strategies into an online repository
4. Gathering and disseminating reports on the mechanism for incorporating demand-side outputs.
5. Ensure interaction with other Priority Areas.

Transition activities from 2008
- Provide assistance and input to development of investment case.

Priority Action 3. Identify gaps in delivery of existing MNCH Core Package of interventions and prioritize implementation research

Outcomes: Consensus on the key interventions for MNCH to be delivered at each level of health care, across the continuum.

Main outputs:

- Dissemination of current package of interventions across the continuum
- Mapping of ongoing research into delivery of MNCH interventions
- Identification of gaps in evidence and agreement on research needed
- resources mobilised for identified research
- Consensus by partners on new evidence
- Advocacy for implementation at scale of delivery strategies for agreed interventions

Expected deliverables:

- Up-to-date report on key MNCH interventions and level of delivery
- Mapping of research and gaps in research identified to complete evidence
- Funds identified
- Meeting on consensus of this information
- Advocacy material (in linkage with Initiative 1).

Leaders/Potential support: WHO / HCP and other partners invited to confirm their participation.

Timelines for 2009: Report and gap identification will be completed in 2009.

Interaction with other initiatives:

- Very close collaboration with PA6 (knowledge management), PA1 on Advocacy for the case of MNCH, and PA7 (Accountability).

Support from the Secretariat:

- Management of consultants
- Contributions to the content of the discussions
- Provision of platform for discussion
- Meeting organization and reporting
- Ensure linkage with other Priority Actions

Transition activities from 2008

- No specific activities.

Priority Action 4. Develop costed strategies to scale up commodity supplies

Access to and availability of health commodities and supplies is critical to the achievement of the Millennium Development Goals (MDGs), particularly MDGs 4, 5 and 6. However, neither of these goals, nor the right to health on which they are based, can be achieved without the dependable provision and proper use of most essential health commodities, vaccines, contraceptives, and other health supplies. There is a fragmented and uncoordinated work at country level. Partners are in a privileged position to use their comparative advantages in helping countries determine the essential MNCH supply and commodity package, forecasts, procurement, quality assurance and build a sustainable logistics systems while at the same time off set stock outs and meet immediate needs of these countries.

Outcomes: Supplies and commodities needs met in selected MNCH priority countries

Main outputs:

1. Identify the supply component of evidence-based MNCH interventions and define a basket of essential commodities.
2. Review and update the existing tools, guidelines and protocols related to commodities security including supply, demand and information at countries to help national capacity development on sustainable supply of these commodities to everyone who needs them.
3. Technical and programming support (in close collaboration with key partners) for improving access to and availability of affordable and quality MCH package when needed. Identify supply and financing gaps. Prioritise commodities undersupplied by markets and/or under-used by countries.

Expected deliverables:

Identify a minimum health package based on discussions and agreement with global and national experts, UN and other partners.

Agreement on a tool, protocol and guideline/ use of modular approach to ensure their sustained supply.

Agreement between agencies to promote unitary and integrated purchasing of specific commodities

Partners database to track progress in five countries (strategic plan for cost recovery, infrastructures, quality assurance and value for money).

Development of strategic or master plan within 5 years to ensure access to these commodities to everyone who needs them.

Indicators:

2009:

- Consensus MNCH package costed for each country and forecasting until 2014 completed

End 2011

- Partners agreement on an integrated purchasing of specific core of commodities per country in effect and implemented (report)

2014

- Stock outs below 10% of X MNCH drugs and supplies by 2014 at district level in focal countries (up to 5)

Leaders/Potential support: UNFPA, UNICEF and other partners WHO, USAID, John Hopkins, DfID, CIDA, KFW, IPPF).

Interactions with other Initiatives: In particular with Initiative 1 (advocacy for funding with the Working Group on Financing in particular.

Support from the Secretariat:

- Facilitate/convening of experts to identify the MNCH supply package + supporting documentation
- Facilitate interaction between working groups on issue of costing (coherence)
- Help monitor through central data base of progress in the selected countries
-Help identify new private sector partners/mapping

Transition activities from 2008

- Complete review of costing tools related to the health MDGs, and develop user-friendly overview that describes the purpose of each tool, its use and the resource needed to use it.
- Develop effective mechanism to facilitate country requests for assistance from partner organizations in the use and adaptation of costing tools.

Priority Action 5. Human resources for MNCH

Outcomes: MNCH health providers and other civil society stakeholders increase their contribution to MNCH policies, plans, initiatives and programs at national, regional and global levels

Main outputs:
1. Define a strategy for broad inclusion of MNCH Health Care providers to increase their contribution to MNCH plans, policies and programs
2. Scaling-up HR strategies and integration into National Health Care Planning in 30 countries
3. Costing strategies for scaling-up HR for health (Drs, Nurses, MWs, other MNCH health care providers, other Civil Society actors).

Expected deliverables
1. Situation analysis on MNCH HR needs and implied costs in 17 countries
2. Ongoing monitoring and evaluation of program plans in 17 countries
3. HCPA representation on the MNCH financing taskforce
4. Strategies for the scale-up of HR for health developed
5 Strategies costed
.

Timeline for 2009
Output 1: .
Define tools for situation analysis and undertake background work for strategy
Situation analysis for deliverables for 17 countries

Output 2.
Situational analysis on bottlenecks for the achievement for the listed deliverables in 17 countries
Workshops conducted in Arab-speaking countries and Latin America
Evaluation tools developed and conducted in 17 countries
Follow-up plan developed including situational analysis for 17 countries with attached budget and implementation table
One meeting per year between UN, Donors and HCPAs at global level

Output 3
Situation analysis on the MNCH HR needs and implied costs in 17 countries
Strategies for the scaleup of HR developed and costed
HCPA report on finance
.

Lead Partners /Contributing Partners
HCPA advisory group, Contributing: GHWA, WHO, national and relevant regional MNCH health care providers, MOH, UNFPA, UNICEF, PMNCH.

Interactions with other Initiatives: Interaction with PA2 (demand creation) and PA3 (identifying gaps in existing core packages of interventions).

Support from the Secretariat:

1. Facilitate meetings and discussions for the development of the strategy, finalize and disseminate document Participate in preparatory work with HCPAs, keep a record of all collaborations with the MOH, all taskforce meetings, signed agreements and plans
2. Participate in consultative meetings and keep records of decisions
3. Organize regional workshops
4. Facilitate costing meetings and discussions following strategy development, follow up on costing strategy development.
5. Link with global initiatives (GHWA)
6. Ensure linkage with other Priority Actions.

Transition activities from 2008

- Issue grant to organization to establish and maintain contact database for HCP associations.
- Provide funding support for technical assistance to NGOs, professionals and others without self-funding capacity. (specifically NGO workshop in Nigeria).

Priority Action 6. MNCH knowledge management portal[1]

Outcomes: Robust knowledge resources readily available through a comprehensive & proactive managed portal.

Main outputs:
1-Mapping of existing knowledge resources relevant to MNCH, and links integrated into existing PMNCH website ("quick win").
2. Proactive managed portal created
3. Strategies and mechanisms implemented for maintaining portal
4. Status of knowledge on critical issues identified through portal and resolution of key gaps facilitated.

Expected deliverables:
1. Opened access, one-stop shop for MNCH information
2. Inventory (map) of knowledge resources available and regularly updated..
3. Continuous integration into portal of new knowledge products, including those generated by other Priority Action areas of PMNCH..
4. Knowledge status reports prepared and updated on critical issues identified by Partners
5. Critical knowledge "gaps" identified through the portal and resolution facilitated through PMNCH.

Timeline for 2009: By late 2009 mapping of existing knowledge resources completed, and by end of the year links available on PMNCH website. Basic portal designed. Guidelines available on knowledge status reports, and first one completed for a critical issue in MNCH.

Leaders/Potential support:
- Academics (U of Aberdeen), AKU, other partners to be confirmed under a small Task Team and Secretariat.

Interactions with other Initiatives: Continuous interaction with Priority Action area 3 on evidence-based information.

Support from the Secretariat:
1.Oversight for development of ToRs for outsourced group, tendering process, and progress of work
2. Manages continuous updating and maintenance, of portal, interfacing with outsource groups.
3. Oversees work of outsourced knowledge group. Supports Board processes to address knowledge gaps.

Transition activities from 2008
- None

[1] Find definitions in footnotes of table PA6 at the end of the paper.

Priority Action 7. Accountable partners for MNCH

Outcomes and Outputs for this Priority action are not as yet well defined, nor is the role of Partners. These topics will be discussed and clarified during 2009. The only elements developed to date are those related to the Countdown and are described below.

Outcomes: Accountable partners for MNCH

Main outputs:

- Additional potential outputs for Accountability.
- An advocacy workplan for the Countdown
- A Countdown meeting in 2010 or 2011
- Updated data on four working groups (coverage, financing, equity and policies & health systems).

Expected deliverables

- A report from the 68 high burden countries for maternal, newborn and child health
- A meeting to discuss/disseminate updated information
- A close link with the Inter-parliamentarian Union for advocacy purposes
- A Lancet special issue focusing on the Countdown and other advocacy actions.

Timeline for 2009
Support for WG completed in 2009

Leaders /Potential support:
Co-chairs of Sub-Committee Anne Starrs (FCI), Flavia Bustreo (PMNCH). All partners, and IPU. Co-chair WG on coverage: Jennifer Bryce (JHU), Tessa Wardlaw (UNICEF). -Chair WG on financing: Peter Berman (WB) - Co-chair WG on equity: Cesar Victora (Pelotas University), Ties Boerma (WHO)- Co-chair WG on policies: Bernadette Daelmans (WHO), Helga Fogstad (NORAD).

Interactions with other Initiatives: Close interaction with PA6.

Support from the Secretariat:
Cochair Advocacy Sub-Committee, -Organization & logistics
- Promotion & dissemination
- F/U 2009 IPU mtg
- Support for Working Groups - Seed contribution funding from PMNCH (USD200,000) to four WGs

Transition activities from 2008
- Continuation of advocacy activities with IPU towards elected countries.
- Facilitate Countdown working groups and continue in role of co-Chair of the advocacy and communications working group of the Countdown.

ANNEX B: PRIORITY ACTIONS , LEAD AND CONTRIBUTING PARTNERS

PRIORITY ACTION TITLE	LEAD PARTNERS	CONTRIBUTING PARTNERS
1. Advocacy for increased funding and for better positioning of MNCH in health systems initiatives	• CIDA (Christine Reissmann), • FCI (Ann Starrs) • Norway (Tore Godal / Helga Fogstad)	WHO, UNICEF, UNFPA, BMGF, USG, Health Care Professional A, India, WB, , WHO, WB, Ethiopia, UNICEF, USAID, UNFPA, BMGF, FCI and other CSOs, Academics.
2. Develop costed national strategies for advocacy and community outreach for increased availability and use of MNCH services	• (CARE) Kwami Togbe • FCI (Ann Starrs) • UNFPA (Hedia Belhadj)	WHO, Mali, CIDA, HCPAs.
3. Identify gaps in delivery of existing MNCH Core Package of interventions and prioritize implementation research	• WHO (Daisy Mafubelu, Liz Mason, Monir Islam) • HCP (Zulfiqar Bhutta)	Academics, Research Community, CARE, USAID, WB, Save the Children, BMGF (MBB tool), Mali, UNFPA.
4. Develop costed strategies to scale up commodity supplies	• UNICEF (Pascal Villeneuve) • UNFPA (Hedia Belhadj)	USAID, WB, WHO, CARE, Mali, CIDA
5. Human resources for MNCH	• HCP (Lalonde, Schaller Lynch), • UNFPA (Hedia Belhadj)	Academics (Z Bhutta), Ethiopia (Medhin)WB, WHO, CARE, Mali, CIDA,
6. MNCH knowledge management portal	• Academia (W. Graham) • HCPA (Z Bhutta)	All constituencies and members of the Board
7. Accountable partners for MNCH	• UNICEF/CD (Pascal Villeneuve, P Salama), • HCPA/CD Z. Bhutta	USAID, Health Care Professionals, WB, UNFPA, WHO, Save the Children, BMGF, FCI, Academics

Priority Action 1: Advocacy for increased funding and for better positioning of MNCH in health systems initiatives						
Outcome: **Profile raised and resources mobilized (additional US$ 30 billion) from G8 and other partners at global and country level to save 3 million mothers and 7 million children by 2015.**						
Value added: The membership of PMNCH represents a mix of constituencies which will enable a broader reach and more effective targeting of relevant audiences. Consensus will ensure harmonization of messages, and enable a more consistent and collective push to getting more funding for MDG 4&5. PMNCH also offers an opportunity to synergize on different lines of work , maximizing on each partner's comparative advantage and reducing unnecessary duplication.						
Outputs	**Objectively verifiable indicator (OVI)**	**Deliverables/ Milestones**	**Time line (2-3 years)**	**Budget & funding**	**Lead Partners**	**Secretariat functions**
1. MNCH profile highlighted and the health system investments needed to achieve MDGs 4 and 5 identified in the HLTF and other fora	Provide effective inputs to the work of the HLTF on Cost and Constrains related to MDG 4&5, and make sure that end results get strategically disseminated to maximize existing resources as well as get increased resources necessary to reach the MDG 4&5 targets	Influenced the HLTF recommendations to adequately reflect MNCH issues. Paper with Core Messages from the HLTF, including 'price tag' for the 49 priority countries strategically used by PMNCH to raise profile and funding for MDG4&5.	Feb-March 2009 By end of June 2009	Norway, DFID Norway, DFID	UN/ Norway/HCPA advisory group, BMGF, WHO/WB	Participate in HLTF WG1; Contribute to paper development; disseminate results on PMNCH website Input, facilitated publishing and make available on PMNCH website
	Contributed to the development and harmonization of the HLTF costing as it relates to scaling up effective packages of MNCH services.	Established interagency working group on costing under the umbrella of HLTF and the International Health Partnership IHP+ (as part of SURG) and provided costing results to HLTF and IHP+ as it relates to MDG 4&5, including health systems strengthening.	Jan-March 2009	Co-funding Norway, DFID (USD 500,000 already provided through IHP+)	UN/WB, Norway,	Participate in WG1 & contribute to the analysis and dissemination
	Facilitated the development of the technical working document (of the HLTF costing), published and made available on PMNCH and partners' websites	Technical working document delineating the assumptions behind the above costing exercise developed, published and made available on PMNCH website and partners' websites. Document also made available to HLTF.	Finalized by March-April 2009	US$10 000 for technical editing and layout of document (Norway provided funding to UoS)	Norway, UN/WB, , Southampton University	Participate in interagency working group on costing; disseminate results on PMNCH website

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
	Critical health system elements and related indicators to achieve MDG 4&5 identified and disseminated to targeted audience (like the "Investment Case" audience)	Critical health system barriers that prevent scaling up identified and guidance provided to achieve MDG 4&5 developed and disseminated strategically.	2009-2011	USAID, Norway	USAID, UN, BMGF, Norway	Input, facilitated publishing and make available on PMNCH website
	Priority health systems constraints that prevent scaling up identified and guidance on this disseminated on PMNCH and partners' websites.	Guidance on priority health systems constraints that prevent scaling up developed, and made available on PMNCH and partners' websites	2009-2011	USAID, Norway	USAID, UN, BMGF, Norway	Input, facilitated publishing and make available on PMNCH website
	Joint UN costing tool developed, and readily available	PMNCH provided inputs to the modules for MDG 4, 5, & 6[2] and consensus reached on the use of these tools among all the partners. Furthermore dissemination strategy developed and tools or web links made available on PMNCH website as well as partners'. Training materials, and capacity building strategies implemented.	By end of 2009 By end of 2009	Co funding: BMGF USAID? Norway (USD 385,000 provided already to WHO and IHP)	WHO/WB, UNFPA, UNICEF, John Hopkins, IMMPACT, UNAIDS, USAID, BMGF, Norway	Contribute to the development of MDG 4 and 5 modules, review final analysis; and country costing tools.

[2] MDG 6 is not part of the mandate of the PMNCH but because of the cross cutting nature of some of the issues and the all inclusiveness of health MDGs in some initiatives, it will be present in a number of the actions in this plan

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
	Paper developed on: 1. Annual ODA to MNCH: (i) Total 2003-2008; (ii) By donor country; (iii) By recipient country 2. Annual Domestic expenditures on MNCH: (i) Total 2008; (ii) Government spending; (iii) Private (out-of-pocket) spending)	PMNCH to provide inputs on the work on monitoring country expenditures on MDG 4&5 (through national health accounts framework) to get a better understanding re current domestic expenditures related to MNCH). Monitor annual Official Development Assistance to MNCH Provide insight into donor and government behavior and challenges to aid effectiveness (contribution to IHP+ and HLTF work	Preliminary results by December 2009, final results by April 2010 (Countdown report and Lancet special issue)	US$120,000 (Co-funding Norway provided funds to WHO)	WHO Members of Countdown Working Group on Financing (WGF): WB, BASICS, IHP (Sri Lanka), LSHTM, MSH, SC UK, UNFPA	Conduct analysis through Countdown WGF;; manage contracts of partners; ; disseminate results on PMNCH website
	Paper developed exploring the extent that maternal mortality can be used as a tracer indicator for a functioning health system	Develop paper, publish and disseminate	By March 2009	US$ 15,000 (Southampton University with Norway and DIFD)	Southampton University	Contribute to the review of the final analysis; disseminate on PMNCH website
	Analysis developed on the extend to which MDG4&5 is currently being addressed in health systems initiatives and how to improve this.	Mapping and analysis of current situation conduced Strategies and plans developed and implemented to ensure a greater focus on MDG 4&5 in these initiatives. Including secondment of MDG4&5 staff member in HLTF and IHP+ secretariat to ensure adequate focus on MNCH.	By end of Feb 2009 By end of 2009	1'000.000 US$ to IHP+ 500,000 US$ mill to HLTF (Norway, co funding) these funds have already been provided to WHO	Norway WHO / WB, UNFPA, UNICEF, BMGF, Norway	Co-prepare mapping and analysis, as well as strategies and plans to improve positioning of MDG4&5

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
2. Effective channels for funding of MNCH and innovative ways to increase financial resources identified and promoted	PMNCH will provide input to HLTF's WG2's work on Innovative financing, which includes analyzing the range of existing innovative financing instruments to respond to the health systems constraints identified in WG1, and make recommendations on instruments that are ready for expansion as well as examine possible new or complementary approaches. This work will take into account the broader discussion and emerging consensus among development partners on how to increase domestic revenue mobilization for health financing. The analysis will also review the efficiency of the present channeling of international funds for health and what changes might be required for.	Developed paper (analysis on the range of existing financing instruments) and provided inputs to the WG2 of the HLTF Identified innovative financing mechanisms for MNCH	By Feb-May 2009	Norway (NOK 500,000 funds already provided to HLSP)	Norway	Participation in High-Level Task Force; Facilitate review of paper, publication and dissemination of results on PMNCH website
	Paper developed on the audit of the experience with the effectiveness of general budget support, basket funding as funding allocation mechanisms etc especially as it relates to prioritizing MNCH).	Audit of experiences Paper developed, published and distributed	By 30 June 2009	250,000 US$ (Norway, funds already provided to WHO)	WHO (HSF) with close interaction with the IHP+ secretariat	Contribute to paper; disseminate results on PMNCH website

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
	X number of national health plans (incl. IHP compacts) that include a long term financial plan with a focus on MDG4&5 marginalized groups. Support for technical coordination between the different international and national partnerships on financing strategies (including the High Level Task Force on Innovative Financing and the Providing for Health Initiative	Provided inputs to work on ensuring that national plans (incl. IHP compacts) include a long tern development of the financing system with a focus on MDG4&5.	By end of 2009	(Co-funding: Norway US$240,000 funds already provided to WHO) Germany (?) France (?)	WHO	
	Products: Global Birth Atlas developed, and dissemination strategy, journal article. (this should may be put under output 3 instead of here??)	Formation of design team and preparation of specification for atlas; Identification of databases and sources for selected variables; Drafting of maps and expert consultation to assure clarity of interpretation and messaging; launch of atlas at appropriate high level event; dissemination roll-out across 10 countries.	Timeline: 12 months from Jan 1st 2009.	Phase 1 (content design/ proof version) ~$76,000; (funds provided by Norway) Phase 2 (print run, launch and diss) ~ $196,000. Funding gap	IMMPACT. Overall design & evidence by WRA and U Southampton and Aberdeen, in liaison with CD	

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
3. Development of messages and advocacy strategies targeting both high level actors (G8,HLTF, etc) and community level actors, using very different media and advocates to raise commitment and resources for MNCH	Core advocacy messages and materials produced and endorsed by all partners, and strategically disseminated to successfully raise resources.	-Strong consistent core messages developed and advocacy strategies tailored to specific audiences both high level and community level actors, using very different media and advocates. -Advocacy materials (fact sheets, briefing cards) developed. -Strategic partners identified -Defined media strategy (op eds by high-level politicians and agency heads) -Worked with priority action group 2 to define a strategy/advocacy tools for demand creation at the community level -Ensure important advocacy hubs such as the GNL, Women Deliver, Countdown, US Coalition, HLTF… are involved in message development and dissemination -Messages incorporated / featured in web sites, e-news, etc. of partners, news services, blogs -High-level events identified and advocacy strategy targeted (G8, -UN events (CSW, CPD, GA), ICPD+15 events organized and conducted.	Messages – by May 2009 Materials – by Jun 2009Strategy – by Apr 2009 G20=April WHA=May G8=July UNGA=Sept	To be developed	FCI + other representatives of all PMNCH constituencies (will include many not on PMNCH Board) BMGF?	Secretariat to coordinate work between the different stakeholders Add to its global event calendar. Participate in message definition and materials dev't Use PMNCH web site and communication channels to disseminate messages

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
4. Mobilization and coordination of partners around MNCH	Number of partners who endorse the consensus statement (indicators and budget for G8)	Parliamentarian alliances and related events in Italy, Canada, other G8 countries (G8) country-specific strategies developed for engagement Mapping of partners plans, capacity to engage, and activities Direct lobbying to health experts to the G8 (Japan, Italy, Canada) Parliamentarian alliances & related events in Italy, Canada & other G8 countries (G8) country-specific strategies developed for engagement Other Global Partnerships and Advocacy Groups.	2009, 2010 Start activities early 2009	WHO (Italy) CIDA (Canada) Other G8 country	WHO (Italy), CIDA, others G8 Sherpas NGOs, HCPAs, CSO, FCI, WB, WHO, *ACPD,* WRA, GAVI , Cochrane, UNFPA), and Secretariat. Canada, US, UK, Norway, Secretariat	Facilitating Italian Parliamentarian meetings, direct lobbying, mapping of partners and their capabilities, analysis of Italian ODA, ensuring that the Countdown information is used as a basis for the development of mobilization strategies

Priority Action 2: Develop costed national strategies for advocacy and community outreach for increased availability and use of MNCH services						
Outcome: **Increased availability and utilization of key MNCH services at national and community level**						
Value added: Broad multisectoral membership of the PMNCH provides a unique opportunity to bring together expertise and access for maximizing knowledge and synergies						
Outputs	**Objectively verifiable indicator (OVI)**	**Deliverables/ Milestones**	**Time line (2-3 years)**	**Budget & funding**	**Lead Partners**	**Secretariat functions**
1. Support local and national civil society alliances for generating community pressure for the adoption for appropriate policies and for funding for MNCH programs / services in 5 countries.	Number of civil society alliances established in targeted countries Number of local and national civil society alliances whose capacity to develop advocacy strategies has been strengthened Number of alliances that launch advocacy campaigns in recipient countries At least 60% of targeted countries have drastically increased their funding for MNCH programs / services Number of national MNCH policies developed resulting from the provision of TA Number of countries abolishing user fees for MNCH services and/or for emergency caesarean sections and RH services	Civil society alliances developed Advocacy strategies developed Advocacy campaigns funded MNCH programs funded 100% of recipient countries developed national MNCH policy At least 80% of recipient countries abolished user fees for MNCH services and/or for emergency caesarean sections	By the end of December 2009	300 000$ for 5 countries (USAID, Norway, EU, DFID, World Bank, etc)	**CARE, UNFPA, FCI, HCPA**, WHO, CIDA, others	Contribute to the review of the civil society alliances' advocacy strategy for MNCH programs / services in recipient countries

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
2. Support costed strategies for the health-seeking behaviour by communities, women and children to request, access, and use quality MNCH services	Review of cost-effective demand creation approaches for the health-seeking behavior of women and children conducted Country specific strategies/action plans for the promotion of health seeking behavior developed in 5 countries Improvement of MNCH service indicators through enhanced national priorities for improving linkages between households and health care for seeking quality MNCH services Existing community groups for community mobilization for MNCH strengthened Number of targeted countries integrating MNCH into existing programs (PMTCT, Malaria control programs, Immunization programs).	Review document available 5 strategies developed MNCH service indicators statistically improved in at least 80% of selected countries At least 80% of targeted countries integrated MNCH into existing programs Advocacy campaigns conducted with focus on MNCH to raise national funding and improve the use quality health services	By June 2009 2009 By December 2010 By December 2011	300 000$ for 5 countries (USAID, Norway, EU, DFID, World Bank, etc)		Contribute to ensuring effective support for the health-seeking behavior by communities, women and children in targeted countries
3. Enhance country's capacity for monitoring & evaluation of impact of demand creation strategies	Number of countries with effective and efficient data collection mechanisms for improved assessment of outputs & impact of cost-effective for demand-creation interventions	At least 50% of targeted countries established mechanisms for incorporating demand-side outputs and impact data into local and national database.	By December 2010	USAID, Norway, EU, DFID, World Bank, etc		

Priority Action 3: Identify gaps in delivery of existing MNCH Core Package of interventions and prioritize implementation research
Outcome: Consensus on the key interventions for MNCH to be delivered at each level of health care, across the continuum.
Value added: PMNCH membership represents an appropriate mix to advocate using a common set of interventions. Partners will jointly identify implementation research gaps.

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
1. Disseminate current packages of interventions for MNCH for delivery at each level.	Document with key interventions across the continuum of care with level of delivery available.	Document by July 09	2009	-	WHO	
2. Mapping of ongoing research into delivery mechanisms (+costs) for interventions at different levels, and identify gaps	Report of mapping completed and gaps identified	Report by end 2009	2009	USD 200,000 (consultant)	**WHO** [Academics / Research Community], HCPs	Support and management of consultant(s)
3. Mobilise funding from partners for identified research.	Resources available	2010	2010-2011	To be identified depending on scope	**WHO** [Academics / Research Community], HCPs CARE, USAID, WB, SCF, BMGF, Mali, BRAC (tbc), UNFPA to be confirmed	Support advocacy for resources

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
4 Consensus building and agreement on how to take forward the consensus reached by all members of partnership and beyond in the light of new evidence	Agreement reached	Meeting report on agreement	Meeting in 2011	USD 100,000	**WHO** [Academics / Research Community], HCPs CARE, USAID, WB, SCF, BMGF, Mali, BRAC (tbc), UNFPA to be confirmed	Facilitate the discussion, organize the meeting
5. Advocacy for implementation at scale of the delivery strategies for agreed upon interventions. Coordinate with the initiative 1 for advocacy	Quantity and impact of advocacy dissemination	2010	2010-2011	USD 50,000 (2010) + USD 50,000 (2011)	**WHO** [Academics / Research Community], HCPs CARE, USAID, WB, SCF, BMGF, Mali, BRAC (tbc), UNFPA to be confirmed	Support with advocacy activities. Coordination with Initiative 1.

Priority Action 4: Develop costed strategies to scale up commodity supplies						
Outcome: Essential MNCH commodities are secured globally and are available and affordable in meeting individuals' needs in selected MNCH priority countries.						
Value added: Partners are currently working separately on developing capacity and meeting supply/commodities needs. Close coordination will harmonize supply policies and strategies and maximize the use of collective resources, increasingly meeting countries' needs with reduced transaction costs.						
Outputs	**Objectively verifiable indicator (OVI)**	**Deliverables/ Milestones**	**Time line (2-3 years)**	**Budget & funding**	**Lead Partners**	**Secretariat functions**
1. Identify the supply component of evidence-based MNCH interventions and define a basket of essential commodities	List of essential MNCH commodities. With guidance on quantifying needs and resources.	Identify MNCH minimum supply package (draw from existing disparate guidelines for MN and C) Activity: (I) expert meeting to develop a minimum core consensus MNCH package at the global level in coordination with WHO essential medicine list. (2) national coordination committee prepares/adopts country specific minimum package	2009 December 2009 2th Qtr 2010	TBD $25,000 includes external experts travel. Participating agencies' support their own technical staff $10,000 (local expenses) per country x 5= $50,000 in 2010	**WHO, UNICEF, UNFPA, USAID** Members of the RH CS Coalition, including World Bank, Save The Children etc.	Facilitate/ convening of experts to identify the components of an essential MNCH supplies package + supporting documentation.

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
2. Review and update the existing tools, guidelines and protocols. ***WORK WITH PA1***	A common guideline and tool for in-country supply management system.	Agree on tools for supply management, forecasting, costing and information management system. This activity under various WG and will be done together with the other groups	1st Qtr 2011	Consultative meetings (up to 3) $120,000; $ 40,000 in 2009 Refer to PA1	**WHO, UNICEF, World UNFPA**, World Bank, USAID, John Hopkins , Norway, Costing Working group Relates to work undertaken by partners contributing to International Task Force on Innovative International Financing for health Systems Working Group 1	Facilitate interaction between working groups and impact assessment.

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
3. Through collaboration with existing partnership initiatives specialized in the provision of technical support (e.g. HHA), build sustainable supply management system in up to 5 countries to ensure access to and availability of affordable and quality MCH package when needed.	MNC commodity security is integral part of national health budgetary projections National health plan M and E framework includes: Proportion of Service Delivery Points reporting MNC supply stock outs in 5 countries reduced by X in 2010 and increasing every year after that.	Strategic plan developed in 5 countries (select 5 from among the following: Ethiopia, Burkina Faso, Niger, Madagascar, Mozambique, Laos, Mongolia, Haiti, Nicaragua) Activities: A costed Master plan prepared based on priority setting/forecasting for an integrated MNCH package Guidelines for in country distribution and storages Guidelines for Forecasting and quality assurances Resource mobilization plan for MNC logistics and supplies developed and 90% requirement met from domestic and development partners resources (including those not in the PMNCH: GAVI)	Starts in 2010-completed by End 2014 2010-2011	Strengthen the capacity of resident Country health Teams by establishing Technical Advisers in selected countries based on need , Global coordination for all countries/ $220,000 Per year (co shared in programme countries by partners) $120,000 in 2009 Hold X in-country and 1-2 regional meetings of 10-20 experts = $115,000 (DSA and Travel not included) (co shared by agencies)	IHP+/HHA (and equivalent in Asia), include WHO, UNICEF,UNFPA, World Bank, and USAID, John Hopkins, DfID, CIDA, KFW, IPPF International Task Force on Innovative Financing, Working Group 1	Help monitor through central data base of progress in the selected countries

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
4. Assess the global availability of essential commodities. Identify supply and financing gaps. Prioritize commodities under-supplied by markets and/or under-used by countries. Develop options to increase availability and utilization of essential MNCH commodities in the all 5 countries	Supply/demand gaps are identified and strategy to address them is developed through public/private dialogue.	PMNCH lead partners engage with public/private sector (economies of scale and leveraging costs)	Mapping of potential public/private sector sources in 2010	Assessment study public-private + Global expert meeting/review of supply and financial gaps $120,000 In 2010 $50,000 in 2011 Evaluation/Assessment of results achieved (data collection + consultancy)	**UNICEF, UNFPA, WHO, USAID** Work with RH commodity security Coalition, GAVI, KFW, GF etc	Help identify new private sector partners/mapping

Priority Action 5: Human resources for MNCH						
Outcome: **MNCH health providers and other civil society stakeholders increase their contribution to MNCH policies, plans, initiatives and programs at national, regional and global levels**						
Value added: PMNCH provides a neutral platform for consultation for HCPAs and other civil society stakeholders. The PMNCH membership will facilitate the building of linkages between HCPAs and members of other constituencies						
Outputs	**Objectively verifiable indicator (OVI)**	**Deliverables/ Milestones**	**Time line (2-3 years)**	**Budget & funding**	**Lead Partners**	**Secretariat functions**
1. Define a strategy for broad inclusion of MNCH Health Care providers to increase their contribution to MNCH plans, policies and programs	Strategy developed and shared with relevant health care providers (strategies should include strengthening organizations of health care providers and development of joint activities with global partnerships such as the GHWA and IHP)	Consultant researches and develops an effective situational analysis tool Situational analysis conducted in 17 countries (countries will be prioritized based on where HCPA workshops have already taken place) Strategy for the inclusion of MNCH health care providers developed	2009 2009 2010	140 000$ consultant/meetings/travel (NORAD?)	**Lead: HCPA advisory group, UNFPA** Contributing: GHWA, WHO, national and relevant regional MNCH health care providers, MOH, UNFPA, UNICEF, PMNCH	Facilitate meetings and discussions for the development of the strategy, finalize and disseminate document

2. Scaling-up HR strategies and integration into National Health Care Planning in 17 countries	Number of countries in which: ▪ HR for MNCH strategies developed ▪ PMNCH has facilitated HCPAs presence on MNCH planning committees/taskforces ▪ MoH MNCH plans/policies/IHP compacts are developed with the participation of MNCH health care providers ▪ MoUs or other documents are signed, demonstrating an agreement between in country MNCH health care providers and MOH. ▪ MoUs or other documents are signed, demonstrating an agreement between in country HCPAs on a priority set of interventions/activities ▪ Working relationships between the UN agencies and donors and HCPAs exist Number of successfully completed regional meetings for the sharing of best practices, coordination of activities and follow up of commitments Structure of follow up and analysis of past regional HCPA workshops developed	Situational analysis on bottlenecks for the achievement of the listed deliverables in 17 countries Implementation plan for activities for output 2 for 2010 New or revised HR MNCH policies MNCH health care providers representatives on relevant taskforces Biyearly meetings between MNCH health care providers and the MoH Signed document highlighting agreed interactions. Signed document highlighting agreed interventions/actions 1 meeting per year between UN, donors and HCPAS Health care professional workshops conducted in Arab speaking countries and in Latin America Evaluation tool developed Evaluation conducted in 17 countries Follow up plan developed for 17 countries with attached budget and implementation table	2009 2009 2010 2009 2009 2009 2009 2009 2009	140 000$ consultant, meetings, travel (2009) 240 000$ HCPA meeting costs 2009 40 000$ 2009	**Lead: HCPA advisory group** Contributing: national and relevant regional MNCH health care providers, MOH, PMNCH	Participate in preparatory work with HCPAs, keep a record of all collaborations with the MOH, all taskforce meetings, signed agreements and plans Participate in consultative meetings and keep records of decisions Organize regional workshops

3. Costing strategies for scaling-up HR for health (Drs, Nurses, MWs, other MNCH health care providers, other Civil Society actors).	Number of strategies for the scale up of HR for health costed	Situational analysis on the MNCH HR needs and implied costs in 17 countries HCPA representation on the Financing for MNCH taskforce Strategies for the scale up of HR for health developed Strategies costed	20009 2009	40 000$ none	**Lead: HCPA advisory group** Contributing: NORAD, WB, national MNCH health care providers, MOH, UNFPA, UNICEF, WHO	Facilitate costing meetings and discussions following strategy development, follow up on costing strategy development

Priority Action 6: MNCH knowledge management portal1
Outcome: **Robust knowledge[2] resources[3] readily available through a comprehensive & proactive managed portal**
Value added: The broad membership of the PMNCH enables the portal to be looked to as the "one-stop shop" providing access to knowledge resources to achieve MDG4 & 5 & flagging key knowledge gaps.[4]

Outputs	**Objectively verifiable indicator (OVI)**	**Deliverables/ Milestones**	**Time line (2-3 years)**	**Budget & funding**	**Lead Partners**	**Secretariat functions**
1. Mapping of existing knowledge resources relevant to MNCH, and links integrated into existing PMNCH website ("quick win")	Inventory of existing knowledge resources available and regularly updated, Links to knowledge resources available via PMNCH website.	Scope of mapping exercise defined & outsourced consultants identified. Mapping completed & inventory available. Links live on PMNCH website	May-Jun 2009 Jul – Oct 2009 Dec 2009	A. ~$30-50K	Mapping outsourced to relevant knowledge management group, with oversight from small Task Team and PMNCH Secretariat	
2. Proactive managed portal created	Proactive managed portal launched (?encompassing PMNCH website)	Technical design document for portal available (designed to take account of resources identified by mapping - output 1 above)	*Beta* version of portal available by late 2009, & fully operational by mid 2010	B. $80-100K in total	Outsourced to expert portal design service, with oversight from small Task Team and PMNCH Secretariat	Oversight for development of ToRs for outsourced group, tendering process, and progress of work
3. Strategies and mechanisms implemented for maintaining portal.	Number and frequency of system updates. Integration into portal of new knowledge products identified, including those generated by other Priority Action areas of PMNCH.	Operations manual available (indicating processes and procedures for identifying new resources & links) & log of quarterly updates.	Draft for consultation by Oct 2009, finalized by Jan 2010.	C. ~$60K per year for IT.	IT aspects undertaken by contract with outsourced expert group. Scanning for new resources undertaken by outsourced knowledge group (see 4 below).	Manages continuous updating and maintenance, of portal , interfacing with outsource groups.

4. Status of knowledge on critical issues for MNCH identified through portal and key "gaps" **flagged** back to the PMNCH for "resolution"	Number of knowledge status reports[5] prepared (by request from other Priority Action areas &/or via the Board) Number of knowledge "gaps" flagged to Board.	Guidelines available on scope of knowledge status reports. First knowledge status report completed Procedure developed for flagging to PMNCH Board critical issues with significant knowledge gaps for onward "resolution".	Draft by mid 2009, finalized by Sept 2009 Dec 2009 In place by Jan 2010	~$60-100K per year for knowledge management function (including HR) undertaken by **outsourced group** (budget dependent on number of knowledge summaries requested. ~$60-100K per year for brokering discussions/ facilitating resolution of high profile gaps.		Oversees work of outsourced knowledge group. Supports Board processes to address knowledge gaps.

Notes:

1 Defined as a website which acts as a gateway or introduction to many other websites, offering a search engine, links to useful resources and other possible services,(see below) such as news pages, discussion groups, online enquiry, and a repository of knowledge appraisals.

2 Knowledge on burden, interventions, measurement tools, implementation, policies, strategies.

3 Websites, portals, knowledge repositories (e.g. Cochrane library).

4 "Gaps" in terms of, for e.g. lack of systematic review, no/few players, unanswered research questions, etc. Note: crucial liaison need with Priority Action 3

5 Knowledge status reports: scope may vary by topic, but likely to comprise simple standardized summary of what is "known" (+key references, ideally to systematic review), who are main actors (web links through portal), ongoing work/initiatives, research questions already identified, etc

Priority Action 7: Accountable partners for MNCH						
Outcome: **Accountable partners for MNCH**						
Value added: The membership of the PMNCH represents an appropriate mix of constituencies						
Outputs	**Objectively verifiable indicator (OVI)**	**Deliverables/ Milestones**	**Time line (2-3 years)**	**Budget & funding**	**Lead Partners**	**Secretariat functions**
ADDITIONAL OUTPUTS ON ACCOUNTABILITY WILL BE DEFINED IN THE COURSE OF 2009	TBD	TBD	2009	TBD	TBD	TBD
CD Advocacy Work-plan	Advocacy Workplan agreed by partners & funded; web-site up to date & peer-reviewed	Workplan approved and funded	3 years	USD 1 million	Co-chairs of Sub-Committee Anne Starrs (FCI), Flavia Bustreo (PMNCH)	Co-chair, Advocacy Sub-Committee. Manage and maintain the Countdown website
CD 2010-11 meeting	Successful meeting is held	Meeting 2010-11 including joint event with IPU	3 years	USD 1 million	All partners, and IPU	-Organization & logistics - Promotion & dissemination - F/U 2009 IPU mtg
Updated data on coverage of MNCH interventions	Data on coverage, financing, equity and policies for Countdown priority countries	Contribution to support the four main Working Groups of the Countdown	Between 2 and 3 years	USD 200,000	-Co-chair WG on coverage: J Bryce (JHU),T Wardlaw (UNICEF). -Chair WG on financing: P Berman (WB) - Co-chair WG on equity: C Victora (Pelotas University), T Boerma (WHO) - o-chair WG on policies: B Daelmans (WHO), H Fogstad (Norad)	- Support for Working Groups - Seed contribution funding from PMNCH (USD200,000) to four WGs