The Partnership for Maternal, Newborn & Child Health

Strategy and Workplan 2009 to 2011

April 2009

Contents

List of acronyms

AD	Advocacy
ADB	Asian Development Bank
BMGF	Bill & Melinda Gates Foundation
BRAC	Bangladesh Rural Advancement Committee
CD	Countdown to 2015
CIDA	Canadian International Development Agency
CP	Core Package
CSO	Civil Society Organization
DFID	Department for International Development
EC	Essential Commodities
FCI	Family Care International
FIGO	International Federation of Gynecology and Obstetrics
FP	Family Planning
GA	General Assembly
GAVI	Global Alliance for Vaccines Initiative
GF	Global Fund
GHI	Global Health Initiative
GHWA	Global Health Workforce Alliance
HCP	Health Care Professional
HCPA	Health Care Professional Association
HLTF	High-level Taskforce
HR	Human Resources
HSF	Health Systems Financing
ICM	International Congress of Midwives
ICPD	International Conference on Population & Development
IHP	International Health Partnership
IMMPACT	Initiative for Maternal Mortality Programme Assessment
IPPF	International Planned Parenthood Federation
IPA	International Pediatric Association
IPU	Inter-Parliamentary Union
JHU	Johns Hopkins University
KFW	German Development Bank
KM	Knowledge management
KMS	Knowledge management system
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MMC	Maternal Mortality Campaign
MNC	Maternal, Newborn and Child
MNCH	Maternal, Newborn and Child Health
MOH	Minister of Health
MSH	Management Sciences for Health
NORAD	Norwegian Agency for Development Cooperation
ODA	Official Development Assistance
OVI	Objectively Verifiable Indicator
PA	Pediatric Association
PMNCH	Partnership for Maternal, Newborn and Child Health
RHCS	Reproductive Health Commodity Security
SIDA	Swedish International Development Agency
SNL	Saving Newborn Lives
TOR	Terms of Reference
TP	Tracking Progress
UN	United Nations
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
US$	US Dollar
WB	World Bank
WG	Working Group
WHO	World Health Organization
WRA	White Ribbon Alliance

1. Introduction

The Partnership for Maternal, Newborn and Child Health (PMNCH) is a global health partnership launched in September 2005. It is a unique entity which joins the maternal, newborn and child health (MNCH) communities into an alliance of almost 270 members to work towards achieving Millennium Development Goals (MDGs) 4 (reducing child mortality) and 5 (improving maternal health). A cornerstone of the Partnership's work is promoting the concept and reality of "continuum of care" across MNCH.

The Partnership is hosted by the World Health Organization (WHO) and is governed by a Board of six constituencies,[1] supported by a small Secretariat of senior technical staff. The PMNCH reinforces and relies on the individual work, mandates, and responsibilities of each partner organization. As a 'partner centric' Partnership it does not duplicate or replace the responsibilities of its Partners but facilitates and ensures that the sum of the collaboration is greater than the individual actions.

This Strategy and Workplan document:

- Reviews current challenges to the achievement of MDGs 4 and 5, and describes the rationale for PMNCH (Section 2);
- Explains how the PMNCH, and its partner organizations, will support these efforts through work to be undertaken under six Priority Action Areas (Sections 3 and 4); and
- Identifies the additional funding required for activities planned in 2010 and 2011 (Section 5).

[1] Constituencies include: (i) Donors and Foundations; (ii) Implementing Developing Countries; (iii) Multilateral Organizations with a health mandate related to MDGs 4 and 5; (iv) Non-Governmental Organizations (NGOs); (v) Health Care Professional Associations (HCPAs); and (vi) Research, Training and Academic Institutes.

Appendix 1 contains more detail on each of the Priority Action Areas, including on outcomes, outputs, objectively verifiable indicator (OVIs), deliverables/ milestones, and the roles of partners.

2. Rationale for PMNCH

With only six years left until 2015, it is evident that MDG 4 (reducing child mortality) will only be reached by a few countries and that MDG 5 (improving maternal health) is lagging even further behind. The challenge facing the global health community is therefore significant and requires accelerated and concerted action. The table below summarizes at a glance MDG 4 and 5 targets and indicators.

Table 1: Millennium Development Goals 4 and 5, targets and indicators

Goal 4: Reduce child mortality by 2015		
	Target	**Indicator**
Target 4 A	Reduce by two thirds from 1990 baseline, the mortality rate among children under five	4.1 Under-five mortality rate
		4.2 Infant mortality rate
		4.3 Proportion of 1 year-old children immunized against measles
Goal 5: Improve maternal health by 2015		
	Target	**Indicator**
Target 5 A	Reduce by three quarters from 1990 baseline, the maternal mortality ratio	5.1 Maternal mortality ratio
		5.2 Proportion of births attended by skilled health personnel
Target 5 B	Achieve by 2015 universal access to reproductive health	5.3 Contraceptive prevalence rate
		5.4 Adolescent birth rate
		5.5 Antenatal care coverage (at least one visit and at least four visits)
		5.6 Unmet need for family planning

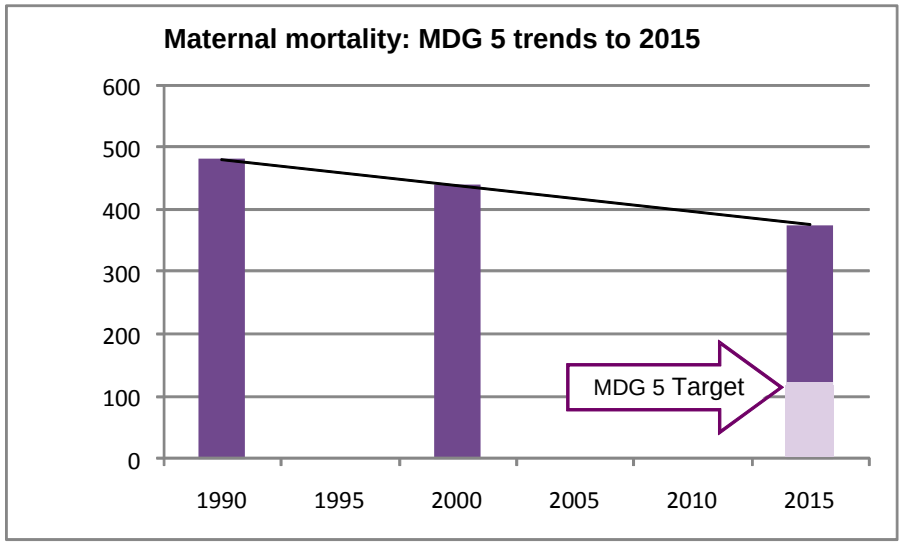
Source: 12th Inter-Agency and Expert Group meeting on MDG indicators, Paris Nov 2007

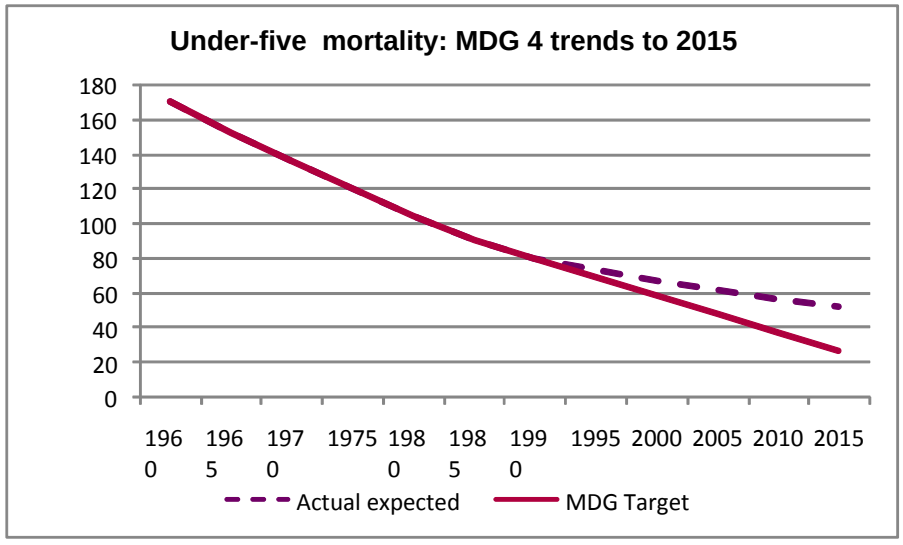
At its meeting in February 2009, the PMNCH Board affirmed its commitment to addressing MDGs 4 and 5 including target 5b. References to MNCH or to maternal health in this document include those elements of reproductive health that are directly related to reducing maternal mortality, as reflected in the indicators for 5b.
In the following section, we describe the challenge involved in achieving MDGs 4 and 5, the role of the *continuum of care* and the rationale and role for PMNCH in this context.

2.1. Context and MNCH challenge

We know how to save the lives of mothers and children and yet, every year about nine million children die and half a million women die due to pregnancy-related causes. These deaths are largely preventable. MDGs 4 and 5 are unlikely to be met in most high-burden countries and this is particularly so for MDG 5. Figure 2.1 summarizes performance to date on both these MDGs.

Figure 2.1: Progress and trends on MDGs 4 and 5





(Sources: Countdown Report 2008 and WHO/RHR)

Reductions in maternal and child mortality require functioning health systems as well as complementary policy developments in a range of other sectors – including education, infrastructure, transportation, and gender equity. Political leadership is therefore essential to ensure that these sectors interact with the health sector in a coherent way to reduce maternal and child mortality.

The poor progress to date reflects a lack of resources and a failure to achieve sufficient improvement in three areas: mobilization of political leadership and promotion of cross-sectoral strategies that affect MNCH; national health strategies and the provision of quality services relating to MNCH; and coordination of support from global and local partners for national MNCH programmes.

2.1.1. Constrained resources for MNCH

Low prioritization of MNCH on political agendas and inadequate investments in MNCH reflect a range of factors, including:

- There is a lack of awareness of the scale of maternal, newborn and child morbidity and mortality;
- The perception that the challenges to improve MNCH are too difficult and too expensive to solve; i.e. solutions are not easily identifiable and are difficult to implement. For example:
  - faltering health systems, which disproportionally affect MNCH programmes, are often deemed too complex to address in the short term;
  - the development of adequate human resources required to provide quality MNCH services need medium to long-term investments; and
  - commodity systems are required to distribute maternal, newborn and child health products.
- The case for investment in MNCH has not been made well enough in a political environment in which economic growth is assumed to be the main driver of development. In this context the wellbeing of women and children is seen as constituting a very long-term investment, with inadequate understanding of the returns on investment on social and economic development;
- Women and children have historically lacked powerful advocates to promote their agenda, and have not been able to voice their needs and demands themselves in policy fora.

The lack of political awareness is clearly reflected in the budgetary allocations for MNCH programmes across the world. MNCH is not a priority that traditionally attracts enough national or international resources. Donor assistance to MNCH did increase between 2003 and 2006 (from USUS$ 2.1bn to USUS$ 3.5bn), but this funding proportionally increased less than investment in other health priorities (e.g. HIV/AIDS, malaria). Furthermore, these funds were often not well-targeted to those most in need.

Findings from the Countdown[2] to 2015, an effort to track progress towards MDGs 4 and 5, indicate that donor funding increased from USUS$ 4 to USUS$ 7 per child between 2003 and 2006. However, it is estimated that 95% of these new resources were allocated to specific projects, which were not always well coordinated with each other nor were they necessarily recognized as the highest priority or the most appropriate by the partner country. Non-earmarked funding, which would be flexible enough to potentially support the most needed programmes considered priority by national governments, was seldom provided. These budgetary constraints and competing priorities are likely to become more acute with the current global economic crisis.

2.1.2. Failure to achieve significant improvements with existing inputs

While the reasons for the relative lack of progress in reducing maternal and child mortality are complex and vary by country, the following factors have often played a role:

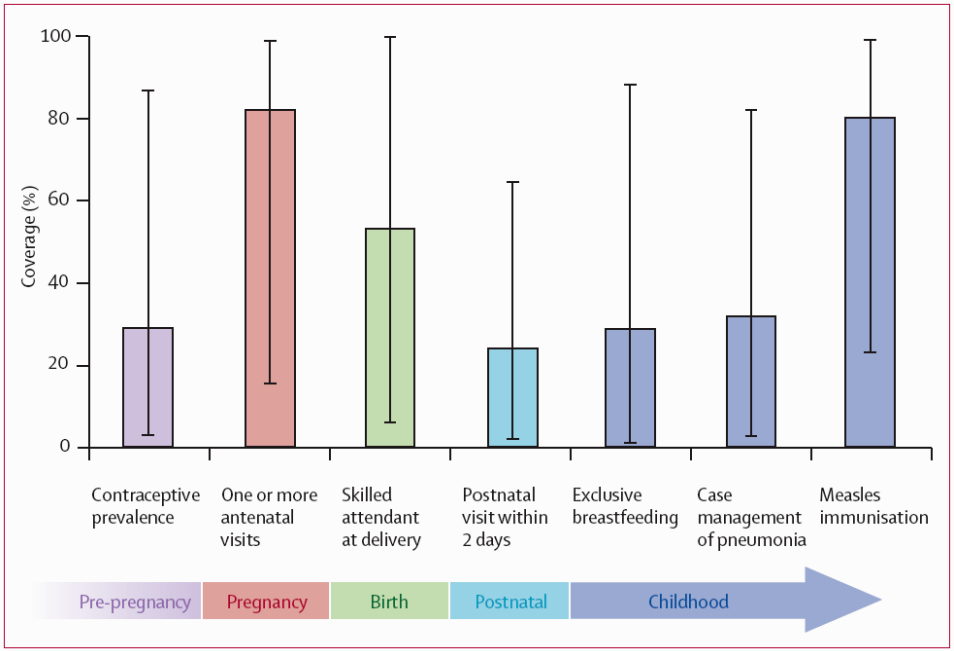
- Maternal, newborn and child health policies, interventions and implementation approaches are often developed independently of each other and are not adequately included in the overall national health development plan;
- MNCH interventions are planned for and delivered in vertically-integrated interventions to separate groups, e.g. nutrition supplementation programmes, reproductive health advice to women;
- The *continuum of care* concept is not well understood and does not figure prominently in planning MNCH activities. Partners are just now becoming aware of its value-added potential;
- The actions of global partners in supporting national agencies are fragmented. Different agencies supporting health of women and

[2] *The Countdown to 2015 Initiative tracks coverage levels for health interventions proven to reduce maternal, newborn and child mortality (www.countdown2015mnch.org).*

children (respectively with their national government partners) operate independent service-delivery infrastructure, sometimes even in the same geographic locations. Improving the effectiveness of collaboration in such circumstances increases efficiency and improves health outcomes for both women and their children;

- As a result, the coverage of interventions across the *continuum of care* is highly variable. Analysis by the Countdown team of interventions needed to improve maternal and child mortality in 68 countries, accounting for 97% of maternal and child deaths worldwide, shows that 80% of women receive one or more antenatal visits and that 80% of children are immunized against measles (Figure 2.2 below). However, coverage is much lower for skilled birth attendance and post-natal visits, and very low for treatment of pneumonia, the major killer of children under five years of age, and contraceptive prevalence rate is 29%.

Figure 2.2: Coverage estimates for interventions across the continuum of care in the 68 priority countries (2000-06).



Source: Countdown to 2015: Tracking Progress in Maternal, Newborn and Child Survival. The 2008 report.

2.1.3. The MNCH challenge and the continuum of care

At the heart of the challenge of MDGs 4 and 5 is the *continuum of care* for women, newborn and child. The continuum concept helps to focus attention on the effective delivery of health services, including gaps in service provision, and highlights the need for human and financial resources. Figure 2.3 (below) shows the *continuum of care* and illustrates its two key dimensions: (i) **time** of care giving; and (ii) **place** of care giving. Key points to note about these dimensions are as follows:

- Time of care giving: Interventions throughout the life cycle need to be linked. For example, antenatal care should promote skilled attendance at delivery, which in turn should be linked to postnatal care for both mother and newborn. By clearly defining integrated packages of care and the modalities for delivery, the *continuum of care* can be an effective framework for integrated service delivery;
- Place of care giving: The essential interventions needed to address the problems affecting women, newborn and children take place at all levels of the health system, i.e., from the home to the community through to the health centre and on to the district hospital and above. Components or building blocks of the health system include health workforce; health service delivery; health information systems; medical products, vaccines and technologies; health financing; health leadership and governance (stewardship). Required resources (human and otherwise) can be better identified when the package of interventions is clearly spelled out and the community dimension identified and addressed. In other words, when services identified through the *continuum of care* are put in place, the health system will be strengthened. Increasingly, the successful delivery of these services is seen as a performance indicator of the health system.

Figure 2.3: Dimensions of Continuum of Care.

Source: PMNCH, Conceptual and Institutional Framework Document, 2005

The *continuum of care* concept can also bring much-needed cohesion to the advocacy community helping to convince policy makers to act. A clearly-articulated and widely-embraced framework facilitates the development and coherent advocacy messages and strategies embraced by a range of stakeholders.[3] Finally, the continuum of care can help in mobilizing increased investment in health by identifying and addressing programmatic and resource gaps, such as care of the newborn.

The challenge for the global health community is to generate additional resources and to use them more effectively for MNCH by focusing on the *continuum of care.* Greater political prioritization for MNCH, enhanced harmonization and coordination of development partners following the Paris Principles, and focusing on high-impact proven interventions targeted to vulnerable populations, can lead to better health outcomes for women and children.

2.2. The Partnership's Framework for action and role

Making greater progress towards achieving MDGs 4 and 5 will require concerted action by a wide spectrum of stakeholders at national, regional and international level. Figure 2.4 provides a framework for stakeholder action and defines the Partnership's 'Theory of Change'. It defines four key steps necessary for achieving MDGs 4 and 5 and indicates who has prime responsibility for each (see 2.2.2 for more discussion of responsibility).

The four necessary steps outlined in Figure 2.4 are as follows:

- Step 1 (Knowledge): To improve the evidence and knowledge base on the key MNCH interventions and approaches to effective delivery in partner countries – taking account the realities of resource availability. As noted above, this includes adopting the continuum of care as the framework of action, recognizing the natural link and critical interdependencies between the health of mothers, newborn and children;

- Step 2 (Planning): Involves national governments prioritizing MNCH and incorporating best practice into their national health strategies and delivery plans. These plans need to take account of: (i) critical interventions; (ii) required MNCH human resources; (iii) access to essential commodities; (iv) health care financing; and (v) quality of health care services provided;

- Step 3 (Resources): Requires increased political awareness and support for MNCH, leading to more financial resources committed at both the global and national levels, and the timely availability of appropriate human resources and commodities including medicines;

- Step 4 (Implementation): Relates to the delivery of MNCH interventions through the continuum of care (such as immunization, access to a skilled birth attendant etc.). The important challenge here for national partners is to translate effective strategy, backed by resources, into MDG 4 and 5 outcomes. In addition to effective delivery mechanisms, this is likely to require concerted effort to increase the knowledge about and the use of relevant services by the communities who will benefit from them. Monitoring and evaluation of implementation efforts are also crucial.

[3] *Shiffman J, Smith S (2007). Generating political priority for global health initiatives: a framework and case study of maternal mortality. In Shiffman's view "frames that resonate internally unify policy communities by providing a common understanding of the definition of, causes and solution to the problem. Frames that resonate externally move critical audiences to action, particularly the political leaders who control the resources that initiatives need."*

National governments have the primary responsibility for all of the steps noted in Figure 2.4 below. Further, in accordance with the Paris Principles, the responsibilities of the donors and multilateral partners relate to: (i) supporting national programmes through improved donor coordination; (ii) better alignment with partner country priorities; and (iii) improving mutual accountability. Providing this support to national governments requires donors, multilaterals, along with NGOs, academics and professional associations ('Partners'), to work together across the continuum of care.

PMNCH is the only global entity today which joins the maternal, newborn and child health communities into a global alliance working towards MDGs 4 and 5, across the *continuum of care* as its primary focus. The Partnership's role is unique, it facilitates its membership to work together to support national governments of countries with a high burden of poor maternal, newborn and child health. .

Table 2.4 below sets out the value added of PMNCH as related to each of the steps in the above framework. The key characteristic of PMNCH as a global health partnership is that it is 'partner centric'. This means that the Partnership is not an implementing or funding agency; instead it acts to support and facilitate the work of the Partners where either: (i) there is value added in Partners working together; and/ or (ii) where the activities are beyond the manageable limits of the Partners in isolation.

Figure 2.4: Framework for stakeholder action

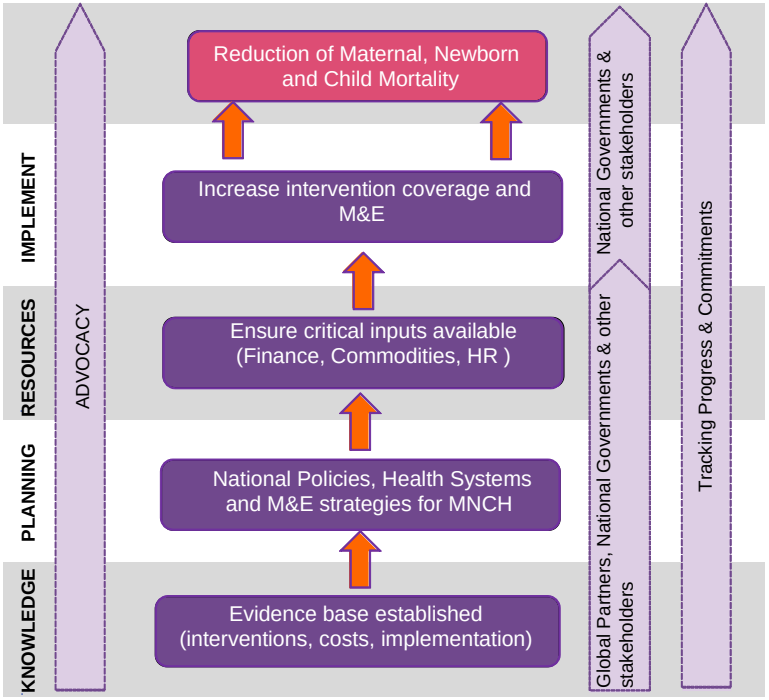


Table 2.4: Partnership's added value

Steps	Added value of the Partnership
Knowledge	Mapping of individual partners' activities, improved communication, facilitating stakeholder interaction and acting as a managed repository of evidence/ information to better enable access to and availability of highly-needed knowledge and lead to improved transparency among partners, maximizing scarce resources and reducing unnecessary duplication of activities; Identifying and agreeing actions to fill key gaps in knowledge about interventions and implementation approaches will reduce unnecessary duplication;
Planning	Linking local and international information on the consensus for effective MNCH interventions and packages in partner countries will increase harmonization, alignment and effective collaboration; Supporting global Partners in agreeing the evolving research agenda on implementation of interventions and advocating their use through programmes in high burden countries;
Resources	Reducing the fragmentation of advocacy efforts and unifying the key messages, both at global and national levels, to ensure greater political support for MNCH programmes; Building advocacy momentum, best achieved through close cooperation of key stakeholders, to raise additional resources for MNCH; Expanding opportunities for individual Partners to harmonize their operations, both globally and at national level, with a view to improve effectiveness of resources utilized, increase efficiencies and reduce duplication of efforts;
Implementation	Providing formal means for Partners to create alliances and coordinating their work across the spectrum of policy interventions, commodity delivery and human resource management; Enhancing greater transparency through the introduction of monitoring and evaluation (M&E) discipline and accountability in the work of individual organizations to the community as a whole to improve implementation of interventions towards achieving MDGs 4 and 5.

3. PMNCH Vision, Mission and Objectives

3.1. Vision and mission

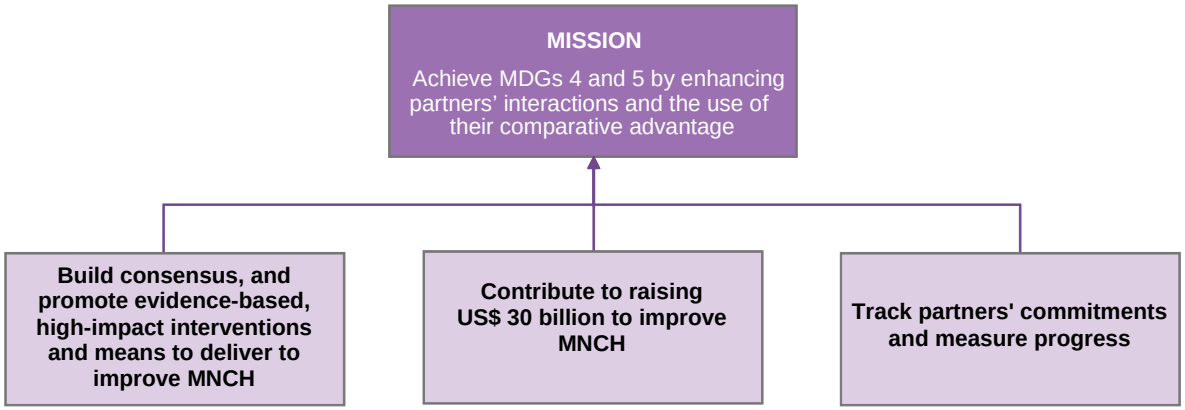
PMNCH's vision is a world where all women and children receive the care they need to live healthy, productive lives.

PMNCH's mission is to support the global health community to work successfully towards achieving MDGs 4 and 5. This is expected to be done by enhancing partners' interactions and using their comparative advantages to achieve the following objectives:

- Build consensus on, and promote evidence-based high-impact interventions and means to deliver them through harmonization;
- Contribute to raising US$ 30 billion (for 2009-2015) to improve maternal, newborn and child health through advocacy; and Areas
- Track partners' commitments and measurement of progress for accountability.

This is summarized in Figure 3.1 below.

Figure 3.1: PMNCH mission and objectives



3.2. The 'Partner Centric' Approach

Given the focus of the Partnership and its 'Partner Centric' approach, the Board has defined the types of activity that PMNCH will be involved in over the next three years as follows:

i. the identification of core packages of interventions and messages, including commodities and human resources for their delivery, which feeds in to the 'knowledge' step of the framework for action;

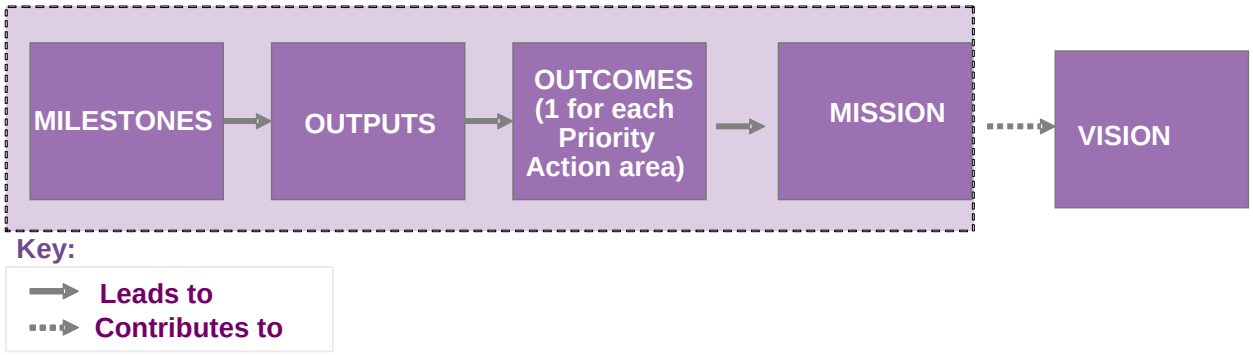
ii. the 'advocacy' drive to convince high-level policy makers and make the case for greater resource allocation to MNCH, which feeds into the 'resources' step;

iii. the 'accountability' function to monitor whether partners and countries follow through on commitments made and to track the coverage and impact of MNCH programmes in countries.

4. Priority Action Areas

To help structure the activities of Partners and the Secretariat, the governing Board of the Partnership identified six Priority Action Areas. These form the PMNCH Workplan. As illustrated in Figure 4.1 below, each Priority Action Area has a series of milestones (reflecting specific activities) which themselves lead to a range of Outputs that is expected to deliver a single 'Outcome'. The six 'Outcomes' identified by PMNCH as the likely result of the six Priority Action Areas will help it to fulfil its own Mission. These six Priority Actions, and consequently their Outcomes. will not by themselves ensure reaching the vision, but are expected to contribute significantly towards the achievement of MDGs 4 and 5 by the global health community.

Figure 4.1: Priority Areas - how to contribute to the vision



The Priority Action areas are: (i) MNCH Knowledge Management system (KM); (ii) MNCH Core Package of interventions (CP); (iii) Essential MNCH Commodities (EC); (iv) Strengthening Human Resources for MNCH (HR); (v) Advocacy for increased funding and for better positioning of MNCH in the development agenda (AD); and (vi) Tracking progress and commitment towards MDGs 4 and 5 (TP).

Table 4.1 at the end of this section provides a summary of each of the Priority Action Areas, together with details on the relevant outputs, objectively verifiable indicators (OVIs) for 2009 through to 2011, and the indicative programme expenditure budget associated with each of the areas. Table 4.2 sets out the Workplan timing for Priority Action Areas. Appendix 1 provides the full detail available, as developed by lead Partners, for each of the Priority Action Areas.

The Priority Action Areas are as follows:

4.1. MNCH Knowledge Management system (KM)

Expanding the evidence base and making the relevant knowledge accessible to stakeholders within the MNCH community is an essential starting point for defining and implementing joint interventions that will take high-burden countries closer towards reaching MDGs 4 and 5. Currently, information on MNCH is scattered over scientific publications, grey literature and case studies reflecting the experiences of policy makers and those implementing policies in countries. It is recognized by the health community that there is no single, easily accessible place where the latest evidence and consensus is available. In this regard, a knowledge management system is required to facilitate communication of evidence, consensus on actions and experiences. The agreed outcome of this Priority Action will be a consensus on the content, delivery strategies and utilization of a core package of MNCH interventions to be delivered at each level of the health system across the MNCH continuum of care, as well as agreement on the "quick win" interventions that can be implemented immediately while strengthening the health systems to provide the full package of services.

The outcome of work under this Priority Action Area will be a robust knowledge resource, which is readily available to the global health community. In addition, it will also identify current knowledge gaps through a comprehensive knowledge management system (KMS), supporting and directing further research efforts.

Achieving progress under this Priority Action Area will add value by enabling the broad membership of the PMNCH to have access to a “one-stop shop” knowledge resource. The PMNCH offers a credible platform for this resource since it links the several constituencies working in the field of maternal, newborn or child health but is not dominated by any single element.

4.2. MNCH Core Package of interventions (CP)

Evidence on the efficacy of single components of interventions is readily available today. However, while interventions have been combined into packages across the continuum of care, there is insufficient evidence on the efficacy of these packages. Developing consensus on a *core* package, derived from the variety of packages available for maternal, newborn and child health, is critical to efforts to reduce child mortality and improve maternal health, and requires inputs from the implementation research. A core package will help define and guide the actions that need to be taken in high-burden countries by international partners, national governments and other local stakeholders (health-care professionals, academics, non-government organizations and others). Work is also needed on the demand side, i.e., increasing the demand for a core package of interventions through community outreach and other means.

Addressing this issue as part of the Partnership’s activities is adding important value because the PMNCH membership represents an appropriate mix of stakeholders to define a common set of interventions. This will also enable a harmonized approach by partners in countries. The Partner Forum, a bi-annual meeting of Partners, also provides an opportunity for the Partners to incorporate implementation research gaps into the discussion.

4.3. Essential MNCH Commodities

Commodities have traditionally been delivered by vertical programmes, for example, child survival commodities are purchased and distributed by child health programmes and reproductive health interventions by reproductive health institutions. To date, the opportunities to join forces across the mechanisms of purchasing and delivering of commodities required to support the efforts across the continuum of care have not been exploited in full. At the same time, the availability of affordable and relevant commodities, such as clinical equipment and medicine, clearly plays a critical role in improving the health outcomes for women, newborn and children.

A successful outcome of this Priority Action Area will see Partners reach a consensus on the essential commodities required for advancing the MNCH. In addition, the Partners' commodity management will be harmonized and implemented in 25 partner (high-burden) countries identified by the H4 (UNFPA, UNICEF, WB and WHO).

Partners often work separately on developing their internal capacity and meeting their supply and commodities needs for in-country activities. Considerable value will be added to these processes as Partners increase their coordination and therefore harmonize supply policies and strategies to maximize the use of collective resources. This will improve their ability to meet country needs with reduced transaction costs.

4.4. Strengthening Human Resources for MNCH (HR)

It has been estimated recently that achieving universal coverage of reproductive, maternal, newborn and child health services will require an additional two million health care workers globally. This calls for concerted efforts among all partners to ensure the necessary training, deployment and retention of staff. Furthermore, delivering any in-country strategy on improving MNCH will require not only additional numbers but also strengthened human resource capacity, whether this be health care professionals (e.g. doctors, nurses, midwives), or administrators. This is a neglected aspect of international and local strategies, with the lack of relevant human resources in developing countries being one of the major impediments to reaching the MDGs.

Outcomes of this Priority Action will include integrated human resource planning as part of national MNCH plans which ensure that MNCH skills and competencies are addressed, knowledge gaps within human resources management adequately addressed, and strengthened health care professional associations involved more directly in national health planning.

Undertaking these activities in the context of the PMNCH adds value by ensuring a platform for common planning and focus on one of the key health systems functions crucial to achieving MDG 4 and 5 targets. It further provides a neutral consultation platform for key partners including the health care professional associations and other civil society stakeholders working towards human resource strategies being tailored specifically for MNCH.

4.5. Advocacy for increased funding and for better positioning of MNCH in the development agenda (AD)

The prioritization and funding levels for MNCH have been low despite historic successes and the availability of proven, high-cost effective strategies for MNCH. As a result, MNCH mortality still remain high, claiming more than ten million lives each year. Recently, this problem has started to feature higher on the agendas of high-level policy makers, at venues such as the United Nations General Assembly, G8 and G20 meetings supported by evidence that investments in the continuum of care can produce tangible results. The High-Level Task Force for innovative Financing of Health Systems has also helped to bring these issues to the health policy agenda. An opportunity exists for PMNCH and its Partners to use the momentum to mobilize a greater level of resources, which -- combined with an improved and more effective way of using those resources -- will considerably advance efforts to meet the targets of MDGs 4 and 5 targets.

Partners are aiming to raise and mobilize an additional US$ 30 billion for the period 2009-2015 from G8 and other stakeholders at global and country level. It is estimated that this outcome would save 3 million women and 7 million children by 2015.

The added value of PMNCH's advocacy for this resource mobilization target is that PMNCH represents key constituencies, which have broad reach and mandate and can therefore mobilize their audiences and resources towards the core target. Consensus among these Partners will ensure harmonization of messages, and enable a more consistent and collective push. PMNCH will also offer an opportunity to synergise on different lines of work, maximize on each partner's comparative advantage and reduce unnecessary duplication.

4.6. Tracking Progress and Commitment towards MNCH (TP)

Funding commitments for health are frequently made at meetings and high-level fora. With regards to funding for MNCH, however, there is little or no follow-up on the implementation of these pledges across the continuum of care – although Partners do have their own accountability and monitoring mechanisms. PMNCH is well placed to track pledges made, assess whether pledges made are actually realized, and to link with global and national advocacy partners to hold donors, agencies and governments accountable. In addition, PMNCH can support and enhance efforts of the Countdown process and its work tracking the progress, coverage of interventions, policies and the funding for MDGs 4&5.

The key outcome of this Priority Action Area will be an accountability and information-sharing mechanism, which works in coordination with the Partners' own processes, for tracking commitments that Partners make in taking forward the MNCH agenda. The membership of the PMNCH represents a unique mix of constituencies, and this in itself will add value by enabling the Partners to track progress on commitments made within the context of the continuum of care

Table 4.1: Summary of Priority Actions, Outputs, Indicators and Budgets ($000), 2009 - 2011

Priority Action	Outputs (What Partners will deliver)	Objectively Verifiable Indicators (2009)	Objectively Verifiable Indicators (2010-2011)	Indicative Budget (US$000)		
				2009	2010	2011
KM (1): MNCH Knowledge Management System	Existing knowledge resources mapped and links integrated into pmnch website; Knowledge portal created and sustained; Knowledge summaries on critical issues for MNCH prepared and gaps flagged to the PMNCH Board.	Inventory of existing knowledge resources available; Links to knowledge resources available on pmnch website; Number of knowledge summaries prepared.	Knowledge portal launched; Number and frequency of system updates to integrate new knowledge products identified; Number of knowledge gaps flagged to Board.	**235**	**335**	**260**
CP (2): MNCH Core Package of Interventions	Consensus developed on content of MNCH packages of interventions at each level of the health system and agreement on how to scale-up; Research gaps into content of core packages of interventions identified, and ongoing research mapped; Consensus built on revised core MNCH packages to be delivered at each level and agreement on how to scale up.	Agreement reached on key interventions across the continuum of care with level of delivery.	Revised core packages and strategy for scaling up published and used by partners; Report on research gaps and mapping completed and gaps identified.	**100**	**200**	**200**

Priority Action	Outputs (What Partners will deliver)	Objectively Verifiable Indicators (2009)	Objectively Verifiable Indicators (2010-2011)	Indicative Budget (US$000)		
				2009	2010	2011
EC (3): Essential MNCH Commodities	Consensus reached on the supply component of evidence-based MNCH interventions, and a basket of essential commodities defined; Set of tools and guidance material agreed and used by partners for country MNCH commodity supply management; Partners' supply management systems harmonized, agreed upon and implemented in up to 25 countries.	List of essential MNCH commodities developed and made available.	Common guideline and tool for in-country supply management developed and available; Common partners' supply management system identified and used by partners; Delivery gaps identified through research and findings made available; Innovative mechanism for procurement and supply identified; Supply / demand gaps in 25 countries identified, and strategy to address them developed.	**415**	**848**	**498**
HR (4): Strengthening Human Resources for MNCH	MNCH aspects of HR adequately included in national health plans and human resource plans; Analysis relating to MNCH content of human resource issues identified and research commissioned; National HCPAs strengthened and involved in MNCH policies, planning and initiatives at the country level.	Role of HR in MNCH programmes in 25 countries defined, and a strategy to involve HR in the design of these programmes developed and shared; Situation analyses undertaken in at least 17 countries for which participants have attended HR workshops; HCPAs' capacity-building workshops carried out successfully and follow-up with participants carried out.	National HCPAs in 25 countries strengthened through seed grants with agreed frameworks and indicators; HCPAs in 25 countries engaged in MDGs 4 and 5 activities and advocacy; Quality and frequency of interactions between HCPAs and policy makers enhanced; Policies resulting from these interactions modified.	**760**	**230**	**0**

Priority Action	Outputs (What Partners will deliver)	Objectively Verifiable Indicators (2009)	Objectively Verifiable Indicators (2010-2011)	Indicative Budget (US$000)		
				2009	2010	2011
AD (5): Advocacy for increased funding and better positioning of MNCH in the development agenda	MNCH clearly prioritized and the health system investments needed to achieve MDGs 4 and 5 identified by the HLTF and other fora; Effective channels for MNCH funding and innovative ways to increase financial resources identified and promoted; Advocacy strategies and messages developed and implemented, targeting high-level actors and national policy-makers; MNCH advocacy partners mobilized and coordinated around key global and national high-profile events.	Greater focus on MDGs 4&5 in IHP+, HLTF resulting in more resources and focus on scaling up MNCH services; Investment Case for MNCH for Asia/Pacific region published; Harmonized and joint UN costing tool developed; Papers developed on key health systems issues pertaining to MNCH; Comprehensive advocacy strategy developed and implemented; Strategic advocacy alliances established; Core advocacy messages and materials produced, endorsed and strategically disseminated by all Partners.	Priority health-system constraints that prevent scaling up identified and information disseminated; Country investment-case papers developed on annual ODA to MNCH, and annual domestic expenditures on MNCH; Partners' Forum held in 2010: global conference on MNCH to prioritize actions needed to promote achievement of MDGs 4 and 5 by 2015.	**900**	**2,036**	**900**
TP (6): Tracking Progress and Commitment for MNCH	Partners' financial commitments to MNCH monitored; Common M&E framework agreed among global health initiatives and disseminated and used by partners in high-priority countries; Progress on MNCH tracked and made available publically; Successful meeting on tracking progress for MNCH held; Work related to reviewing indicators relevant to MNCH and analysis of their progress undertaken and published.	Advocacy plan to disseminate updated data, estimates and trends for MNCH developed and made available; *Countdown* website up-to-date and peer-reviewed.	Common M&E framework used by priority countries; M&E gaps identified and addressed; *Countdown* website maintained up-to-date & peer-reviewed; Tracking progress on MNCH visibility increased *through support of the Countdown.*	**350**	**875**	**1,275**

Table 4.2: Timeline for PA areas

Priority Actions	***2009***				***2010***				***2011***			
	Q1	***Q2***	***Q3***	***Q4***	***Q1***	***Q2***	***Q3***	***Q4***	***Q1***	***Q2***	***Q3***	***Q4***
	Outputs											
KM (1): MNCH Knowledge Management System		Knowledge resources mapped;										
			Knowledge portal created and sustained;									
		Knowledge summaries prepared.										
CP (2): MNCH Core Package of Interventions		Consensus developed on content of MNCH package of interventions;										
			Research gaps into core package of interventions identified, and ongoing research mapped;									
					Consensus built on core MNCH packages and agreement on how to scale up.							
EC (3): Essential MNCH Commodities secured globally and in countries			MNCH basket of essential commodities defined;									
			Set of tools and guidance material agreed and used for country MNCH commodity supply management;									
			Partners' supply management harmonized agreed upon and implemented in up to 25 countries;									
			Sustained supply of quality commodities to developing countries.									
HR (4): Strengthening Human Resources for MNCH			MNCH aspects of HR included in national health plans and HR plans;									
			Analysis relating to MNCH content of human resource issues identified and research commissioned;									
			National HCPAs strengthened and involved in MNCH policies, planning and initiatives at the country level.									
AD (5): Advocacy for increased funding and for better positioning of MNCH in the development agenda		MNCH clearly prioritized and the health system investments needed to achieve MDGs 4 and 5 identified by the HLTF and other fora;										
		Effective and innovative channels for MNCH funding identified and promoted;										
		Advocacy strategies and messages developed and implemented, targeting high level actors and national policy-makers;										
		MNCH advocacy partners mobilized and coordinated around key global and national high profile events.										
TP (6): Tracking Progress and Commitments for MNCH.				Partners financial commitments to MNCH monitored annually;								
				Common M&E framework agreed and disseminated by Partners in high priority countries;								
			Tracking progress on MNCH (supporting Countdown's work plan in 2010);									
											Successful meeting on tracking progress of MNCH;	
										Reviewing relevant MNCH indicators (coverage, equity, financing, policy & health systems).		

5. PMNCH Expenditure and Available Funding

5.1. Programme Expenditure

In this section we summarize the expected PMNCH Programme Expenditure, details of which are set out in Appendix 1 in each of the Priority Action Area tables. Table 5.1 below, indicates that:

- the Programme Expenditure budget for the three year period is US$ 10.4m;
- Priority Action Area 5, focusing on advocacy work, is expected to be the most resource intensive at US$ 3.9m, followed by Priority Action Areas 6 (on tracking progress and commitment for MNCH) and Priority Action Area 3 (on essential MNCH commodities); and
- year 2010 is assumed to have the most intensive period of activity.

Table 5.1: Summary of PMNCH Programme Expenditure by Priority Action, over three years, US$000

Priority Action	2009	2010	2011	Total
MNCH Knowledge Management System	235	335	260	830
MNCH Core Package of Interventions	100	200	200	500
Essential MNCH Commodities	415	848	498	1,760
Strengthening Human Resources for MNCH	760	230	-	990
Advocacy for increased funding and for better positioning of MNCH	900	2,036	900	3,836
Tracking Progress and Commitment towards MDGs 4 and 5	350	875	1,275	2,500
TOTAL	**2,760**	**4,524**	**3,133**	**10,416**

Table 5.2 sets out details of the proposed expenditure in categories required to achieve the workplans of individual Priority Action Areas. Key points to note at this stage are:

- Expenditure associated with organizing conferences (e.g. MNCH milestone conference in 2010) or supporting other important meetings (e.g Countdown, HCPA regional capacity building workshops, etc) are currently estimated to be in the region of US$ 2.8m;

- 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$ 5.1m over the three-year period, with the bulk of it (US$ 2.3m) happening in 2010;

- Other outsourcing refers to additional costs that may be associated with IT / web support as linked to specific Priority Action Areas. as well as any coordination / advocacy support (e.g. server rental, software, IT consultancy to manage specific websites). This expenditure is expected to be around US$1.0m 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 beyond salaries. 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$ 1.6m for the period.

Table 5.2: Summary of PMNCH Programme Expenditure, by cost category, over three years, US$000

Category	2009	2010	2011	Total
Conferences and meetings (including travel)	610	1,198	978	**2,785**
Consultants	1,355	2,255	1,450	**5,060**
Other outsourcing (including IT work, software, etc)	260	506	235	**1,001**
PA specific activities by Secretariat (beyond salaries)	535	565	470	**1,570**
Total	**2,760**	**4,524**	**3,133**	**10,416**

5.2. Funding requirements

Table 5.3 below shows the estimated total costs for the Partnership, including Programme Expenditure, as noted above, as well as costs associated with the core functions of PMNCH Board and its committees, and Secretariat staffing. It also includes details of the funding that is currently available to the Partnership. The key points to note include that:

- In addition to the Programme Expenditure costs, the Secretariat and PMNCH core costs as approved by the Board are estimated to be around US$ 3 million per year over the next three years;
- For the year 2009, PMNCH already has available around US$ 2.2 million of unrestricted funding and around US$ 3.7million of restricted funding – a total of US$ 5.9million;
- The available funding is estimated to be sufficient to cover the costs of all PMNCH operations in 2009;
- Additional funding, US$ 13.6 million will be required for years 2010 and 2011.

Table 5.3: Overall PMNCH expenditure and available funding (US$000, excluding allowance for inflation)

Category	2009	2010	2011	Total
Budgeted expenditure:				
Total PMNCH Programme Expenditure	2,760	4,524	3,133	10,416
Secretariat staff costs and overheads*	2,196	2,031	2,031	6,258
PMNCH Core function costs	900	900	1,000	2,800
Total	**5,856**	**7,455**	**6,164**	**19,475**
Funding available	5,858	-	-	5,858
Surplus / (Funding requirement)	**2**	**(7,455)**	**(6,164)**	**(13,617)**

* WHO overheads amount to 13% and are applied where required.

Appendix 1: Priority Actions, Lead and Contributing Partners

PRIORITY ACTION - TITLE	LEAD PARTNERS *	CONTRIBUTING PARTNERS
KM (1): MNCH knowledge management system	• Academia (W. Graham) • HCP (Z. Bhutta)	All Board members and others
CP (2): MNCH Core Package of interventions	• WHO (E. Mason) • HCP (Z. Bhutta)	Ethiopia, Academics, Research Community, BRAC, CARE, USAID, WB, Save the Children, BMGF, Mali, UNFPA
EC (3): Essential MNCH Commodities are secured globally and in countries	• UNICEF (P. Villeneuve) • UNFPA (H. Belhadj)	USAID, WB, WHO, CARE, Mali, CIDA , BRAC
HR (4): Strengthening Human Resources for MNCH	• HCPA (A. Lalonde, J. Schaller, B. Lynch), • WHO (M. Islam)	UNFPA, Academics (Z. Bhutta), Ethiopia, WB, CARE, Mali, CIDA, Global Health Workforce Alliance (GHWA)
AD (5): Advocacy for increased funding and for better positioning of MNCH in the development agenda	• Norway (H. Fogstad) • FCI (A. Starrs)	Ethiopia, India, Mali, WHO, UNICEF, UNFPA, WB, BMGF, USAID, CIDA, DfID, SIDA, HCPA, Academics, other CSOs
TP (6): Tracking Progress and Commitments for MNCH	• UNICEF/Countdown (P.Villeneuve, P. Salama) • HCPA (Z Bhutta) • Academics (W. Graham) • World Bank (S. Chowdhury)	UNFPA, WHO, Save the Children, SNL, BMGF, FCI, USAID, Norway

* The name underlined refers to the main contact person.

Appendix 2: Details on Priority Actions, Outputs, OVIs, Timelines and Budgets

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
Priority Action KM (1): MNCH knowledge management system **Outcome:** Robust knowledge[4] resources[5] readily available and knowledge gaps[6] flagged through a comprehensive knowledge management system (KMS) **Value added:** The broad membership of the PMNCH enables Partners to contribute and the knowledge management system to be looked to as the "one-stop shop" providing easy access to knowledge resources to achieve MDG4 & 5.						
1. Mapping of existing knowledge resources relevant to MNCH, and links integrated into existing PMNCH website ("quick win")	**1.1** Inventory of existing knowledge resources available and regularly updated; **1.2** Links to knowledge resources available via PMNCH website.	Scope of mapping exercise defined (to include locating existing relevant resources and then identifying specific remit for the PMNCH KMS to add value) & outsourced consultants identified; Mapping completed & inventory available; Links live on PMNCH website.	May-Jun 2009 Jul – Oct 2009 Dec 2009	US$ 50 000	Mapping outsourced to relevant knowledge management group, with oversight from small Task Team; W Graham and Z Bhutta	Ensure smooth and coordinated interactions between PAs; Initiate TOR of task team; Establish mechanism to identify consultants to map existing knowledge Manage consultants and expectations and communicate with partners Oversee reporting.

[4] *"Knowledge" on burden, interventions, measurement tools, implementation, policies, strategies (note: final definition of "knowledge" and delimiting of topics depends on initial scoping exercise – output 1).*

[5] *Websites, other portals, knowledge repositories (e.g. Cochrane library), etc.*

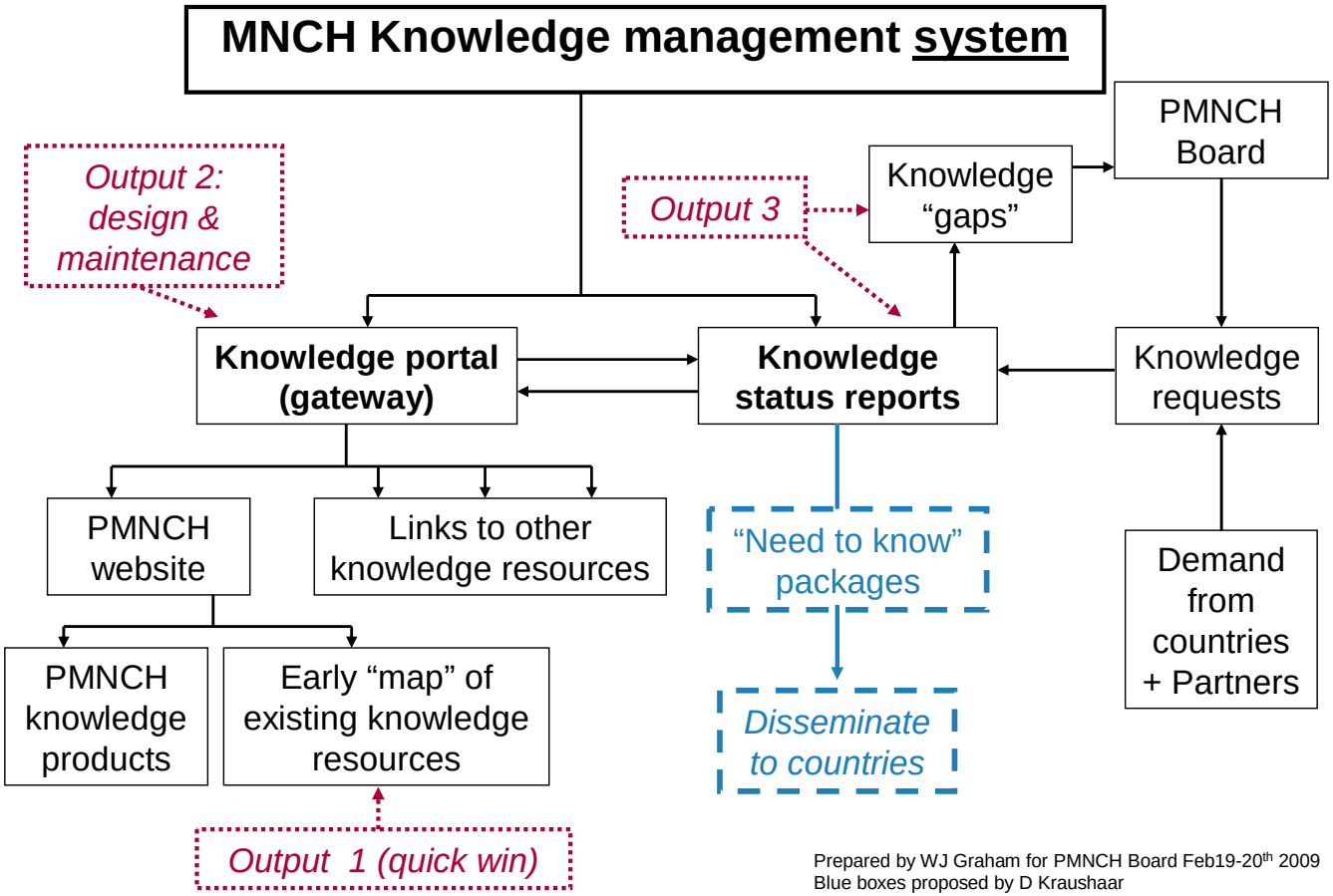
[6] *"Gaps" in terms of, for e.g. lack of systematic review, no/few players, unanswered research questions, etc. Note: crucial liaison need with Priority Action 3*

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
2. Knowledge portal[7] created and sustained.	**2.1** Knowledge portal launched; **2.2** Number and frequency of system updates to integrate new knowledge products identified, including those generated by other Priority Action areas of PMNCH.	Technical design document for portal developed and available (designed to take account of resources identified by mapping - output 1 above); Operations manual available.	*Beta* version of portal available by late 2009, & fully operational by mid 2010	US$100 000 in total for design of knowledge portal (costs US$ 25/75 in 2009/10); ~US$ 60 000 per year for IT.	Outsourced to expert portal design service, with oversight from small Task Team; IT aspects of routine maintenance undertaken by outsourced expert group.	Oversight for development of ToRs for outsourced group, tendering process, progress of design work, and routine maintenance contract.
3. Knowledge summaries on critical issues for MNCH prepared and key "gaps" flagged to the PMNCH Board.	**3.1** Number of knowledge summaries[8] prepared (by request/demand from other Priority Action areas, the Board or from countries). **3.2** Number of knowledge "gaps" flagged to Board.	Guidelines available on scope of knowledge summaries; First requested knowledge summary completed; First tailored knowledge package available to priority countries; Procedure developed for flagging to PMNCH Board significant knowledge gaps.	Draft by mid 2009, finalized by Sept 2009 Dec 2009. Dec 2009 In place by Jan 2010	~US$100 000 per year for knowledge management function (including HR) undertaken by outsourced group (budget dependent on number of knowledge summaries requested); ~US$100 000 per year for brokering discussions/ facilitating filling of key knowledge gaps.	Small Task Team.	Oversees work of outsourced knowledge group. Supports Board processes to address knowledge gaps.

[7] *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.*

[8] Knowledge summaries: scope may vary by topic, but likely to comprise simple standardized proforma on what is "known" (+key references, ideally to systematic review), who are main actors (web links through portal), ongoing work/initiatives, gaps and research questions already identified, etc.

Priority Action area KM (1)



Prepared by WJ Graham for PMNCH Board Feb19-20th 2009
Blue boxes proposed by D Kraushaar

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
Priority Action CP (2): MNCH Core Package of interventions **Outcome:** Consensus on the content, delivery strategies and utilization of for a core package of MNCH interventions to be delivered at each level of the health care delivery system across the continuum of care. **Value added:** PMNCH membership represents an appropriate mix to advocate using a common set of interventions, thereby increasing the harmonization of evidence-based approaches. Partners will jointly identify implementation research gaps.						
1. Consensus developed on content of MNCH package of interventions at each level of the health care delivery system and agreement on how to scale up.	**1.1** Document with key interventions across the continuum of care with level of delivery available.	Document by July 09 to be discussed for consensus in 2009-2010.	Activities completed in 2009	US$100 000	WHO, HCPs (Z Bhutta) Academics, BRAC	Facilitate discussions between partners and assist in the finalization of the consensus document; Contribute to the process; Ensure smooth and coordinated interactions between PAs.
2. Research gaps identified into content of core package of interventions identified, and ongoing researched mapped and synthesized.	**2.1** Report of research gaps and mapping completed and gaps identified.	Report by end 2009.	2010	US$ 200 000	WHO, HCPs Academics / Research Community, BRAC	Support and management of process (commissioning of systematic reviews etc).
3. Consensus built on revised core MNCH packages and agreement reached on how to scale up implementation.	**3.1** Document with revised core packages and strategy for scaling up.	Synthesis report on core packages; Meeting report on agreement on strategy for scaling up.	Meeting in 2011	US$ 200 000	WHO , HCPs (Z Bhutta) BRAC	Facilitate the discussion and assessment, organize the meeting and assist in the finalization of the document.

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
Priority Action EC (3): Essential MNCH Commodities are secured globally and in countries **Outcome:** Consensus reached on the essential commodities for MNCH and partners commodity management harmonized and implemented in 25 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.						
1. Consensus reached on the supply component of evidence-based MNCH interventions and define a basket of essential commodities identified	**1.1** List of essential MNCH commodities developed and made available; **1.2** Country-specific minimum commodity package determined in 25 countries.	MNCH minimum supply package identified (draw from existing disparate guidelines for MN and C); Expert meeting to develop a minimum core consensus MNCH package (including FP) at the global level in coordination with WHO essential medicine list; Country specific minimum package of commodities determined and adopted by national coordination committees in 25 countries.	2009 December 2009 2nd Qtr 2010	US$25,000 includes external experts travel. Participating agencies' support their own technical staff; US$ 10 000 (local expenses) per country x 3= US$ 30 000 in 2009; x15=US$150 000 in 2010; x 7=US$ 70000 in 2011.	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. Assist with the development of the list/document; Ensure smooth and coordinated interactions between PAs.
2. Set of tools and guidance material agreed and used by partners for country MNCH commodity supply management.	**2.1** A common guideline and tool for in-country supply management system developed and made widely available.	Agree on tools for supply management, forecasting, costing and information management system and their use by Partners.	Tools designed and tested in 2009, 2010. Final version ready in 2011.	Consultative meetings (up to 5): US$ 300 000; US$ 60 000 in 2009. Refer to PA1	WHO, UNICEF, World UNFPA, World Bank, USAID, John Hopkins , Costing Working Group	Facilitate interaction between working groups and impact assessment; Facilitate development of guideline and tool and disseminate when available.

3. Partners' supply management system harmonized, agreed upon, and implemented in up to 25 countries.	**3.1** A common, harmonized partners supply management system emerging from country assessments leading to global action; **3.2** Identification of existing delivery gaps through research.	Strategic plan developed for 25 countries; A costed master commodity plan prepared based on priority setting for an integrated MNCH package; Commodity guidelines for in country distribution; Guidelines for forecasting and quality assurances; Resource mobilization plan for MNC (incl FP) logistics and supplies developed and 90% requirement met from domestic and development partners' resources.	Starts in 2010- completed by End 2014 2010-2014	US$ 100 000 per country (co-shared) consisting of: 3 pilots in 2009 (US$ 300 000); 2 pilots in 2010 (200,000); 10 second phase countries in 2010 (at US$ 20 000); US$ 200 000; 10 in 2011 at 20,000= US$ 200 000: Total US$ 900 000; In-country and 1-2 regional meetings of 10-20 experts = US$ 115 000 (US$ 57.5 in 2010 and 2011. DSA and Travel not included. 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. Facilitate meetings and partner discussions leading to the development of the supply management system;
4. Global availability and efficiency in procurement by innovative ways for sustained supply of quality commodities to developing countries.	**4.1** Innovative mechanism of procurement and supply identified at global level; **4.2** Supply/demand gaps are identified in 25 countries, and a strategy defined to address them is developed through global public/private dialogue.	PMNCH lead partners engage with public/private sector (economies of scale and leveraging costs). New solutions for cheaper medicines, new commodities, global manufacturing to increase supply of commodities; Reduction in price with quality commodities obtained. Patent and generic production related trade issues evaluated and agreed.	Mapping of potential public/private sector sources in 2010	Assessment study public-private + Global expert meeting/review of supply and financial gaps US$120 000 In 2010; US$ 50 000 in 2011; Evaluation/ Assessment of results achieved (data collection+ consultancy);	UNICEF, UNFPA, WHO, USAID. Work with RH commodity security Coalition, GAVI, UNITAID, KFW, GF etc.	Help identify new private sector partners/mapping; Manage consultants to contribute to the assessment of new solutions for cheaper medicines, global manufacturing and commodities; Contribute with technical inputs on drafts; Advocate dissemination of reports emerging from this work;

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
Priority Action HR (4): Strengthening Human Resources for MNCH **Outcome:** Include integrated human resource planning as part of national MNCH plans which ensure that MNCH skills and competencies are addressed, knowledge gaps within human resources management adequately addressed, and strengthened health care professional associations involved more directly in national health planning. **Value added:** PMNCH provides a neutral platform for consultation for HCPAs and other civil society stakeholders for HR strategies to be made specifically for MNCH. The PMNCH membership will facilitate the building of linkages between HCPAs and members of other constituencies.						
1. Ensure that MNCH aspects of HR are adequately included in national health plans and human resource plans	**1.1** Assessment of HR for scaling-up MNCH services (incl FP) in 25 countries; **1.2** 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 and framework for mapping; Strategy for the inclusion of MNCH health care providers developed. Inputs will include number of countries in which: HR for MNCH strategies have been developed, MoH MNCH plans/policies/IHP compacts developed with the participation of MNCH health care providers;	2009 2009 2010	US$ 50 000 consultant/ meetings/ travel; US$ 60 000 for development of framework and documentation.	**Lead: WHO** Co-lead HCPA organizing group Contributing: HCPA advisory group, National Government and the H4 (UNFPA, UNICEF, WHO and WB), and GHWA.	Draft TORs for the consultant, process contract and follow up on deliverables; Facilitate meetings and discussions for the development of the strategy, finalize and disseminate documentation; Monitor health care provider presence on relevant taskforces; Liaise with partners to outline activities in countries and follow up on their implementation;

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
2. Analysis relating to MNCH content of human resource issues identified and research commissioned;	**2.1** Analyses undertaken through meetings with country HR and reported in at least 25 countries; **2.2** HCPAs workshops carried out successfully; **2.3** Follow-up with participants carried out.	Three operational research studies undertaken (e.g. on task shifting and task sharing); Situational analysis conducted in 17 countries increasing to 25 countries (countries will be prioritized based on where HCPA workshops have already taken place) on HR distribution/gaps and bottlenecks for the achievement of the listed deliverables in 17 countries. Implementation plan for activities specified in output 2 for 2010. Two Healthcare professional workshops conducted in Arab speaking countries and in Latin America based on the list of 25 priority countries; Evaluation tool developed & Evaluation conducted in 17 countries (subsequently 25); Follow up plan developed for 17 countries with attached budget and implementation table (subsequently 25).	2009-2010 2009-2010 2009-2010 2009-2010 2009-2010	US$ 140 000 consultant/ academic organization, meetings, travel (2009); US$ 210 000 for three operational research studies. US$ 240 000 HCPA meeting costs 2009 US$ 30 000 US$ 10 000	**Lead: HCPA advisory group** Contributing: national and relevant regional MNCH health care providers, MOH;	Draft TORs for the consultant, process contract and follow up on deliverables including situational analyses, development of an evaluation tool and drafting of follow-up plans; Participate in preparatory work with HCPAs to identify and undertake studies, keep a record of all collaborations with the MOH and other partners, all taskforce meetings, signed agreements and plans; Organize and provide logistic support for the HCPAs regional workshops. Participate in consultative meetings and keep records of decisions; Secretariat to ensure smooth and coordinated interactions between PAs.

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
3. National HCPAs strengthened and involved in MNCH policies, planning and initiatives at the country level	**3.1** Strengthening national HCPAs in 25 countries (infrastructure, organization, communication etc) through seed money grants and agreed frameworks and indicators **3.2** Engagement of HCPAs in MDG4 and 5 planning and policies in country; Number and quality of interactions between HCPAs and policy makers; Modifications of policies resulting from these interactions.	Reports of meetings and interactions between HCPs and Governments at country level; New or revised HR MNCH policies; One meeting per year between UN, donors and HCPAs and documentation of outcomes from inputs.	2009-10 2010	US$ 250 000 approximately US$ 8000-15 000 per country depending upon size;	**Lead: HCPA advisory group** Contributing: WB, national MNCH health care providers, MOH, UNFPA, UNICEF, WHO	Liaising with national HCPAs and keep informed of needs and progress; Process proposals for HCPA strengthening, manage grant provision and follow up; Monitor policy changes and HCPA interactions with policy makers; Ensure smooth and coordinated interactions between PAs.

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
Priority Action AD (5): Advocacy for increased funding and for better positioning of MNCH in the development agenda **Outcome:** Profile on MNCH 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 MNCH 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 of efforts.						
1. MNCH clearly prioritized and the health system investments needed to achieve MDGs 4 and 5 identified in the HLTF and other for a.	**1.1** Provide effective inputs to the work of the HLTF on Cost and Constraints 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; HLTF messages used strategically by PMNCH to raise profile and funding for MDG4&5; Ensured input from civil society and other PMNCH partners on HLTF process and recommendations.	Feb-March 2009 By end of June 2009 March-June 2009	Norway, DFID	Norway, USAID, HCPA advisory group, BMGF WHO, WB, UNICEF, UNFPA	Participate in HLTF WG1; Contribute to paper development; disseminate results on PMNCH website Input, facilitated publishing and make available on PMNCH website; Ensure smooth and coordinated interactions between PAs.
	1.2 Contributed to the development and harmonization of the HLTF costing as it relates to scaling up effective packages of MNCH services (incl. FP).	Established interagency WG on costing under the umbrella of IHP+ (as part of SURG) and provided costing results to HLTF as it relates to MDG 4&5, including health systems strengthening.	Jan-March 2009	Co-funding Norway, DFID (US$ 500 000 already provided through IHP+)	UN/WB	Participate in WG1 & contribute to the analysis and dissemination.

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
	1.3 A technical working document of the HLTF costing, published and made available on PMNCH and partners' websites.	Technical document delineating the assumptions behind the above costing exercise developed, published and made available on PMNCH website and partners' websites.	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.
	1.4 Critical health system elements and related indicators to achieve MDG 4&5 identified and disseminated to targeted 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, DfID, Sida	USAID, UN, BMGF, Norway	Input, facilitated publishing and make available on PMNCH website.
	1.5 Priority health systems constraints that prevent scaling up identified and disseminated in 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, DfID, Sida	USAID, UN, BMGF, Norway	Input, facilitated publishing and make available on PMNCH website
	1.6 'Investment Case' for MNCH programmes for the Asia/Pacific region.	Asia/Pacific 'Investment Case' published and disseminated; Exploration towards expanding to develop an African 'Investment Case'.	2009-2011	US$ 30 000	ADB, AUSAID, BMGF, UNICEF, UNFPA, WHO, World Bank	With partners, coordinate development, production of materials and disseminate;

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
						Contribute to a launching event; Disseminate through PMNCH website/KMS and other means; Explore expanding to Africa.
	1.7 Country specific 'Investment Case'.	Reports from countries having undertaken it (5 to date).	2009- 2010	US$ 250 000 (US$ 50,000 per country) (ADB, UNICEF, UNFPA, WHO, World Bank)	ADB, AUSAID, BMGF, UNICEF, UNFPA, WHO, World Bank	With partners, facilitate country-specific ICs; Participate in technical work; Disseminate through PMNCH website.
	1.8 Joint UN costing tool developed and readily available.	Consensus reached on the use of these tools among all the partners. Dissemination strategy developed and used.	By end of 2009	Co funding: BMGF, USAID, Norway (US$ 385 000 provided already to WHO and IHP)	WHO/WB, UNFPA, UNICEF, John Hopkins, IMMPACT, UNAIDS, USAID, BMGF, Norway	Contribute to the development / dissemination of MDG 4& 5 modules, review final analysis and country costing tools.
	1.9 Paper developed on: 1. Annual ODA to MNCH: (i) Total 2003-2008; (ii) By donor country; (iii) By recipient country.	PMNCH to provide inputs on the work on monitoring country expenditures on MDG 4&5 on current domestic expenditures;	Preliminary results by December 2009, final results by April 2010 (Countdown	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,	Conduct analysis through Countdown WGF; Manage contracts of partners;

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
	2. Annual Domestic expenditures on MNCH: (i) Total 2008; (ii) Government spending; (iii) Private (out-of-pocket) spending.	Monitor annual Official Development Assistance for MNCH	report and Lancet special issue)		MSH, SC UK, UNFPA	Disseminate results on PMNCH website.
	1.10 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 July 2009	US$ 15 000 gap	Southampton University, IMMPACT, Norway	Contribute to the review of the final analysis; Disseminate on PMNCH website
	1.11 Study on the extent of investment by global initiatives for MDGs 4&5.	Analysis developed on the extent to which MDG4&5 is currently being addressed in health systems initiatives and how to improve this; Better coordination at country level ensured to increase MDG4&5 focus in national health plans at country level (25 countries).	2009		Norway 4H (WHO, UNICEF, UNFPA, WB), DFID, Norway, SIDA, USAID	Co-prepare mapping and analysis, as well as strategies and plans to improve positioning of MDG4&5; Provide global health initiatives with coordinated details of partners; Assist in the facilitating the partner dialoguing;
	1.12 Research conducted on the social and economic impact of poor maternal health,	Research findings produced and published, and fed into advocacy messages and strategies.	Mid-2009 - end 2011	US$ 500 000 (to be raised)	FCI, working with ICRW, London School, Immpact	Contribute to the development of evidence-based advocacy messages

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	linking it to newborn and child health and well-being					and to the dissemination of findings.
2. Effective channels for funding of MNCH and innovative ways to increase financial resources identified and promoted.	**2.1** PMNCH provided inputs to HLTF's WG2's work on ways to increasing resources and effectively channelling funds focusing on especially on MDG 4&5.	Developed paper (analysis on the range of existing financing instruments) and provided inputs to the WG2 of the HLTF; Inputs from PMNCH on the work of WG2 developed and submitted to HLTF; Recommendations from HLTF used strategically by PMNCH to increase funding for MDG4&5.	2009 March-May 2009 May-Dec 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; Compile and submit comments to HLTF on behalf of PMNCH; Make records from HLTF available with comments from PMNCH on website.
	2.2 Paper developed on the audit of the experience with the effectiveness of general budget support, basket funding as funding allocation mechanisms.	Analysis of the effectiveness of general budget support and basket funding. Paper developed, published and distributed	2009	US$ 250 000 (Norway, funds already provided to WHO).	WHO (HSF) with close interaction with the IHP+ secretariat.	Contribute to paper; disseminate results on PMNCH website.
3. Advocacy strategies and messages developed and implemented,	**3.1** Comprehensive advocacy strategy defined, specifying priority audiences, tailored messages, and	High-level events identified and researched, including timing, location, key participants (G8, G20, HLTF, IHP+, etc.); Media strategy defined,	By mid-2009	Workshop for finalization of strategy: US$45,000	Norad and FCI, working in collaboration with: ▪ UN agencies ▪ Other donors	Expand global event calendar. Contribute to the development of the

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
targeting high level actors and national policy-makers.	key events/opportunities.	utilizing media/PR departments of main partners/ agencies, including new and mainstream media.			▪ Other civil society reps	strategy.
	3.2 Strategic advocacy alliances established within MNCH community and with related sectors (HIV, human rights, etc.) around core messages and principles.	Mapping of advocacy capabilities of key stakeholders and partners; Capacity of civil society advocacy partners, especially in country, strengthened through training, strategic support, and sharing of tools and information resources Advocacy partnerships developed: *Within MNCH community: Network of Global Leaders, MHTF, Women Deliver, Maternal Mortality Campaign, US Coalition for Child Survival, Global Movement for Children;* With allied sectors: Human rights, HIV, RH, gender empowerment.	By July 2009 By Sept. 2009	Mapping: US$ 15 000 Capacity-building: 2009: US$ 100 000 in 2010: US$ 300,000: Two alliance-building consultations: US$ 60 000 total	FCI + civil society, including WRA, MMC, CARE, Save the Children Alliance, MHTF, World Vision, Women & Children First, PAI, US Coalition for Child Survival, FIGO, ICM, IPA; Allies from other sectors: Amnesty International, Int'l HIV/AIDS Alliance, IPPF. Work to be carried out in close contact/ collaboration with advocacy/ communications depts of UN and donor partners.	Mapping of partners and their capabilities; Contribute to the establishment of the strategic alliances; Coordinate work between the different stakeholders.
	3.3 Core advocacy messages and materials produced, endorsed, and strategically	Advocacy messages on MNCH *continuum of care* developed with participation of key stakeholders/	Messages – by 2009	Message development: US$ 75 000	FCI/Norad, w/ other bilateral, UN agencies and civil society groups (including Save the Children for	Participate in message definition and materials development;

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	disseminated by all partners; will draw on report/ recommendations of HLTF/WG1 as well as Countdown.	constituency groups, addressing: Global, regional and national costing estimates for MNCH, with consistent "ask" ; Identification of effective MNCH strategies, interventions; Benefits of MNCH investments (lives saved / deaths averted); Advocacy materials reflecting core messages developed in English and French; Core advocacy messages featured in web sites, e-news, news services, blogs.	Materials – by July 2009	Materials: US$150 000	child health core messaging).	Use PMNCH web site and communica-tion channels to disseminate messages/ materials; Coordinate dissemination of Countdown findings.
	3.4 Global Birth Atlas available	Global Birth Atlas developed, incl. identification of databases and sources for selected variables across 10 countries; Launch of Global Birth Atlas.	12 months from Jan 1st 2009, costs in 2010.	US$ 272 000 (US$ 196 000 to be funded) for 2 phases (content design/ proof version, then printing, launch, dissemination) (funds from Norway)	IMMPACT. Overall design & evidence by WRA and Univs of Southampton and Aberdeen, in liaison with CD, Norway.	Linkage with the countdown Dissemination of products in the website.
4. Mobilization and coordination of MNCH advocacy	**4.1** Statements and outcomes from targeted bodies and events	Coordinated advocacy and messaging with parliamentarian alliances	See schedule of events in column 1; to	Advocacy and outreach at G8, WHA, GA,	WHO (Italy), FCI	Facilitating Italian Parliamentarian meetings, analysis of

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
partners around key global and national events Global 2009: G20=April IPU =April WHA=May G8/HLTF=July UNGA=Sept Etc. (to be expanded)	reflecting core messages, including resource mobilization targets for the achievement of MDGS 4&5 and Countdown findings and recom-mendations.	and other stakeholders at MNCH related events in Italy, Canada, other G8 countries; Key influencers of G8 participants (First Ladies, high visibility champions) identified and contacted/ mobilized; Direct lobbying conducted to sherpas and health experts to the G8 (Japan, Italy, Canada, US); Materials disseminated and face-to-face lobbying conducted at key events by range of advocacy partners;	be expanded	HLTF, ICPD at 15 - US$ 150 000		Italian ODA Participate in the coordination and mobilization of partners and health experts.
	4.2 Partners Forum: Global conference on MNCH to prioritize actions needed to promote achievement of MDGs 4&5 by 2015; link to/ incorporate Countdown and Women Deliver events.	Unified, coherent call to action for MNCH continuum of care at global and national level (focus on Countdown countries); Up-to-date evidence on effective strategies/ interventions consolidated and shared.	Late 2010 (planning to begin third quarter 2009)	US$US 500 000 (some funds budgeted for Countdown conference in PAA6; this is additional for Forum/other elements)	Countdown Coordinating Committee; UN agencies; FCI and Women Deliver.	Plan and implement the Partners Forum; Plan Countdown-related elements; Coordinate with other key players.
	4.3 Expanded national advocacy in selected countries by civil society	Generate messages/ materials for national context, adapting from	Second half 2009: 2 pilot countries	US$ 50-75 000 per country:	CARE, BRAC, WRA, FCI, Save the Children, + other civil	Facilitate use of Countdown data.

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	alliances calling for increased policy and funding commitments by national governments, as well as accountability/ monitoring of commitments (social watch function).	global sources above; Link messages to specific country situation/data, based on Countdown; Use national data for advocacy and accountability purposes.	2010: 3 pilot countries 10 additional countries 2011: 10 additional countries	2009: US$150 000 2010: US$ 200 000 US$ 600 000 (new countries) + US100,000 (first 5 countries) 2011: US$600 000 (new countries) + US$300 000 (first 20 countries)	society groups	Ensure smooth and coordinated interactions between PAs.

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
Priority Action TP (6): Tracking Progress and Commitments for MNCH **Outcome:** Monitored commitment and progress towards MDGs 4 and 5 and used to improve decision making at global and country levels. **Value added:** The membership of the PMNCH represents a unique mix of constituencies essential to track progress on commitments made by Partners.						
1. Partners (donors, govts, multi-laterals, large NGOs) financial commitments to MNCH monitored annually.	**1.1** Documentation on whether commitments are met (or unmet) by partners	Review of Partners' commitments and progress towards their expressed commitments developed and published	2009-2011	US$150,000	World Bank (outsourced to independent entity)	To write TORs for a contract and manage the process for outsourcing the mapping work; Ensure smooth and coordinated interactions between PAs.
2. Common M&E framework agreed among GHI and disseminated and used in high priority countries	**2.1** Global Health Initiatives agreeing on common M&E framework to be used in priority countries; **2.2** M&E gaps identified and addressed through existing groups or new collaborations if needed.	Interrelated indicators for MNCH programmes process and impact proposed and measured; M&E gaps identified and addressed.	2009-2011	US$150,000	Norway, Academics	Disseminate framework to countries; Monitor activities undertaken to address identified gaps.
3. Advocate the use of Countdown products and information, and making them publicly	**3.1** Advocacy Workplan for updated data, estimates and trends	Data, estimates and trends agreed, gathered and analysed;	2009-2011	US$ 1 million (Need to review budget and secretariat to	Sub-Committee Co-chairs: A Starrs (FCI), F. Bustreo (PMNCH)	Co-chair, Advocacy Sub-Committee: Manage and maintain the Countdown website;

Outputs	Objectively verifiable indicator (OVI)	Deliverables/ Milestones	Time line (2-3 years)	Budget & funding	Lead Partners	Secretariat functions
available;	for MNCH progress developed, peer-reviewed, and made available.	Advocacy plan developed, funded and implemented Countdown website updated and maintained.		distinguish/ check for overlap with overall PMNCH advocacy).		Ensure smooth and coordinated interactions between PAs.
4. Successful meeting on tracking progress for MNCH held (support provided to Countdown 2010 conference)	**4.1** Successful Countdown Conference 2010 organized and held; **4.2** Level and breadth of participation and concrete outcomes achieved.	Countdown Conference 2010-11 held including joint event with IPU.	2009-2011	US$ 1 million (US$ 300 000 in 2010 and US$700 000 in 2011)	All partners, and IPU	Organization and logistics of Countdown conference; Promotion and dissemination of Countdown results; F/U 2009 IPU meeting.
5. Tracking progress on MNCH.	**5.1** Support provided to countries to review their MNCH indicators, especially as it relates to coverage, equity, financing, policy and health systems (through the Countdown).	Analysis of relevant indicators (coverage, equity, financing, policy and health systems) updated and published in Countdown report 2010 and other materials (support provided to the work of the Countdown).	Between 2 and 3 years	US$ 200,000	-Co-chair WG on coverage: J Bryce (JHU),T Wardlaw (UNICEF); WG financing: P Berman (WB); WG Equity: C Victora (Pelotas University), T Boerma (WHO); WG Policies: B Daelmans (WHO), H Fogstad (Norad).	Support for Working Groups, through seed contribution funding from PMNCH; (US$200,000 for four WGs).

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