THE PARTNERSHIP

For Maternal, Newborn & Child Health

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Conceptual and Institutional Framework

THE PARTNERSHIP
For Maternal, Newborn & Child Health

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EXECUTIVE SUMMARY

Newly-formed global health partnership aims to harmonize and intensify actions at country, regional and global levels in support of the Millennium Development Goals for maternal and child health.

Why a new global health partnership for maternal, newborn and child health?

Each year, more than half a million women die in pregnancy or childbirth, and more than 10 million children die before their fifth birthday, almost 40% in the first month of life. Recent research finds that at least two-thirds of these deaths could be prevented with proven, cost-effective interventions that could and should be available to every woman and child today. By expanding access to these interventions and integrating maternal, newborn and child health efforts, an estimated 7 million deaths of women and children could be prevented each year. Given the scope of this challenge, no individual country, organization, or agency can address it alone.

What is The Partnership for Maternal, Newborn & Child Health?

The Partnership for Maternal, Newborn & Child Health is a global health partnership launched in September 2005 to accelerate efforts towards achieving Millennium Development Goals (MDGs) 4 and 5. This new partnership is the result of a merger of three existing partnerships: the Partnership for Safe Motherhood and Newborn Health, the Child Survival Partnership and the Healthy Newborn Partnership. The Partnership aim is to intensify and harmonize national, regional and global action to improve maternal, newborn and child health.

Who is in The Partnership for Maternal, Newborn & Child Health?

The Partnership joins together the maternal, newborn and child health communities, encouraging unified and effective approaches that promise greater progress than in the past. The Partnership is made up of a broad constituency of members representing partner countries, UN and multilateral agencies, nongovernmental organizations, health professional associations, bilateral donors and foundations, and academic and research institutions.

What does The Partnership for Maternal, Newborn & Child Health offer?

The Partnership provides a forum through which members can combine their strengths and implement solutions that no one partner could achieve alone. The Partnership supports country-led efforts towards universal coverage of essential interventions for maternal, newborn and child health by focusing on the following:

- **Country Support** - actively promoting improved partner coordination in countries and supporting the creation, implementation and evaluation of a single national plan.
- **Advocacy** – raising the profile of maternal, newborn and child health on political agendas and advocating for increased resources - financial and other.
- **Effective interventions** – promoting the assessment, scaling up, and delivery of evidence-based, cost-effective interventions, with a focus on reducing inequities in access to care.
- **Monitoring and evaluation** – assessing progress by holding stakeholders at all levels accountable in meeting their financial and policy commitments.

How can we get involved?

The Partnership for Maternal, Newborn & Child Health welcomes new members. To learn more about the Partnership's activities and how you can become involved, please contact:

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1 BACKGROUND

1.1 Women, newborn and children – over 11 million deaths each year

Pregnancy and childbirth should be a reason for celebration. Yet every year, more than half a million women die from the complications of pregnancy and childbirth, and more than 10 million children under the age of five die from largely preventable causes.[1]

Most maternal deaths – more than 75% – happen during or shortly after delivery. In addition, 3.3 million babies are stillborn every year, and 3 million die within a week of being born.[2] Almost all of these deaths reflect women's poor health and nutritional status before and during pregnancy, or the poor quality care they and their newborn receive during the critical period just before, during and after childbirth. Similarly, many of the 7 $^{1}/_{2}$ million child deaths that occur after the newborn period (First 28 days of life) are a direct reflection of poor nutrition, poor care, and inadequate, inaccessible health services.[3]

Almost all maternal, infant and child deaths – 99% – occur in low- and middle-income countries. And families with the lowest socio-economic status have the highest risk of death. However, these deaths are just the tip of the iceberg; millions more women and children suffer illnesses and long term disability that could be prevented.

The economic and social impact of these deaths and disabilities – on families, communities, and nations – is considerable, encompassing the cost of caring for disabled or sick women and children; lost earnings; and an ongoing cycle of poverty and deprivation for poor families and societies.

1.2 Solutions exist to prevent these deaths – but don't reach those most in need

The direct causes of maternal, newborn and child deaths are largely preventable and treatable using proven, cost-effective and currently available interventions. Recent series in The Lancet have estimated that around two-thirds of both newborn[4] and child deaths[5] could be prevented with low cost, low-tech, existing interventions. This adds up to over 6 million avoidable deaths of children under 5 years every year. The majority of maternal deaths can also be averted with current knowledge.[6]

To save these lives and maximize opportunities for healthy women and children, there needs to be a continuum of care that begins prior to pregnancy, preferably during adolescence; continues throughout pregnancy, childbirth and after delivery; and ensures care for children and adolescents in the crucial years of life. The required interventions can be made available to women and children through an effective health system that reaches them at home, in the community and at basic health facilities. Women are the lynchpin of this continuum; protecting their health – especially their reproductive health – before, during and after pregnancy is essential for ensuring healthy newborn and children.

Despite the global recognition of the rights of women and children to basic care, the reality is that those most in need are often excluded from life-saving information and essential services.[7] In sub- Saharan Africa and South Asia, for example, two-thirds of women deliver without a skilled attendant, while in wealthy countries skilled care during pregnancy and childbirth is almost universal.

The priority now is to accelerate the implementation of proven interventions so that they reach those most in need.

1.3 International commitment – but failing progress

The number of maternal, newborn and child deaths each year is more than double the number of people who die from HIV/AIDS, malaria and TB combined. Yet this issue does not receive attention and funding in proportion to the problem. As the world has rightly invested and committed to addressing HIV/AIDS, it is only logical and just to invest in saving the lives of these mothers and children.

For decades the global community has expressed its commitment to the health of women and children. The United Nations has led the global community in articulating a rights-based approach to health, including reproductive health, giving particular attention to women and children as articulated in the CEDAW, CRC, ICPD and FWCW consensus documents. The child survival revolution was launched in the 1980s, culminating in the World Summit for Children held in New York in 1990, but then losing momentum. In the late 1980s attention moved to reproductive health with the launching of the Safe Motherhood Initiative in 1987, and the Cairo and Beijing Conferences in 1994 and 1995 respectively. More recently, the 4 million newborn deaths that occur each year have been highlighted as a problem that is neglected in most global policies and national programmes.

In 2000, the United Nations adopted eight Millennium Development Goals, holistically addressing priorities crucial for progress in development. Every country in the world has committed to these targets and to supporting rapid progress to achieve the goals (see Annex I). Two of these goals specifically address maternal, newborn and child mortality:

- Goal 4 is to reduce child mortality by two-thirds by 2015
- Goal 5 is to improve maternal health with a target to reduce maternal mortality by threequarters by 2015

Today, despite the scope of the problem, the availability of solutions and the stated global commitment, progress is inadequate; in some countries mortality gains have even been reversed. Less than one quarter of the world's population lives in countries that are on track to achieve the MDGs for maternal health and child survival[16]. The problem is not a lack of knowledge about effective interventions, but low coverage of these interventions due to weak health systems[8] and implementation bottlenecks. While levels of investment are inadequate, problems are also caused by fragmented approaches with multiple partners and stakeholders pulling governments in different directions[9].

Efforts are being made to increase funding and action, but still many countries and regions will miss the targets unless funding is dramatically increased and the inputs are effectively harmonized within countries and across programmes.

1.4 The power of Global Health Partnerships

Given the size of the problem and the challenges to be overcome, no individual country, agency or organisation can address these alone. Over the last few years, Global Health Partnerships (GHPs) have been created to address health issues that cannot be resolved by individual organisations operating independently. These partnerships channel synergistic skills and resources in support of governments, hence increasing the effectiveness and efficiency of each partner's investments, whilst minimizing duplication and reducing competition.

Two recent reports[17] examined GHPs and concluded that they had an overall positive impact, in terms of achieving their objectives and of being welcomed by partner countries. Markers of successful partnerships included the following:

- A clear and compelling goal;
- Clearly stated roles and relationships;
- An agreed focused scope;
- Effective performance measurement;
- Approaches for generating participation at national and international levels;
- Strategies for capacity-building, technical assistance, resource mobilisation and sustainability at the country level;
- Mechanisms for accountability.

Within the field of maternal, newborn and child health, three separate but partly overlapping partnerships have been in existence (see Box 1). In early 2005, agreement was reached to establish a united Partnership for Maternal, Newborn & Child Health (The Partnership) combining the three existing partnerships in order to strengthen and accelerate the response to MDGs 4 & 5 and provide a unifying framework for action.

The new Partnership works with existing national planning processes to promote donor convergence at the country level and provide leadership and collaboration with relevant players, including other GHPs such as GAVI, GFATM, RBM, etc.

BOX 1: The Partnerships

Partnership for Safe Motherhood and Newborn Health

Launched in 2003 and developed from the Safe Motherhood Inter-Agency Group, which was established in 1987, the Partnership for Safe Motherhood and Newborn Health was based at WHO, Geneva. The Partnership aimed to strengthen maternal and newborns' health efforts in the context of poverty reduction, equity, and human rights, as well as advocate for increased political will and progress towards the Millennium Development Goals.

Healthy Newborn Partnership

Formed in 2000, the Healthy Newborn Partnership was led by Save the Children/USA's Saving Newborn Lives initiative, based in Washington, DC. The partnership aimed to promote awareness and attention to newborn health; exchange information on programmes, research, and technical advances; and support incorporation of newborn care into health policies and programmes.

Child Survival Partnership

The Child Survival Partnership, established in 2004, was hosted by UNICEF, New York, and aimed to galvanise global and national commitment and action for accelerated reduction of child mortality worldwide, through universal coverage of essential cost-effective interventions for child health.

1.5 The Value of The Partnership for Maternal, Newborn & Child Health

By developing and promoting a clear vision around maternal, newborn and child health, The Partnership represents a powerful, unprecedented collaboration to achieve MDGs 4 & 5 by:

- Coordinating, harmonizing and aligning the activities of individual partners to scale-up proven, cost-effective interventions;
- Integrating efforts to develop solutions that no one partner can achieve alone;
- Enhancing advocacy by forging a clear, unified message that carries the weight of all members standing together;
- Filling gaps in the total solution through the strategic alignment of partner contributions.

The value of The Partnership is evident from the following benefits:

Bringing maternal, newborn and child health together

A single partnership ensures that these three issues are effectively inter-linked by:

- Developing effective global leadership, with a united and powerful voice at the international level;
- Maximizing the linkages between maternal, newborn and child health using the continuum of care and a rights-based approach as a framework and ensuring that no priority issue is forgotten;
- Developing a single set of consistent messages that will be accessible to a wide and diverse audience;
- Providing a consistent and sustained approach to the mobilisation of both financial and technical resources as well as political will and commitment;
- Building effective linkages with other initiatives, including other GHPs;
- Avoiding duplication of investments and actions through coordination of effort and direction.

The depth and breadth of The Partnership constituency

The Partnership has a broad constituency that includes country partners, international agencies, donors, non-governmental organisations, professional associations and research and academic institutions. By bringing together its broad constituency, The Partnership ensures that its value is greater than that of the sum of its parts. This unique constituency will have the following benefits:

- Building on the strengths and experience of the individual members and of the three predecessor partnerships;
- Developing a global technical framework that can be adapted at country level;
- Creating and maintaining consensus on the nature and content of effective interventions and intervention packages, as well as on an agreed technical and operational research agenda;
- Synthesizing and sharing knowledge and lessons learned from the wide range of its partners, thus enabling evidence-based best practice to be available to countries as they develop, implement and monitor their plans for maternal, newborn and child health, within the context of efforts to strengthen the health system.

Accelerating action at country level

At the country level, The Partnership works in response to country needs, supporting national leadership, advocating for increased resources and bringing together the work and resources of all stakeholders in MNCH within existing national planning and financing frameworks. This maximizes the impact, investment and efficiency of the work of each individual stakeholder within the country, while avoiding the problems of over-burdening countries. This is done by:

- Promoting convergence of different stakeholders around and in support of a country-driven coordinated strategy, plan, investment and monitoring mechanism for maternal, newborn and child health;
- Supporting countries to increase coverage of essential interventions for maternal, newborn and child health as well as addressing the bottlenecks that prevent their implementation and scaling up;
- Mobilising financial and human resources, building on existing instruments and mechanisms at the country level and providing catalytic funding if needed;
- Leveraging change in policy, programme or technical interventions that would be beyond the influence or capacity of individual partners.

Promoting accountability

The Partnership promotes accountable behaviour among its partners and acts as a watchdog for progress. It serves the following constituencies:

At the International Level

- International professional organisations, via journals, annual meetings, and special committees and reports;
- The research and academic community, with mechanisms such as a biennial conference on maternal, newborn and child health;
- Donors, via appropriate and transparent allocation of funds and support of national decisionmaking and government led action;
- International non-governmental organisations, via facilitation of civil society participation and pressure on governmental and inter-governmental bodies;
- The international mass media, via reporting of maternal, newborn, and child mortality, and pressure on the governments of high-income countries to meet their agreed funding targets.

At the National Level

- Ministers of Health, Finance, and Planning, via transparent and responsible fund allocation based on assessed need and the promotion of health-systems strengthening and increasing operational research as well as monitoring and evaluation;
- Professional organisations and academics, via the assessment of national progress and public debate;
- The national mass media, reporting on government spending and whether national targets for health spending, particularly on maternal, newborn, and child health, are being met;
- Civil society including advocacy and women's groups in particular, by providing a channel for demanding and monitoring access to high-quality health care, information and services.

Value for money

The Partnership improves efficiency and effectiveness by:

- Maximizing the use of available resources while minimizing duplication of investments and activities – for example, through promoting a single integrated planning and budgeting processes and coordinating inputs;
- Avoiding duplication and outcome competition, through the development and agreement of coordinated approaches among all partners.

2 CONCEPTUAL FRAMEWORK

2.1 Scaling up essential interventions throughout the continuum of care for women, newborn and children

The shift in global policy focus towards health systems strengthening as the means to improve maternal, newborn and child health (MNCH) has been articulated in several documents. These show strong consensus on the need for attention to strengthen care before and during pregnancy, childbirth and after delivery leading onto care for children in the crucial early years of life and during adolescence. The 2005 World Health Report emphasized the need for integration of maternal, newborn and child health (MNCH).[1] Also, the report of the UN Millennium Task Force on child and maternal health called for new focus on the rights of women and children and the need to invest in MNCH systems, as well as ensure universal access to reproductive health.[6] And finally, the Lancet Neonatal Survival series (April 2005) emphasized the importance of the continuum of care, while focusing on the effect for impact for newborn survival.[11] Proven costeffective interventions, delivered through a continuum-of-care approach and grounded in the recognition of the rights of women and children, can prevent millions of needless deaths and disabilities, providing necessary essential services for pregnant women, newborn, infants, children and adolescents.

The concept of a "continuum of care" to address maternal, newborn and child mortality has emerged as a new paradigm. There are two dimensions to this continuum:

Time – From pre-pregnancy (including adolescence), through pregnancy, childbirth, the crucial early days and years of life (fig 1)

Place – Between homes, the community and health facilities, with linkages between various levels (fig 2)

The rationale for approaching maternal, newborn and child health as a continuum of care by time (fig 1) incorporates a number of factors:

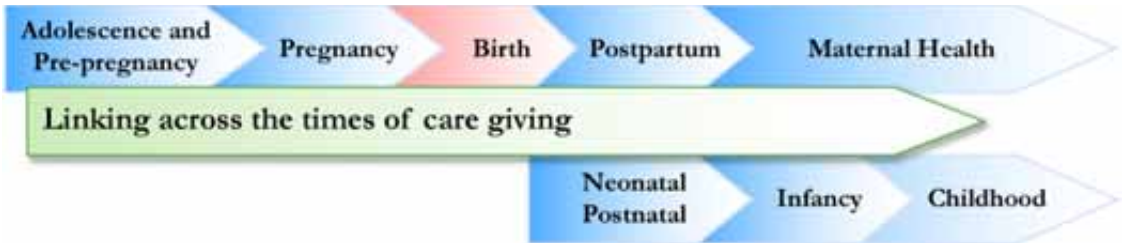
1. Specific interventions, delivered in a specific time frame, have multiple benefits. For example, improving care during childbirth improves maternal and newborn survival, and reduces stillbirths and child disability.

2. Linking interventions in packages can reduce costs by allowing greater efficiency in training, monitoring and supervision, and strengthening supply systems.

3. Integration or linking of services increases uptake and promotes continuation of positive behaviours. For instance, counselling for breastfeeding in the immediate postpartum period provides an opportunity for promoting postpartum/postnatal and newborn care. Counselling and services for family planning in the post-partum or post-abortion period can help space births and reduce unsafe abortions.

4. Intergenerational benefits are more easily achieved. For example, improving the nutritional and educational status of young girls and adolescents, and providing the means to avoid unintended pregnancy, improves birth outcomes for the next generation, as the poor nutritional status of women and inadequate birth spacing are major determinant of low birth weight and ill-health.

Figure 1. Connecting Care Giving across the Continuum for Maternal, Newborn and Child Health



The second dimension of the continuum of care is required to link households and communities to health services (figure 2) by promoting healthy home-based practices, mobilising families to seek the care they need, addressing gender inequities, and increasing access to and quality of care in health facilities at both primary and referral level. Although a large proportion of deaths occur at home without any contact with health facilities, preventive health behaviours at home could save many lives, as could prompt recognition of health problems and prompt action to seek appropriate care. Empowerment of women, families and communities, and encouraging a shared sense of responsibility for pregnancy and childbirth, is central to addressing the political, socio-economic, and cultural factors that so often prevent women and infants from reaching good quality care. Many studies have highlighted these factors for maternal,[13] newborn[14] and child health.

Figure 1. Connecting Care Giving across the Continuum for Maternal, Newborn and Child Health

The work of The Partnership focuses on promoting universal coverage of interventions throughout the MNCH continuum, reflecting crosscutting issues, such as gender awareness, the human rights framework, nutrition, family planning, education and access to affordable, safe services. The continuum of care framework facilitates the development and implementation of interlinked MNCH initiatives and balanced programmatic approaches, thus ensuring that women, newborns and children all benefit and that all components of the health system are addressed, including the role of the community, NGOs and the private sector. Initial priority will be placed where most deaths occur h/transition/C&IFfinal 12-05 11 – in high mortality countries, at home and in communities, and when most deaths occur – during pregnancy, at the time of birth, the postnatal period, and in infancy.

In addition to recognition of the continuum of care approach as an important paradigm, it is also recognised that there is no single model of care to prevent maternal, newborn and child morbidity and mortality. The design and implementation of country-level programmes must be tailored to the needs and realities of the national and sub-national settings, employ a rational mix of quality family/community, outreach and clinical services in public and private sectors, and focus on scaling up effective interventions.

2.2 Reducing maternal, newborn and child mortality: the broader context and contributing factors

In addition to health system issues there are a range of social, cultural and economic factors that influence maternal, newborn and child health. These include educational status, gender equity and women's empowerment, access to employment and income-generating opportunities, the availability of water, sanitation and housing, transport and energy infrastructure, predominant sociocultural and religious beliefs, and the legal and judicial system. The Partnership is dedicated to establishing linkages with initiatives addressing these factors and working collaboratively whenever and wherever possible.

2.3 The vision, goal and priorities of The Partnership

The Vision: to intensify and harmonize national, regional and global action to improve maternal, newborn and child health.

The **Goal**: to support the achievement of Millennium Development Goals 4 & 5, reducing maternal, newborn and child mortality through:

- Strengthening and accelerating co-ordinated action at global, regional, national, sub-national and community levels
- Promoting rapid scaling up of proven cost effective interventions
- Advocacy for increased commitment

The **Priorities**:

1. Country support: To support national efforts to accelerate universal coverage of essential interventions for maternal, newborn and child health in high mortality countries.
2. Advocacy: To establish the priority of, and mobilise the necessary financial investment in, maternal, newborn and child health, globally and at national levels.
3. Effective interventions:
   a) To promote the development and adoption of evidence based, cost-effective interventions for maternal, newborn and child health, and promote effective delivery strategies;
   b) To promote the development of new interventions.
4. Accountability:
   a) To promote stakeholder coordination and accountability in meeting commitments regarding:
      - Resources
      - Policy and programme implementation
   b) To actively monitor and evaluate progress in the implementation of key interventions through the use of robust data.

2.4 Priority areas of work

The main thrust of The Partnership is to accelerate the scaling up of essential interventions to reduce maternal, newborn and child mortality. Partners are committed to the principle of coordinated, concerted and complementary action in all countries. Members of The Partnership recognize the importance of addressing basic and underlying causes of maternal, newborn and child mortality and will therefore promote close linkages with other programme areas and sectors. The Partnership will use its joint force to leverage change that is beyond the influence or capacity of individual partners.

The scope of the work of The Partnership is set out in biennial work plans, which reflect internationally agreed consensus frameworks, including the framework of the Millennium Development Summit, the Convention for Rights of the Child (CRC) and the targets set in the UN General Assembly Special Session on Children, Commission for the Elimination of Discrimination Against Women (CEDAW), the International Conference on Population and Development (ICPD) and Fourth World Conference on Women (FWCW) and the five-year follow-up conferences. The Partnership addresses the primary causes of maternal, newborn and child mortality with a focus on the priority problems being faced in each country.

Country support

The Partnership harmonizes support for reducing maternal, newborn and child mortality in all countries and regions and intensifies support to high-burden countries. In these priority countries, partners facilitate a country-led, coordinated and systematic process of planning to identify the optimal mix of interventions and delivery strategies to reduce maternal, newborn and child mortality, to maximize the use of available resources whilst minimising the burden placed on countries. After an initial assessment of MNCH, a coordinated mechanism, led by government and civil society, is established to implement activities and to ensure that overcoming inequities is a priority. Countrydriven technical assistance will be provided by partners, coordinated through The Partnership and, as needed, supported by catalytic financial and other resources.

By 2015, Partnership activities at global and country levels in this area will result in the following outcomes:

- Collaboration between partners at national level will be reflected in a single coordinated implementation plan, a joint coordinating body, and one resource mobilisation plan, and one monitoring and evaluation plan of all partners, led by the government, building on the existing work of stakeholders and within national development plans;
- The coverage of essential interventions for reducing maternal, newborn and child mortality in countries will have been increased to preset targets according to indicator and baseline level, as defined in the work plan. Outcomes of increased coverage and quality of care will also be made visible and measurable;
- Major advances will be made in the three-quarters reduction of maternal mortality ratio and the two-thirds reduction of under-five mortality rate in high burden countries, with robust data to confirm such progress.

Advocacy and Resource Mobilisation

The Partnership advocates to raise the profile of maternal, newborn and child health on global and national agendas and to increase the resources available, by speaking with one voice and communicating clear and consistent messages. Advocacy is a core activity in all the priority areas and involves, amongst others, resource mobilisation, political mobilisation, support for agreed technical intervention frameworks and packages and tailor-made messages at country and global levels.

By 2015, Partnership activities at global and country levels in this area will result in the following outcomes:

- Political commitment to and media coverage of maternal, newborn and child health will have been significantly increased in high mortality countries and within the international community;

- Resources available for maternal, newborn and child health from global and national budgets will have increased, and more funds will be available in countries with the highest burden of deaths while sustaining or increasing investment in other countries;
- Consensus will have been achieved on proven effective interventions and intervention packages and the results of the implementation of these on maternal, newborn and child mortality and morbidity numbers.

Effective Interventions

There is considerable consensus about which major interventions are effective in reducing maternal, newborn and child mortality. Through The Partnership, members work together to adapt existing tools or identify new ones, to promote the delivery of the agreed essential interventions in an integrated and effective manner. This includes interventions at the facility, community and household levels. The Effective Interventions Working Group also evaluates successful and unsuccessful models for scaling up and aiding the adaptation of interventions and strategies for other settings.

By 2015, Partnership activities at global and country levels in this area will result in the following outcomes:

- Tools to promote effective technical implementation of essential interventions to reduce maternal, newborn and child deaths in programmes will have been developed and disseminated by partners;
- Positive and negative lessons learnt in the process of scaling up will have been evaluated and shared to promote more rapid progress;
- Research priorities to accelerate the scaling up of interventions will have been systematically identified and the funding for applied research for MNCH increased;
- National leadership in and global capacity for applied research on MNCH issues as well as on operational matters will have been strengthened.

Monitoring and Evaluation

The Partnership has a coordinated approach to monitoring and evaluation to assess progress towards achieving maternal, newborn and child health outcomes, measure indicators of programme inputs, and track resource allocation at national and global levels. Partners work closely to promote generation of data and close linkages with existing initiatives such as the Health Metrics Network. The Partnership will serve as a watchdog for progress and hold partners and countries accountable for their contributions to improving maternal, newborn and child health.

By 2015, Partnership activities at global and country levels in this area will result in the following outcomes:

- Indicators related to coverage of priority interventions for maternal, newborn and child health policies and legal frameworks will have been routinely monitored and results fed back to decision-makers to improve accountability in policy making and programming;
- Progress towards achieving the Millennium Development Goals for maternal and child mortality reduction will have been regularly evaluated and results fed back to decisionmakers;
- The assessment of equity and trends in equity gaps for mortality and coverage of essential interventions will be part of routine monitoring and evaluation, and inequities will have been reduced;
- Resource allocation and funding flows will be monitored and published to increase accountability of both rich and poor governments in meeting commitments.

2.5 Guiding Principles

The Partnership will:

- Focus initially on countries with the highest burden of maternal, newborn and child mortality and morbidity;
- Support countries' leadership role in achieving MDGs 4 and 5, respecting national needs and perspectives and encouraging the participation of civil society;
- Work to reduce inequities within and among countries;
- Work so as not to increase transaction costs for governments;
- Make effective use of existing and additional resources and expertise;
- Use existing planning processes and systems, including PRSPs, SWAps, MTEFs etc.;
- Collaborate and coordinate with other relevant partnerships;
- Build on partners' comparative advantages, without duplicating their work;
- Focus on a prioritized agenda set out in work plan, but not constrain partners from working within their own mandates outside The Partnership;
- Manage its activities in accordance with good governance;
- Encourage partners to support and buy in to The Partnership's activities and speak with one voice (to the extent that they can);
- Ensure systematic and co-ordinated approach to country support, by developing guidelines for use by partners to harmonize efforts at country level.

3 INSTITUTIONAL FRAMEWORK

The Partnership is an alliance of international organisations, governmental and non-governmental agencies, partner countries, donors, foundations, health professional organisations, academic and research institutions and interested individuals who have a shared interest in, and commitment to, the achievement of the maternal and child mortality Millennium Development Goals and are willing to be committed to short- and long-term measures to achieve them. The Partnership will work within internationally agreed frameworks including ICPD, FWCW and MDG. Member agencies are committed to providing adequate and sustainable funding for the continued operation of The Partnership, including its Secretariat. The Partnership is not an independent entity, but a collaborative mechanism between the Members.

The figure below describes the proposed institutional framework for The Partnership:

3.1 The Forum

The Forum meeting serves as a regular global platform for the renewal of commitment to the mission and purpose of The Partnership, for global high level advocacy and for achieving broad consensus on the strategy and priorities of The Partnership. Members are expected to commit to the aims of The Partnership and to contribute to its activities either financially or in-kind over a period of time. These contributions may be formalized within The Partnership work plans. The Forum is constituted of all constituencies/members and meets biennially during a global maternal, newborn and child health conference.

3.1.1 Functions

The Forum:

a) Selects representatives from each constituency group to serve on the Steering Committee;

b) Consolidates and increases members' commitment to the objectives of The Partnership and maintains and reinforces high level political commitment;

c) Enriches plans and activities through the active exchange of information and experience;

d) Highlights any special opportunities and constraints that would warrant the attention of the Steering Committee;

e) Reviews overall progress, review reports presented by the Steering Committee and makes recommendations;

f) Makes use of the Forum meeting for advocacy, communications activities and social mobilisation at national and global levels;

g) Provides a forum for dissemination of good practice and experience;

h) Considers any matter related to The Partnership referred to it by the Chair of the Steering Committee or by the Director.

Any of the constituencies may table matters for discussion after adequate prior consultation and acceptance by the Steering Committee.

3.1.2 Criteria for Membership

The criteria for membership of The Partnership will be agreed by the Steering Committee but will include a commitment to MNCH, in accordance with the guiding principles, internationally agreed frameworks and the conceptual framework. In addition, the following membership categories are identified:

Country Membership

Country members will bring their experience with MNCH at country level to the deliberations and decisions of the Forum and the Steering Committee. They will be from the Ministry of Health, but also be knowledgeable of the issues of health care providers, NGOs and other stakeholders within their country.

Organizational Membership

Organizational members should be active in one or more of The Partnership's priority areas (maternal, newborn and child health) and work in accordance with the principles of The Partnership.

Honorary Membership

Honorary members will be invited by the Steering Committee, based on their personal contribution to the priority areas of The Partnership, to attend Forum meetings and participate in activities. They may be members of working groups and ad hoc groups by invitation, when their costs may be paid. They will:

- Be individuals who have made an outstanding contribution in the MNCH field;
- Have demonstrable knowledge, skills and experience in MNCH.

3.1.3 Composition

The Forum will be made up of representatives of all the Members. There shall be no limit to the size of such member representation at the global conference but a maximum of three representatives of any one organisation may attend the Forum.

3.1.4 Operation

a) The Forum will be convened in regular session at least once every two years by the Steering Committee, through The Partnership Secretariat. This will be confirmed no later than six months before the meeting and members will be informed accordingly.

b) After consultation with the Steering Committee members, the Director prepares the provisional agenda of the meeting for approval by the Steering Committee and for posting on The Partnership's website no later than three months before the Forum.

c) The Director will provide the secretariat function of the Forum.

d) The consolidated report of the session will be finalized by the Director and circulated after clearance with the Chair of the Steering Committee and posted on The Partnership's website.

3.2 The Steering Committee

The Steering Committee (SC) is the governing body of The Partnership and holds decision-making authority. The Members of the Steering Committee represent a balance among the members subscribing to The Partnership. SC membership is institutional or representative of a constituency; SC members normally speak for their institutions/constituencies and indicate when they are reflecting a personal view.

The Partnership SC has a Chair and two Co-chairs who act in support to, and in the absence of, the Chair. As far as possible, the Chair and co-Chairs reflect a balance between Maternal, Newborn and Child Health interests and represent different constituencies and geographical areas. They are elected in a transparent manner by the Steering Committee.

The Chair and Co-Chairs represent The Partnership in communications with organisations, countries and other initiatives.

3.2.1 Selection of Steering Committee Chair, Co-Chairs and Members

Steering Committee members will be selected at Forum meetings from candidates put forward by their constituencies.

The Chair and Co-Chairs will be selected by the Steering Committee members by a process of voting following a request for nominations.

When a member vacancy is identified, the Director will inform all members from that constituency three months before the Forum date. Members from that constituency will be invited to make written nominations supported by details of the potential personal contribution of the individual nominated within four weeks from date of receipt. In the event of more than one nomination, the names and supporting documentation will be circulated to the relevant constituency members one month before the Forum. The Director will organise a ballot of the constituency at the Forum and the successful nominee will be identified by simple majority vote. Postal votes will not be admissible. Each member organisation in that constituency will have one vote.

Should a vacancy arise at a time when a Forum meeting is not imminent (more than six months) then a similar process will be undertaken by the Director and member organisations will be required to register for a postal vote.

3.2.2 Functions

The Steering Committee:

a) Endorse the initial Institutional Framework including the criteria for Partnership membership as laid down by the Transition Team and propose/endorse future changes

b) Sets policy, establishes goals, priorities, strategies and targets for The Partnership in line with evidence-based health policy, internationally agreed frameworks and in the light of input from the Forum;

c) Develops and oversees the implementation of agreed long- and medium-term Global Plans of Action for the realisation of the mission and objectives of The Partnership;

d) Endorses the work plan and budget of the Secretariat and approves the operational plans and budgets of the other components of The Partnership;

e) Mobilizes adequate funds for the effective operation of The Partnership and its various components;

f) Supports resource mobilisation efforts in pursuance of the mission and objectives of The Partnership;

g) Is responsible for the use of all funds made available to The Partnership for the steering and coordinating functions of the SC, the work of the Secretariat and other related activities;

h) Has management responsibility for the Secretariat through the Director;

i) Provides a consensus recommendation to the Director-General of WHO concerning the appointment of the Director of The Partnership Secretariat (as per due processes of the host agency described in the Memo of Understanding);

j) Monitors performance through regular reports and budget statements presented by the Director;

k) Supports and coordinates the various constituencies and other components (working groups and ad hoc sub committees) of The Partnership;

l) Oversees intensified and sustained advocacy for increased political commitment and for increases in global and national funding available for maternal newborn and child survival programmes, through existing funding channels;

m) Individually as Steering Committee members (when mandated by the Steering Committee) and through the Chair and Co-Chairs, represent The Partnership to donors, countries, institutions and in other appropriate fora;

n) Fosters and safeguards a harmonious working relationship with the hosting agency (WHO);

o) Monitors continuously and reports periodically on progress in implementing the agreed work plan;

p) Where appropriate, time limited, special interest groups may be established to address a specific topic;

q) Approves all Partnership publications, supported by the advice of the appropriate working group. This may be undertaken by an editorial committee appointed by the Steering Committee;

r) Reviews any other matter related to The Partnership as may be referred to it.

3.2.3 Operations

a) The Steering Committee meets three to four times a year, of which at least two will be face-toface meetings. The Chair may call for extraordinary meetings or electronic conferencing whenever necessary;

b) The Director prepares the provisional agenda for each SC session or electronic conferencing in consultation with the Chair and Co-Chairs and circulates it and the available supporting papers two weeks before the planned meeting;

c) Members are selected to sit on the SC on the recommendation of the respective constituencies;

d) The term of office for all rotating members shall not exceed two terms consecutively. One term of office consists of two years;

e) The SC elects from among its members two Co-Chairs to assist the Chair in the performance of his/her duties whose term are two years and renewable. The Co-Chairs shall not serve for more than two consecutive terms. Co-chairs are identified from constituencies different from that of the Chair and support the chair in his/her duties and perform the function of chair in his/her absence;

f) The term of office of the Chair is two years and renewable. However, the Chair shall not serve for more than two terms consecutively;

g) The Chair and Co-Chairs collectively have executive authority to make decisions when required in a short time scale and these are to be reported to the SC for ratification;

h) The Director is the Secretary of the SC;

i) The Director shall prepare a detailed report of each SC meeting or electronic conference and circulate it as soon as possible, posting it on The Partnership website once ratified;

j) Decisions of the SC are not legally binding upon the member organisations and will not override decisions of their respective governing bodies;

k) Except for its policy and work plan/budget approval related functions, the SC may delegate tasks to designated officer(s) in The Partnership secretariat or working groups of The Partnership;

l) Selection of members and officers of the SC shall always be timely, fair and open with explicit criteria for selection;

m) The Secretariat develops, for the approval of the SC, a rational schedule for the periodic rotation of members ensuring that no more than 50% of members change in any year.

n) Members of the Steering Committee have the right to opt out of specific Partnership agenda items, publications or activities if they so wish. To the maximum extent possible, Steering Committee decisions are determined by consensus, with the quorum being the majority (50%+1) of the members. Nevertheless, should a vote be required, decisions are taken on the basis of a simple majority of the members present and voting, with each member having one vote only. In the case of a hung vote, the Chair will have an additional casting vote. There is no power of veto.

3.2.4 Composition

The Steering Committee consists of no more than 23 members selected from amongst the members. It is made up of representatives from the following partner constituencies ensuring there is a balance between maternal, newborn & child health and between national and international NGOs as well as a mix of geographical representation.

a) Donor governments/agencies and Foundations (four, including one specific slot for foundations);

b) Implementing Developing Countries represented through the Ministry responsible for health (four);

c) Multilateral Organisations with a health mandate related to MDGs 4 and 5: UNICEF, UNFPA, WHO and World Bank (four);

d) Non-Governmental Organizations (four);

e) Research and academic institutions (three);

f) Representatives of health professional organisations (three);

g) Optional seat which might be filled by an additional bi-lateral donor if appropriate.

The cost of SC attendance for developing country members is met by The Partnership.

The selection of members is made by their constituencies and is guided by defined criteria such as:

- Currently and actively working in field of MNCH;
- Level of profile within the constituency and globally/ regionally;
- Willingness and ability to afford the time and resources required for Committee activities.

3.2.5 Observers

A maximum of ten persons are invited with observer status. Such persons are not to be decisionmakers and do not carry a vote. No person or constituency has permanent observer status. Observers from other Global Health Partnerships will be welcomed in the interest of collaboration and complementarities. No more than two observers will be permitted from any single organisation and their attendance will be based on the relevance of their presence to items on the agenda.

3.3 The Secretariat

The Secretariat is the permanent and operational arm of The Partnership, responsible for supporting the execution of plans and decisions of the Steering Committee. The secretariat is led by a Director. The Director is accountable to the Chair who is responsible for his/her performance management. This recognizes the employment status of the Director within the host organisation.

3.3.1 Functions

a) Provides support to the Forum, Steering Committee and Working Groups and, as requested in connection with their participation in The Partnership, to the Members;

b) Is responsible for carrying out and managing the day-to-day operations of The Partnership and coordinating the implementation of the work plan;

c) Prepares the work plans and budgets of The Partnership in collaboration with the Working Groups for approval by the Steering Committee;

d) Prepares and submits for scrutiny by the Steering Committee, a six-monthly progress report on implementation of the plan and budget;

e) Facilitates coordination of the provision of technical support by partners in agreed key countries;

f) Facilitates The Partnership's delivery of high-level advocacy at global and country levels;

g) Represents The Partnership and its goals and objectives in international fora, countries and with other key stakeholders, in accordance with the agreed work plan;

h) Supports the members of the Steering Committee in the mobilisation of funds and other resources for the work of The Partnership at global and national levels;

i) Supports the Working Groups in the tracking of resource flows and collation and dissemination of best practices.

3.3.2 Operation

The Secretariat is not incorporated as a legal entity, but will be hosted by WHO using its convening power, legal status, administrative, financial management and logistics systems. The conditions under which the Secretariat operates are detailed in the Memorandum of Understanding (MOU) that is an integral part of this institutional framework document. The MOU covering the initial period of three years is signed by the Chair of the interim Steering Committee and the Director-General of WHO. It will be renewable and amendable on mutual agreement.

The Director is accountable to the Steering Committee but is employed through WHO (and thus complies with its employment terms and conditions of service). All other staff of the Secretariat account directly to the Director.

3.3.3 Composition

The composition of the Secretariat will be cost effective and driven by the agreed functions of The Partnership and the availability of funding. The Director commands respect and hearing at the highest levels and has excellent networks globally, both politically and within the health sector.

The Secretariat will initially comprise of a core team of:

a) Director

b) Deputy Director (Country Co-ordination and Liaison)

c) Senior Adviser in Advocacy

d) Communications Officer

e) Resource Mobilisation Officer

f) Senior Adviser for Country Support

g) Senior Adviser on Effective Interventions

h) Senior Adviser on Monitoring and Evaluation

i) Finance Officer

j) Administrative Assistants x2

k) Secretary

Staff for the Secretariat will be selected in open, competitive processes based on an agreed person specification and competency framework and ensuring a balanced representation of technical expertise, constituents and geographic experience. This process will comply with the requirements of the host organisation.

3.4 Working Groups

Four Working Groups (WGs) are constituted by the Steering Committee to support the work of The Partnership: Country Support, Advocacy, Effective Intervention, and Monitoring & Evaluation. These working groups are subject to periodic review.

3.4.1 Constitution of Working Groups

Members of the Working Groups are identified by the Steering Committee following an invitation to all Members to submit the names and potential contribution of potential members. The composition of working groups will vary over time to reflect the tasks undertaken but, overall, a balance of interests, constituencies and geographical location will be maintained.

Each Working Group identifies a leader who will chair meetings. The leader liaises with the Senior Advisor on the content of agendas and timing of meetings. The relevant Senior Advisor provides support and secretariat functions to the working group and ensures effective linkages with other Working Groups. The Working Groups may establish sub-groups as appropriate. The Working Groups and sub-groups perform such functions and undertake such tasks and activities as the Steering Committee shall establish.

3.4.2 Generic Functions

The Working Groups provide a platform to guide and coordinate the inputs of the members and jointly design and implement strategies that will lead to increased resources and action for MNCH in countries. Working groups have concrete and specific tasks. Their expected outputs are clearly defined. The WGs will facilitate but not take on the work of the individual partners. Their generic functions are:

a) Ensure that there is coherence between the policies and objectives and work plans of The Partnership with those of their respective constituencies and member organizations;

b) Coordinate the implementation and monitoring of the plans on country level implementation, advocacy, technical interventions and monitoring and evaluation, so as to assure coherence and synergy;

c) Identify appropriate partners and/or other sources to fund and/or undertake planned tasks and activities on behalf of the WG and the wider Partnership.

3.4.3 Outputs of the working groups

Each working group develops the following:

a) An agreed work plan, identifying specific outputs;

b) A dissemination plan for information-sharing;

c) A list of existing tools for implementation and new ones that need to be developed;

d) An annual report on their work.

3.4.4 Support to Working Groups

The Secretariat facilitates the work of the Working Groups, including provision of secretarial support. A leader will be identified from among the member agencies to guide the work of the Working Group. This person works in close collaboration with the Senior Adviser assigned to the Working Group. A budget for activities as defined in the Working Group work plan is identified annually and approved by the Steering Committee.

3.4.5 Time Commitment of Members

Meetings are held four times a year and may be virtual. However, meeting time is only part of the time commitment required of Working Group members. There is an expectation that these Working Groups are involved in activities, not merely policy development, and members are therefore required to dedicate reasonable time for working group activities. Each organisation accepting to participate in a Working Group should indicate the percentage of time and other resources that the focal person (and organisation as a whole) can dedicate to Working Group activities.

3.4.6 Interface between Working Groups and Partners

For organisations wishing to contribute to the work of Working Groups but unable to make such commitment, the Secretariat will keep a listing so they can be engaged in advisory functions upon invitation by the core members of the Working Group.

The Working Groups produce and distribute to all Partnership members, through the Secretariat, regular periodic informal reports of activities carried out and planned. Through this report, or through specific requests circulated via the Secretariat, the Working Groups identify all opportunities for Partnership members to participate in, or support, specific activities.

3.4.7 The Country Level Support Working Group

The Working Group on country level support is established by the Steering Committee with the following remit:

a) To identify and recommend engagement with countries for support by The Partnership;

b) To intensify support to selected countries to accelerate coverage of essential maternal, newborn and child health interventions and add value by promoting consistent, coherent and coordinated approaches that maximise the use of available resources;

c) To provide information on effective interventions based on research findings and sharing best practice with an emphasis on South/ South country exchange;

d) To identify potential key stakeholders in identified countries, including health professional organisations and community groups and facilitate support that will allow them to be full stakeholders and development partners;

e) To develop close working relationships with Ministries of Health and Finance in priority countries and their donor co-ordination mechanisms;

f) To develop coordination mechanisms and collaboration with the private sector;

g) To support development of national plan of action with input from all members, each according to its mandate, resources and comparative advantage, in scaling up effective implementation of the core set of cost-effective interventions, jointly developed and agreed upon by the members and in conjunction with other partnerships and initiatives. This will be undertaken through existing country planning and budgeting processes including PRSPs and SWAps;

h) To ensure that The Partnership initiatives are timed to support country level planning and budgeting processes and integrate with country level processes;

i) To support the identification and sharing of good practice and ensure that this is available to the countries.

This working group is supported by the Senior Adviser in Country Level Support who acts as Secretary.

3.4.8 The Advocacy Working Group

The Advocacy Working Group is established by the Steering Committee with the following remit:

a) To galvanise global support and attention to the need to generate extraordinary actions to achieve the MDGs 4 & 5;

b) To devise a strategic advocacy plan for The Partnership;

c) To identify and engage champions for MNCH;

d) To quantify financial resources that are available and needed to achieve the MDG 4 of child mortality reduction in the highest burden countries and MDG 5 of maternal mortality reduction in close coordination with the Task Force on Country Support;

e) To advocate for and raise additional resources for implementation of country action plans;

f) To incorporate the outputs of country level and other monitoring processes into effective advocacy messages and activities;

g) To identify significant global events and help coordinate and promote stakeholder participation, providing a platform for The Partnership;

h) To identify key advocacy messages at national and international levels and methods for their dissemination.

This Working Group is supported by the Senior Adviser in Advocacy who acts as Secretary.

3.4.9 Monitoring and Evaluation Working Group

The Working Group on Monitoring and Evaluation provides information to the Steering Committee including tracking progress in partnership formation, programme implementation and healthoutcomes in countries. The working group does not set up new systems for collection and analysis of information but rather identifies what is already available and proposes possible adaptations for use of such data by The Partnership.

The Monitoring and Evaluation Working Group is established by the Steering Committee with the following remit:

a) Work closely with the Secretariat in the tracking of resource flows, programmatic inputs and service outcomes and in the dissemination of such data and information for more effective advocacy;

b) Identify key output areas for M and E study, including monitoring and addressing inequities in maternal, newborn and child health;

c) In cooperation with the Effective Interventions Working Group, develop indicators and interim targets and benchmarks for progress towards internationally agreed MNCH goals;

d) Provide information to support advocacy activities.

This Working Group is supported by the Senior Adviser in Monitoring and Evaluation who acts as Secretary.

3.4.10 Effective Interventions Working Group

This Working Group is established by the Steering Committee with the following remit:

a) To identify and synthesize new research findings and experiences which have applicability in the field of MNCH and forge consensus prior to recommendation and dissemination.

b) Liaise with the Country Level, Advocacy, Effective Intervention and Monitoring and Evaluation Working Groups to ensure synergy and consistency.

c) Provide recommendations on policy, strategic and technical aspects relevant to in-country implementation.

d) Identify cost-effective mechanisms for dissemination and updating of research findings.

e) To source and facilitate the development of tools pertinent to the planning process and the identification of effective interventions in countries.

f) To support dissemination of knowledge and networking of organisations and individuals with the aim of increasing knowledge and skills.

g) Assist in identifying critical gaps in knowledge, experience and resources and make appropriate recommendations to address them.

h) Work closely with the Secretariat in the collection, collation and dissemination of best practices.

This Working Group is supported by the Senior Adviser in Effective Interventions who acts as Secretary.

4 Final Provisions

4.1 Legal Status

The Partnership is not a legal entity and does not possess the juridical personality. It therefore cannot contract, acquire and dispose of immovable and movable property or institute legal proceedings. For this reason, it is hosted by an international organisation, WHO. This arrangement permits The Partnership to benefit from the mechanisms of the host institution.

4.2 Dissolution

The Partnership will exist as long as needed. The Steering Committee, nevertheless, may decide on its dissolution.

4.3 Withdrawal of Members

Any member may withdraw from participation by notifying the Director of its intention to do so.

4.4 Amendments to the Institutional Framework

The present institutional framework, at the request of any member of the Steering Committee, may be amended after approval by the Steering Committee.

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ANNEX 1: Millennium Development Goals

In September 2000, the United Nations Millennium Summit brought together the largest gathering of world leaders in history. In the summit's final declaration, signed by 189 countries, the international community committed to a specific agenda for reducing global poverty.

The goals, listed below, today guide the efforts of virtually all organisations working in development and have been commonly accepted as a framework for measuring development progress.

Goal 1. Eradicate extreme poverty and hunger

- Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day.
- Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

Goal 2. Achieve universal primary education

- Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

Goal 3. Promote gender equality and empower women

- Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.

Goal 4. Reduce child mortality

- Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.

Goal 5. Improve maternal health

- Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

Goal 6. Combat HIV/AIDS, malaria and other diseases

- Have halted by 2015 and begun to reverse the spread of HIV/AIDS.
- Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

Goal 7. Ensure environmental sustainability

- Integrate the principles of sustainable development into country policies and programmes and reverse the losses of environmental resources.
- Halve by 2015 the proportion of people without sustainable access to safe drinking water.
- By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers.

Goal 8. Develop a Global Partnership for Development

- Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.
- Address the special needs of the least developed countries.
- Address the special needs of landlocked countries and small island developing States.
- Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term.
- In cooperation with developing countries, develop and implement strategies for decent and productive work for youth.
- In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.
- In cooperation with the private sector, make available the benefits of new technologies, especially information and communications.

ANNEX 2

Acronyms used in this document.

CEDAW	Commission for the Elimination of Discrimination Against Women
CRC	Commission on the Rights of the Child
CSP	Child Survival Partnership
FWCW	Fourth World Conference on Women (Beijing 1995)
GHP	Global Health Partnership
HNP	Healthy Newborn Partnership
ICPD	International Conference on Population Development (Cairo 1994)
MDG	Millennium Development Goal
MNCH	Maternal, Newborn and Child Health
NGO	Non-Governmental Organisation
PMNCH	The Partnership for Maternal, Newborn & Child Health
PSMNH	Partnership for Safe Motherhood and Newborn Health
SC	Steering Committee
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WG	Working Group
WHO	World Health Organization