

Strengthening National Advocacy Coalitions for Improved Women's and Children's Health



The Partnership
for Maternal, Newborn
& Child Health

Introduction

In recent years civil society organizations have grown in number and prominence in many countries where women's and children's health demands greater priority and accountability. However, given the range of interests and actors, such organizations have not always received adequate support to come together to speak with one voice and be heard effectively in forums where decisions are made.

The Partnership for Maternal, Newborn & Child Health (PMNCH) represents over 500 members across seven constituencies, including government, multilaterals, donors, the private sector, health professional organizations, non-governmental organizations (NGOs) and academia. Of this, nearly 400 PMNCH members are NGOs. This represents a significant opportunity for PMNCH to support national coalitions of civil society actors to come together with common positions, strategies and messages, acting together through joint efforts to demand greater accountability and action.



These joint efforts can support the implementation of commitments made through national processes, as well as those pledged through regional efforts such as the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA), or through global efforts, such as Every Woman Every Child, supporting the Global Strategy for Women's and Children's Health, launched by UN Secretary-General Ban Ki-moon in 2010.

This document, *Strengthening National Advocacy Coalitions for Improved Women's and Children's Health*, reports on the work of national CSO coalitions in 10 countries, supported by PMNCH over the past 18 months to intensify joint action to enhance accountability relating to women's and children's health.

Responding directly to the recommendations of the Commission on Information and Accountability for Women's and Children's Health (CoIA), PMNCH began in late 2011 to provide catalytic financial and technical support for the development or strengthening of national civil society alliances for Reproductive, Maternal, Newborn and Child Health (RMNCH) advocacy in key countries in Africa and Asia where the mortality burden is high and where clear pledges for action have been made. These CSO coalitions are now present in 10 countries: Bangladesh, Burkina Faso, Ethiopia, Ghana, India, Indonesia, Kenya, Nigeria, Uganda and Tanzania.

The coalitions are anchored by two focal points per country: one nationally headquartered NGO and one internationally headquartered NGO, ensuring a deliberate link between national action and regional and global political processes and interests. In the case of the Africa-based coalitions, PMNCH partners with the Africa MNCH Coalition to build capacity among the coalitions to facilitate the implementation of the African Union's Integrated RMNCH Advocacy Strategy, which seeks to reconcile existing African commitments and platforms with the Global Strategy.

A total of US\$ 35 000 in catalytic funds was provided to each country by PMNCH in 2012. These funds were to be used to:

1. Conduct a rapid mapping of CSOs intervening in women's and children's health in each country
2. Organize a national advocacy stakeholder meeting to discuss and agree on common priorities, needs and workplans
3. Develop a sustainable coalition with resource mobilization capacity
4. Support a limited number of specific joint activities emerging from the joint workplans, including possible support for national Countdown to 2015 products and events

During this time, national coalitions were encouraged to align priorities and activities in view of existing national plans and processes. As such, varying models have developed.

- For instance: some countries, like Tanzania, Burkina Faso and Kenya, recognized the lack of space for discussion and alignment of CSOs across the RMNCH continuum of care, and decided to prioritize efforts on creating and expanding RMNCH-focused CSO coalitions;
- Other countries, like India and Ethiopia, identified the key challenge as the opportunity for CSOs to participate in broad-based RMNCH policy and planning, and focused on securing CSO participation within multistakeholder RMNCH alliances, including government, donors, and the UN;
- Within both models, some alliances restricted membership to stakeholders involved in RMNCH advocacy, while others, such as Nigeria and Uganda, also included those working on social and environmental determinants of health.

As the country profiles in this report suggest, participants have taken full advantage from the creation of these collaborative spaces. In most of the 10 countries, these are the first CSO coalitions to cover the entire continuum from pre-conception to child and adolescent health. In countries where these coalitions were pre-existing – such as in Ethiopia or Bangladesh – membership was expanded and the remit of the group was re-focused on evidence-based advocacy. In all cases, these coalitions have built on pre-existing efforts and are focusing specifically on aligning advocacy efforts.

These partnerships have resulted in the implementation of innovative approaches, such as:

- The creation of a joint advocacy toolkit in Tanzania to increase the enrolment of youth in midwifery training
- The creation of voluntary contribution schemes in Indonesia, Ghana and Uganda to cover the cost of alliance activities
- Strengthening the role of media in accountability in Ghana, Indonesia, Nigeria and Tanzania
- Collaboration with parliamentarians on policy and budget support for health plans in nearly all countries
- Capacity building of CSOs to develop and implement locally relevant advocacy strategies in Ghana
- Monitoring by the coalitions of implementation of workplan commitments by CSOs in Burkina Faso and Uganda

Countries remain at varying stages in building their CSO coalitions. However, in producing the country reports that make up this document, the coalition leads indicate their belief in the value-added of these joint efforts. In Uganda, for example, the national CSO coalition led by ACHEST and World Vision Uganda worked with legislators to delay the budget approval process by two weeks, until the allocation to health was increased. The Ugandan Coalition has also been instrumental in advocating for the leadership of the Ministry in undertaking a national Countdown process. The Coalition is also supporting the implementation of Uganda's national accountability roadmap funded by the CoIA workplan, and is lending its advocacy capacity to the East African Community Open Health Initiative to Improve Maternal and Child Health in East African Partner States -- a south-south collaborative initiative building on the exchange of information and capacity to improve health outcomes. The Coalition has developed a three-year costed strategic plan to guide its activities.

In Kenya and Burkina Faso, the CSO coalitions are leading in the proposal of country Countdown to 2015 processes. In Burkina Faso this advocacy has resulted in the Minister of Health making Countdown to 2015 a national health advocacy priority and allocating resources for its implementation. The RMNCH CSO network is now also in consultation with the global Countdown committee and the national government to advise on the implementation of the Burkina Faso Countdown to 2015 advocacy strategy.

In India, the reproductive, maternal, newborn, child and adolescent health (RMNCH+A) Coalition, led by Save the Children India under the auspices of the Government of India, as authority to provide direction and advocate for RMNCH+A policy and programming. The first of its kind, the coalition which includes central and state government agencies, academia, research and training institutes, health care professional associations, local bodies (Panchayats and Nagarpalikas), nongovernmental organizations, CSOs, faith-based organizations (FBOs), media, corporate organizations, bilateral and multilateral donors and United Nations agencies, aims to work more effectively with stakeholders to enhance joint action and accountability, and to support the implementation of national commitments and policies.

During the past 18 months, PMNCH has supported two technical meetings to develop this programme: In March 2012, alongside the Women Deliver Africa regional consultation meeting, and in Washington, DC, in June 2012, alongside the Promise Renewed for Child Survival event, linked with the launch of the Countdown to 2015 report.

During this process, support has been received from Norad, the Bill and Melinda Gates Foundation, and the Commission on Information and Accountability for Women's and Children's Health to strengthen this programme of national advocacy.

Future efforts will include support for an Africa regional budget-tracking capacity building workshop with civil society, parliamentarians and the media, to be held this year with the support of CSO coalitions from Uganda, Tanzania, Kenya, as well as the Inter-Parliamentary Union, the Open Health Initiative, Evidence for Action (E4A), Save the Children, the White Ribbon Alliance, and World Vision.

PMNCH looks forward to continued support to its NGO constituency and these country coalitions to ensure that civil society is enabled to maximize its voice and impact in advocating for greater results for women and children.

Geneva

June 2013



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Africa

Burkina Faso

Ethiopia

Ghana

Kenya

Nigeria

Tanzania

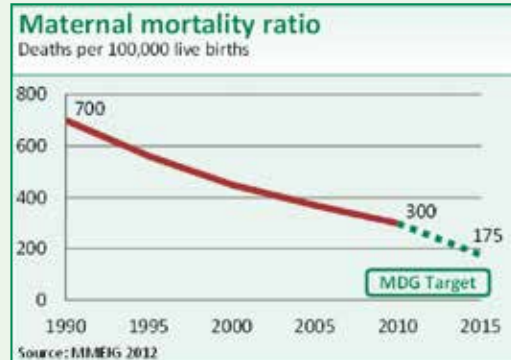
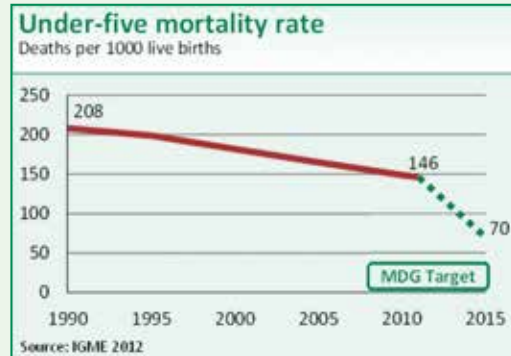
Uganda



Burkina Faso



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Source & MDG target calculation: Countdown to 2015 Report

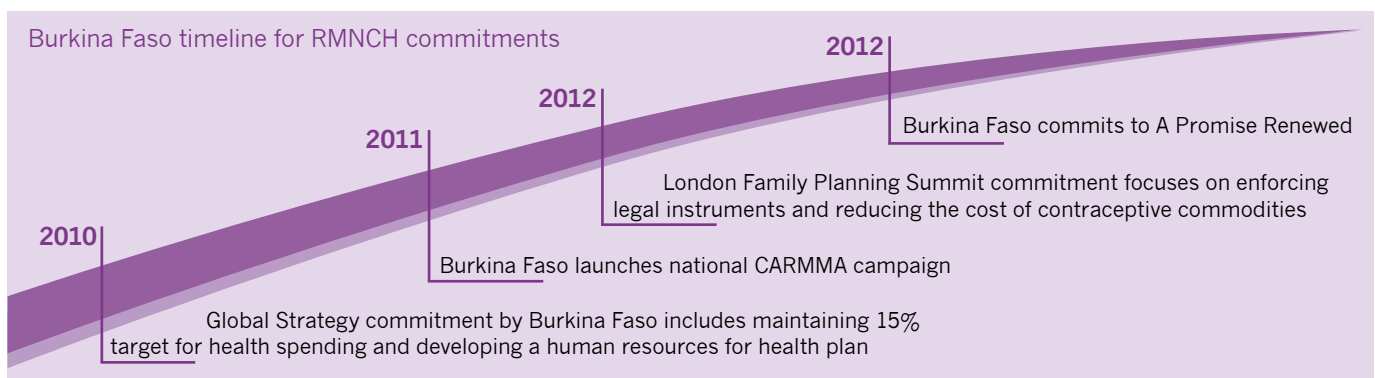
Introduction

Efforts to increase CSO collaboration in Burkina Faso in 2012 has led to a collaborative network of CSOs, which now successfully undertakes monitoring, support and advocacy activities on RMNCH issues. The lead organizations are Family Care International-Burkina Faso (FCI/BF) and the Union des Religieux et Coutumiers du Burkina en Santé et Développement (URCB/SD).

This alliance includes CSOs from the following five pre-existing groups: A Consortium of National and International NGOs working in the fields of health and HIV (to which FCI belongs), the Coalition des Réseaux et Associations Burkinabé (CORAB) (created in 2007), the afore-mentioned URCB/SD created in 2007, the Coalition Nationale des Organisations du Secteur privé et des entreprises de lutte contre le VIH et pour la santé (CNSPE) created in (2008), and the Fédération Burkinabé des Associations pour la promotion des Personnes en situation de handicap (created in 1994).

Members of this alliance were identified through a stakeholder-mapping process led by FCI and URCB in March 2012. FCI and URCB identified about 100 organizations working in Burkina Faso on RMNCH issues. On 20 March 2012, FCI and URCB brought 22 of these organizations together in a stakeholder meeting to identify common advocacy priorities and to develop a joint advocacy work plan.

In this meeting partners agreed to develop the network of CSOs, which now undertakes joint advocacy to support the implementation of national commitments to improve the health of women and children. FCI and URCB provided network members with comprehensive information on the Global strategy and Burkina Faso's commitments to this strategy, many members being introduced to the strategy for the first time.



Following this meeting, the network analyzed and discussed key regional policy documents that could be used to underpin advocacy strategies, such as the Declaration of African Union Head of State on Maternal, Infant and Child Health and Development in Africa, adopted in Kampala in 2010, and the Pan African Parliament resolutions on budget and policy support for the implementation of this declaration.

In June, July and November 2012, FCI and URCB represented the network in meetings with the World Health Organization (WHO), the Director of The Department for Maternal and Child Health at the Ministry of Health, as well as UNFPA representatives, to discuss how collaborative CSO advocacy can best support national efforts to improve RMNCH outcomes.

All partners agreed on the important role played by CSOs in tackling RMNCH issues, and they committed themselves to lending technical and/or financial support to the CSO coalition.

FCI and URCB then held discussions with the Ministry of Health to determine which advocacy activities should be undertaken by the CSO coalition. These discussions led to the recognition of the need for CSOs to assist in the development of a National Accountability Framework on Women's and Children's Health, as recommended by the Commission on Information and Accountability.

As a result in June 2012, FCI and URCB, on behalf of the network, actively participated in the development of this national roadmap.

Coalition aims for 2013

- I. Conduct a situational analysis on the implementation of the relevant RMNCH policies in Burkina Faso and, through discussions with H4+ partners and the Ministry of Health, identify the most effective advocacy strategies.
- II. Assess the strengths and weaknesses of network members and using a questionnaire identify their further training and capacity building needs in supporting the coalition's advocacy work.
- III. Develop a joint advocacy work plan and resource mobilization strategy based on the findings of the above research.
- IV. Support the government on the finalization of the country accountability framework.
- V. Support the government in the implementation of the Country Countdown process.

More effective collaboration with government – the development of a RMNCH CSO advocacy network in Burkina Faso.

In November 2012, during the national consultation organised by the Minister of Health to finalise the Roadmap on Accountability for RMNCH, FCI and URCB represented the network in leading one of the six working groups to deal with the following topics: "Process Review of Health Sector Performance" and "Advocacy/Awareness" in RMNCH.

As a result of this activity, the Minister of Health has made Countdown to 2015 a national health advocacy priority and has allocated US\$ 10 000 for its implementation. In addition, the Department of Family Health has revised their 2013 action plan to include Countdown. The RMNCH CSO network is now also in consultation with the global Countdown committee and the national government to advise on the implementation of the Burkina Faso Countdown to 2015 advocacy strategy.

Conclusion

With support from PMNCH and partners, such as local UN agencies and the Ministry of Health, CSOs in Burkina Faso have been mobilized to work together in improving maternal and child health outcomes. In forming a coalition, CSOs are now better able to perform effective monitoring, advocacy and support activities. As outlined above, they have a clear strategy for ensuring that RMNCH commitments made by Burkina Faso are met.

RMNCH situation

Region

- Africa

Population

- 16.4 millionⁱ

U5MR

- Third highest U5MR in the world: 176 per 1000 live births in 2010 (from 205 in 1990)ⁱⁱ

MMR

- 300 per 100 000 live births in 2010 (from 700 in 1990)ⁱⁱⁱ

Challenges

- 35% of children under five are stunted (2010)^{iv}

Social factors

- Only 15% of girls are enrolled in secondary school; gender inequities such as early marriage (48% of girls are married by the age of 18^v)

Health sector factors

- Lack of human resources for health; poor access to essential medicines and equipment; limited financing

Key initiatives/commitments

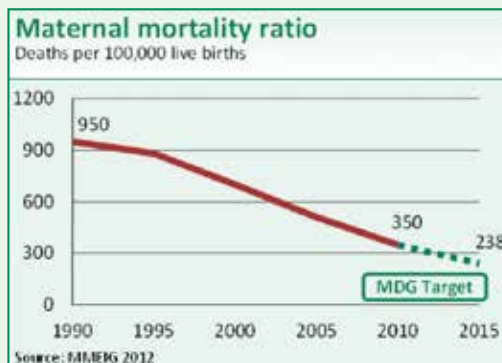
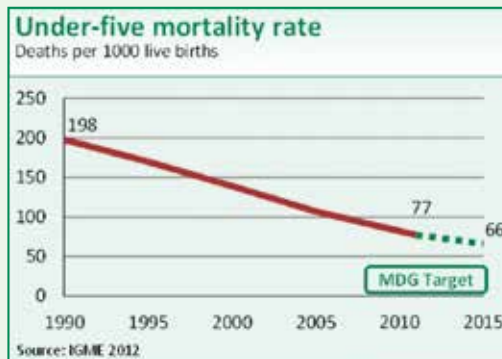
- The government has met the 15% health spending target in the Abuja Declaration
- The government also has in place a Roadmap for Accelerated Reduction of Maternal and Newborn mortality with a national Plan 2006-2015 and a Reproductive Health Commodities Security Strategic Plan 2009-2015



Ethiopia



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Source & MDG target calculation: Countdown to 2015 Report

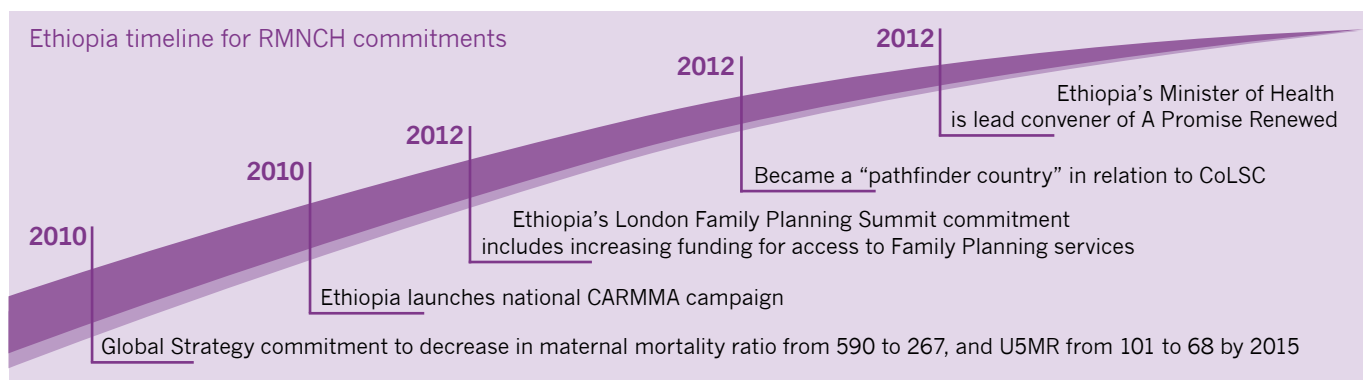
Introduction

In 2012, the Ethiopian Midwives Association (EMA) and the Family Guidance Association of Ethiopia (FGAE) drew up a comprehensive list of the 43 CSOs working on RMNCH in Ethiopia, and met with the Federal Ministry of Health (FMOH) to determine the government's RMNCH priorities and how these could be supported by CSOs.

EMA and FGAE subsequently organized a large-scale multi stakeholder consultation involving the FMOH, USAID, Addis Ababa University, JHPIEGO, H4+, Packard Foundation and others. This meeting identified key RMNCH policy issues, aligned advocacy agendas and alerted potential stakeholders to the need for increased collaboration to improve RMNCH. A workshop discussion on RMNCH commitments identified gaps in the implementation of government policies and in strategies to improve child and maternal health.

Based on these discussions, partners agreed to join up efforts to address some of these gaps through a range of initiatives, including:

- Promoting midwifery as a career
- Improving the quality of midwifery education
- Establishing regulatory bodies for the profession
- Advocating for the role of midwifery in improving child and maternal health outcomes
- Strengthening human resources in the health sector, particularly those working on RMNCH.



The workshop also resulted in the establishment of a technical working group for promoting RMNCH policy, led by the FMoH, to guarantee the continued involvement of CSOs in RMNCH policy-making and advocacy and access to funding for future projects.

Coalition aims for 2013

- I. Strengthen the referral system among hospitals and health centres by identifying areas for improvement in current processes.
- II. Use best practice examples from successful hospitals to encourage reform.
- III. Implement a code of ethics and conduct for health professionals.
- IV. Strengthen partnerships and mobilize resources to increase advocacy and awareness of RMNCH issues.

Safe Motherhood Campaign: Promoting RMNCH in Ethiopia

The Ethiopian FMoH Urban Directorate Safe Motherhood Taskforce, comprised of representatives of the FMoH, the United Nations and CSOs, declared January 2013 Safe Motherhood Month as part of a wider campaign to promote RMNCH. Using the slogan of the Campaign for the Accelerated Reduction of Maternal Mortality in Africa – “No mother should die giving birth” – the Safe Motherhood Campaign generated significant media coverage promoting institutional delivery and addressing the three delays that contribute to maternal mortality.

The campaign brought together community leaders, celebrities, politicians and goodwill ambassadors to deliver the message that skilled birth attendants save lives. It included six TV spots, brochures and posters, as well as TV and radio interviews featuring top midwives discussing their professional achievements. The campaign was funded through contributions from CSOs such as EMA, H4+, among other partners, and the Ethiopian Government as part of its overall RMNCH focus.

Conclusion

CSOs in Ethiopia are working together with key RMNCH stakeholders, and the Ethiopian government, to institute wide-ranging health sector reforms, to address health recruitment, standards of care and education. The coalition aims to improve the quality and accessibility of RMNCH services in Ethiopia on RMNCH, thereby reducing child and maternal mortality.



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RMNCH situation

Region

- Horn of Africa

Population

- 85 million^{vi}

U5MR

- 106 per 1000 live births in 2010 (from 180 in 1990)^{vii}

MMR

- 350 per 100 000 live births in 2010 (from 950 in 1990)^{viii}

Challenges

- 9,000 maternal deaths in 2010; Only 10% live births attended by skilled health personnel in 2011^{ix}

Social factors

- Inequities in access; low levels of secondary education completion particularly for girls

Health sector factors

- Challenges with quality of care; too few health facilities; need to recruit midwives and health-sector workers

Key initiatives/commitments

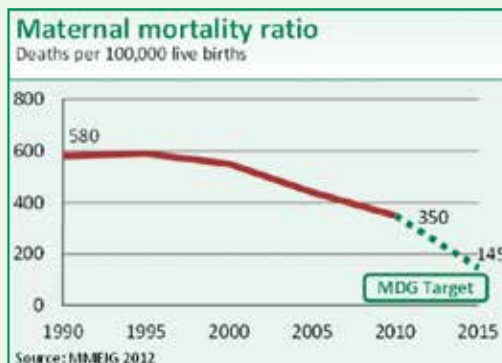
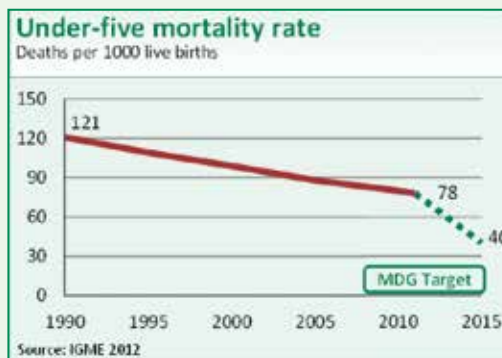
- Health Sector Development Plan targets education, sanitation, and child and maternal health. The government has implemented a successful health extension worker (HEW) programme that has provided over 30,000 additional workers available and has launched a health development army to supplement HEWs
- Government has committed to the Global Strategy for Women's and Children's Health to increase the number of midwives from 2,050 to 8,635, and the proportion of births attended by a skilled professional to 60% and to uphold the right of Ethiopians to access voluntary family planning services



Ghana



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Source & MDG target calculation: Countdown to 2015 Report

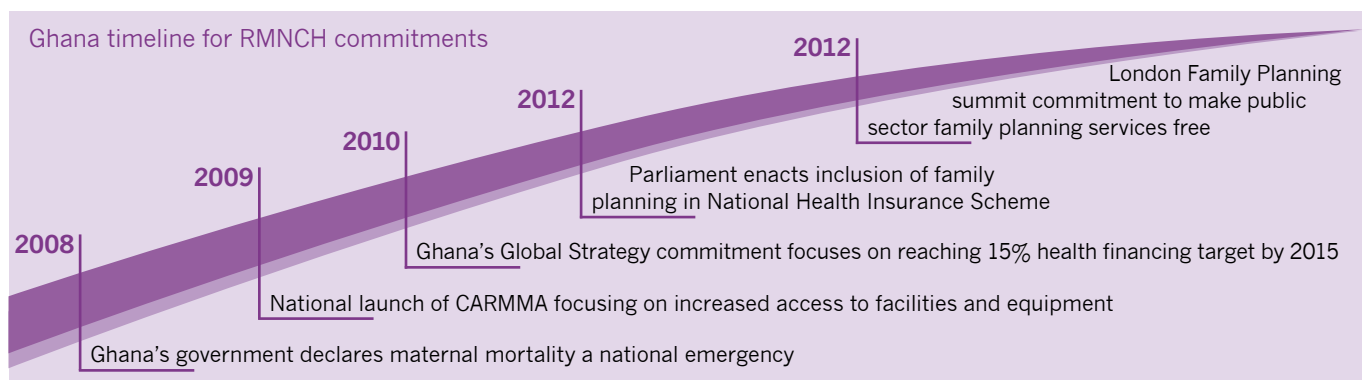
Introduction

In May 2012, the Alliance for Reproductive Health Rights (ARHR) and Planned Parenthood Association of Ghana (PPAG) conducted a mapping of stakeholders and held a national stakeholder consultation to form a larger, farther-reaching, national RMNCH CSO coalition with partners ranging across the continuum of care from pre-conception to childbirth. These efforts resulted in an expanded CSO coalition, which built on a 2011 network led by ARHR, PPAG and Ipas Ghana.

The first meeting of the CSO coalition discussed common priorities for advocacy on women's, newborn and child health in Ghana, identifying approaches, strategies and joint activities to be adopted in this collaborative effort, as well as determining the capacity needs of members and proposing ways of addressing identified capacity gaps. The meeting, which brought together over 40 stakeholders, also identified advocacy priorities for coalition members. They discussed gaps in advocacy action, which included: a lack of focused media involvement, a lack of technical advocacy skills by NGOs, a lack of funding, and a resulting lack of suitable and locally relevant advocacy strategies.

Members agreed the need to focus advocacy efforts on:

- Increasing numbers of midwives
- Ensuring free access to services,
- Increasing knowledge amongst populations of national health insurance
- Improving health facilities and infrastructure and increased male involvement.



They also identified gaps in capacity, including those related to research, media engagement and data gathering and management.

The newly formed CSO coalition on RMNCH aims to effectively advance national commitments to improve women's and children's health and to accelerate progress in achieving MDGs 4 and 5 by supporting coordinated RMNCH advocacy at all levels and by working with parliament to achieve the implementation of the national MDG Acceleration Framework. To underscore the crucial importance of their work, members agreed to support the financial obligations of the coalition themselves.

Coalition aims for 2013

- I. Discuss common priorities for advocacy on RMNCH in Ghana.
- II. Identify approaches, strategies and joint activities to be adopted in the collaborative effort.
- III. Identify and address capacity needs of members in order to better deliver RMNCH advocacy.
- IV. Create a national work plan for advocacy to support the Global Strategy and the COIA recommendations.

In addition, in 2013, the coalition aims to monitor the Ghanaian government's commitment towards the Global Strategy by advocating for the following:

- A significant increase in health funding.
- 95% of Ghanaian women to have access to comprehensive prevention of mother-to-child transmission (PMTCT).
- 85% of pregnant women and children under five to sleep under insecticide treated nets.

Harmonizing partner efforts linked to evidence-based advocacy

E4A is a five-year programme that aims to improve maternal and newborn survival in six sub-Saharan countries. Funded by the UK Department for International Development (DfID), it focuses on using better evidence and improved advocacy and accountability to save lives in Ethiopia, Ghana, Malawi, Nigeria, Sierra Leone and Tanzania. The core objectives of E4A include:

- *To develop and implement a tailored methodology that provides evidence on maternal and newborn mortality for context-specific planning;*
- *To support the actions of maternal and newborn health advocates at regional, national and sub-national levels in the generation and use of MNH data;*
- *To strengthen accountability mechanisms at all levels for progress on maternal and newborn health (MNH).*

In Ghana, PMNCH and E4A efforts are being implemented in a complementary manner. The CSO coalition provides a space for the use of the evidence-based materials supported by E4A partners and provides a platform for the implementation of E4A advocacy initiatives.

Conclusion

The national RMNCH CSO coalition in Ghana is now in a strong position to work with government and other organizations to advocate for improved RMNCH outcomes and to have a positive impact on influencing the social determinants of health in the country.

RMNCH situation

Region

- Africa

Population

- 25 million*

U5MR

- 74 per 1000 live births in 2010 (from 122 in 1990)^{xi}

MMR

- 350 per 100 000 live births in 2010 (from 540 in 2000)^{xii}

Challenges

- About 80% of maternal deaths are due to direct causes, such as severe bleeding, infections and eclampsia. The remaining 20% of deaths are often from preventable causes (anaemia, malaria and HIV)^{xiii}

Social factors

- Poor infrastructure; gender inequities; low literacy rates among women; harmful cultural norms and practices.

Health sector factors

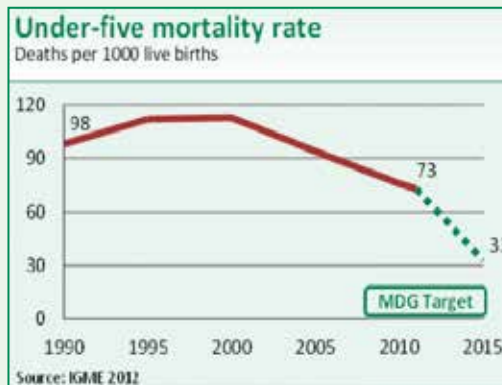
- Inadequate supplies; too few midwives and obstetricians; substandard health facilities; lack of emergency obstetric care services and facilities.

Key initiatives/commitments

- 1987 – Safe Motherhood Initiative
- 1995 – National Safe Motherhood Programme
- 1999 – The Ghana Community Based Health Planning (CHPS)
- 2000 – Adolescent Reproductive Health Policy
- 2006-10 – Roadmap for repositioning family planning in Ghana
- 2007-11 – Reproductive Health Strategic Plan
- 2008 – Free Maternal Healthcare Initiative



Photo: WHO /Christopher Black



Introduction

CSOs active in Kenya cover the full RMNCH continuum. Before 2012, some had already formed partnerships and successfully worked together around particular aspects of RMNCH. However, coordinated messaging around RMNCH advocacy was a challenge, particularly when engaging with government.

In May 2012, Family Care International (FCI) and the African Women's Development and Communication Network (FEMNET) led a consultation with key RMNCH advocacy organizations in Nairobi to discuss advocacy strategies for RMNCH. The aim was to ensure the implementation of Kenya's commitments to the Global Strategy, as well as other key regional and national commitments. During this meeting, it was agreed that a CSO coalition was urgently needed to harmonize various advocacy efforts and ensure successful collaboration between CSOs and government.

As a result of this meeting, the development of an implementation workplan to form a new CSO coalition to advocate for RMNCH was initiated. A national steering committee, chaired by FCI and FEMNET, was also formed to oversee operations of the coalition.

Kenya timeline for RMNCH commitments



The National CSO steering committee is currently engaged in the following activities:

- Developing terms of reference for the national coalition and national steering committee.
- Undertaking an in-depth mapping of key advocacy partners addressing advocacy programmes and gaps.
- Convening a capacity building workshop to respond to RMNCH advocacy gaps.
- Developing a CSO position paper, a national coalition strategic framework, and action plan.
- Building the capacity of CSOs on areas of need (informed by an in-depth mapping).

Coalition aims for 2013

- I. Build on initial advocacy activities by planning future efforts, including a briefing with the Ministry of Health.
- II. Create a national CSO advocacy strategy.
- III. Link national advocacy strategies with regional efforts.
- IV. Continue and grow collaboration between CSOs to support RMNCH advocacy efforts.
- V. Mobilize additional funding (as already awarded to FCI) to support national RMNCH advocacy efforts, in particular a Kenya Country Countdown process.

Increasing advocacy impact in Kenya

At the May 2012 meeting convened by FCI Kenya and FEMNET (outlined above), 21 CSO participants discussed best practice, challenges and ways to increase the effectiveness of advocacy around RMNCH issues.

Key recommendations for moving forward included:

- Lobbying for increased financial support
- Developing a harmonized communications strategy
- Improved political engagement,
- Conducting a skills mapping of CSOs
- Enhancing capacity to support RMNCH advocacy

Conclusion

The launch of the national CSO coalition addresses a clear need for better coordination between CSOs for improved advocacy on RMNCH issues. With the effective support and leadership of FCI and FEMNET, the national coalition will continue to provide targeted capacity-building to strengthen CSOs advocacy efforts for effective delivery.



UN Photo / Albert Gonzalez Farran

RMNCH situation

Region

- Africa

Population

- 41 million^{xiv}

U5MR

- 85 deaths per 1000 live births in 2010 (99 in 1990)^{xv}

MMR

- 360 deaths per 100 000 live births in 2010 (400 in 1990)^{xvi}

Challenges

- 56% of births are not assisted by a skilled birth attendant^{xvii}
- 40% of women have an unmet need for family planning^{xviii}

Social factors

- Cultural norms pose challenges to health behaviour and education

Health sector factors

- Insufficient levels of health financing
- Inefficient and ineffective use of resources allotted for health

Key initiatives/commitments

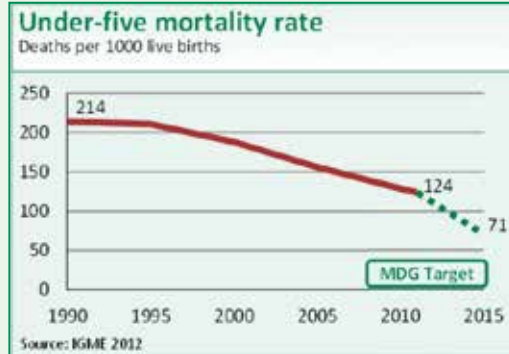
- Kenya has an Adolescent Reproductive Health and Development Policy Plan of Action, a Child Survival and Development Strategy, a National Roadmap for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya and a National Reproductive Health Strategy
- Kenya will launch a National Maternal Health Council, chaired by the President



Nigeria



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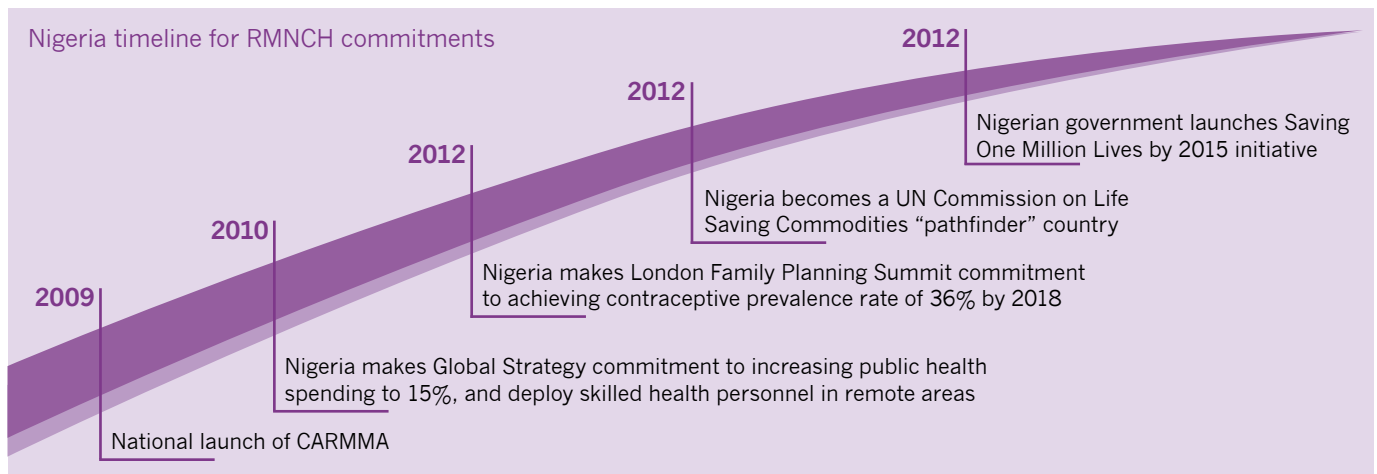


Source & MDG target calculation: Countdown to 2015 Report

Introduction

The collaboration of the Nigeria chapter of the Africa Coalition on Maternal, Newborn & Child Health with the White Ribbon Alliance for Safe Motherhood Nigeria (WRAN) has enabled the creation of Nigeria's first umbrella network for RMNCH advocacy. Through the catalytic support of PMNCH, this umbrella network carried out a mapping exercise, identifying about 128 CSOs actively involved in RMNCH social determinants (water, nutrition, sanitation and hygiene, environment, education etc.), strengthening health systems, policy and research and women's and children's rights. The Africa MNCH Coalition Nigeria and WRAN organized a consultation in Lagos in August 2012, bringing these CSOs together with media organizations.

Through discussion, participants identified key issues and advocacy opportunities, and agreed on the need for CSOs to work together as a collaborative platform, to unite and focus RMNCH advocacy in Nigeria. It was also agreed that the Africa MNCH Coalition Nigeria, which already works with WRAN and whose membership covers the entire continuum of care, from preconception to child health, should continue to mobilize all CSOs working on improving maternal and child health outcomes.



Coalition aims for 2013

- I. Push for continued advocacy engagement with government and parliamentarians to improve the implementation of existing national RMNCH policies and plans, accountability to RMNCH commitments (global and African) and increase budgets for overall health.
- II. Research and produce Nigeria-specific knowledge products, disaggregated by state and highlighting challenges and required interventions.
- III. Mobilize active media participation in the Nigeria RMNCH advocacy process through a media event and site visit to a maternity hospital. This is intended to strengthen the media's understanding of RMNCH and to encourage reporting of maternal and newborn health issues.
- IV. Mobilize active community participation in RMNCH advocacy and raise awareness of the right to health through outreach, aimed at women, faith-based groups and professional and community associations. This strategy is intended to tackle the challenge posed by myths and misconceptions that limit the uptake of RMNCH services, particularly antenatal and immunization services at the grass-roots level.

Working collaboratively to advocate for RMNCH

The national civil society consultation in Lagos (described above) identified national RMNCH advocacy priorities and developed a national RMNCH advocacy workplan, which will drive civil society advocacy action on RMNCH in Nigeria.

The following national RMNCH advocacy priorities were identified:

- Address reproductive, sexual, youth & adolescent health and family planning;
- Increase supply and access to commodities, pharmaceuticals, immunization and vaccination;
- Increase MNCH services and human resources for health;
- Improve newborn and child health survival and address social determinants;
- Improve health financing & investment;
- Tackle HIV/AIDS, tuberculosis and malaria;
- Improve investment in civil registration and statistics.

Conclusion

The Nigeria CSO coalition is poised to become the central point of engagement for government in relation to civil society input on national plans and policies. To facilitate this, the CSO coalition has now joined the National MNCH Core Technical Committee, hosted by the Department of Family Health, Federal Ministry of Health.



RMNCH situation

Region

- Africa

Population

- 158 million^{xix}

U5MR

- 143 per 1000 live births in 2010 from 213 in 1990^{xx}

MMR

- 630 per 100 000 live births in 2010 from 1100 in 1990^{xxi}

Challenges

- Maternal mortality from causes such as haemorrhage, infection, unsafe abortion, obstructed labour and eclampsia/hypertension. Diseases such as malaria, anaemia and HIV/AIDS are also common causes of maternal death
- The main causes of child mortalities include preventable diseases such as malaria, pneumonia, diarrhoea and malnutrition

Social factors

- 62% of births in Nigeria occur at home^{xxii}

Health sector factors

- Low levels of birth attendance by skilled personnel
- Lack of adequate supplies, equipment and human resources; poor health infrastructure; insufficient budgeting for health

Key initiatives/commitments

- The Community Health Insurance Scheme and the Midwives Service Scheme include a focus on the establishment of maternal and child health centres

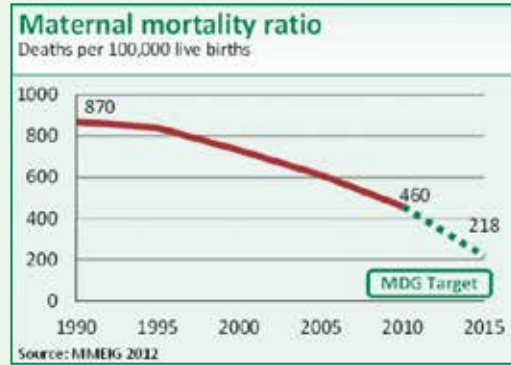
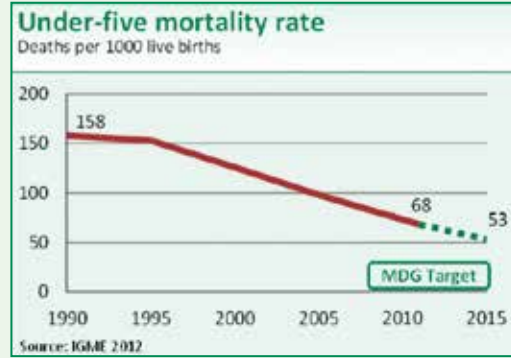


Tanzania

Convening CSO Partners:



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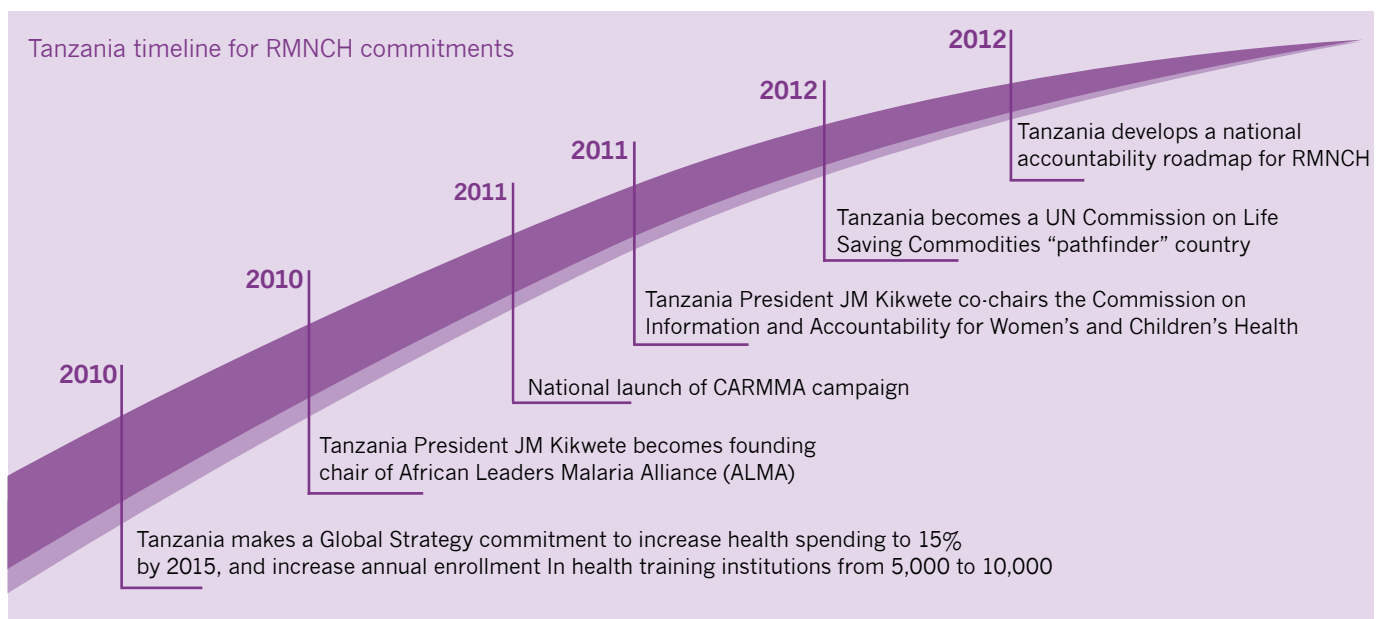


Source & MDG target calculation: Countdown to 2015 Report

Introduction

In May 2012, White Ribbon Alliance Tanzania (WRATZ) and the Tanzania Midwives Association (TAMA) invited 40 key partners focusing on all issues across the continuum of care and from different regions across Tanzania to collaborate on improving RMNCH outcomes. These CSOs met to discuss how best to work together on RMNCH advocacy. At this meeting a number of strategies and actions were agreed upon, primarily focused on the recognition of the need for an increase in skilled health professionals, including midwives.

This newly formed partnership builds on previous collaborative efforts in Tanzania such as the Tanzania Partnership for Maternal, Newborn and Child Health (TPMNCH), which was launched in 2007 alongside the PMNCH Partners Forum.



Coalition aims for 2013

- I. Work closely with media and parliamentarians to advocate for midwives and midwifery.
- II. Consider working with the US Peace Corps and Voluntary Service Overseas, (VSO) to employ volunteer nursing and midwifery tutors.
- III. Use personal testimonies of midwives to raise awareness of the profession among young people.
- IV. Produce posters and leaflets and other materials for distribution and exhibition in schools.
- V. Find cost-effective ways to work with the media to execute CSO coalition advocacy strategies.
- VI. Work with Council Management Team and District Executive Directors in providing financial incentives to enable youths to train as midwives.
- VII. Identify five RMNCH priorities to convince donors and development partners to support the recruitment, training, employment, retention and improvement in working conditions for midwives.
- VIII. Encourage WRATZ members to financially support H.E. Mrs Salma Kikwete in hosting a high-level advocacy event to which prominent public figures and organizations would be invited to promote midwifery.

Working together to Advocate for Midwifery

In the second phase of the CSO coalition, TAMA and WRATZ launched a campaign to encourage young people to train as midwives, called “Be in Science, Choose Midwifery”. In collaboration with Restless Youth for Development and Evidence for Action, TAMA and WRATZ developed an advocacy package geared towards encouraging youth to choose “midwifery as a life-saving career”. The advocacy package outlines the burden of women’s and children’s mortality and positions midwives as central to the strategy to improve women’s and children’s health. It also outlines the roles of policy-makers in promoting midwifery training and increasing the budget allocation for it.

This material is being distributed through youth clubs, beginning in Mtwara. Members of the CSO coalition are each responsible for setting up a youth club and implementing the campaign in their respective regions, and reporting back on progress to TAMA and WRATZ.

Conclusion

Alongside the commitments made by government, the CSO coalition led by WRATZ and TAMA is working effectively to improve RMNCH outcomes in Tanzania. Currently it is mainly focused on addressing the lack of skilled health professionals in the country, but the coalition is beginning to work with new partners to address RMNCH more widely.



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RMNCH situation

Region

- Africa

Population

- 44.8 million^{xxiii}

U5MR

- 76 per 1000 live births in 2010 (from 155 in 1990)^{xxiv}

MMR

- 460 per 100 000 live births in 2010 (870 in 1990)^{xxv}

Challenges

- A high percentage of maternal deaths are from preventable causes such as haemorrhage (34%)^{xxvi}
- 130 000 children under five die each year (36% of these are neonatal deaths)^{xxvii}

Social factors

- Only 51% of women deliver at health care facilities^{xxviii}

Health sector factors

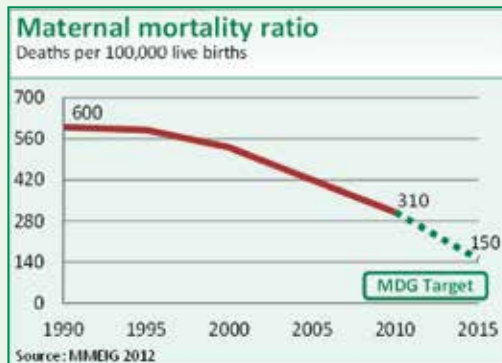
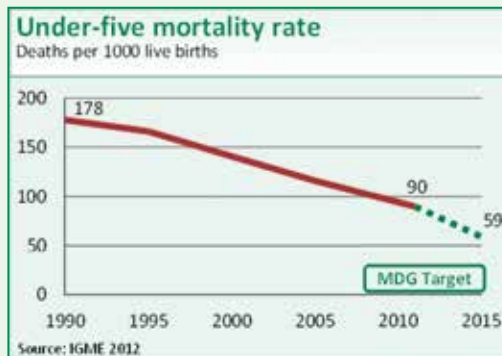
- Lack of skilled staff; poor access to health care
- Only 2.5 doctors, nurses and midwives per 10 000 people^{xxix}
- Currently no community treatment with antibiotics of pneumonia, which causes 15% of under-five deaths^{xxx}

Key initiatives/commitments

- President Kikwete launched a national campaign for improved health outcomes in 2008 – Deliver Now for Women and Children in Tanzania. This followed the launch of a national Tanzanian multistakeholder partnership for RMNCH in 2007
- Tanzania also benefits from a National Roadmap Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths



Photo: WHO /Christopher Black



Source & MDG target calculation: Countdown to 2015 Report

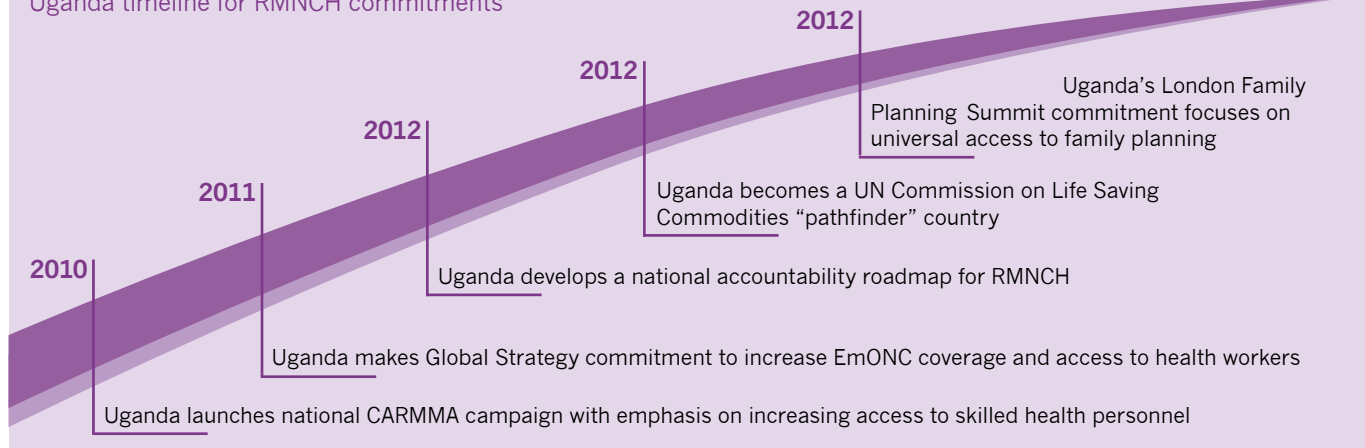
Introduction

In March 2012, African Centre for Global Health and Social Transformation (ACHEST) and World Vision Uganda (WVU) began a process to scale up MNCH partnership among CSOs by strengthening CSO alliances to improve RMNCH outcomes in Uganda. This coalition built on CSO joint advocacy campaign in Uganda to help shape the Inter-Parliamentary Union resolution (proposed by Uganda, India and Canada) on RMNCH.

To begin, ACHEST coordinated a mapping exercise of RMNCH stakeholders. The report was shared with key stakeholders and shaped engagement of additional members. In November 2012, following a consultative stakeholder meeting, the coalition developed a workplan that included raising awareness on the need for improved CSO collaboration, sharing and disseminating information and mobilizing resources.

The initiatives undertaken by the coalition focus on Uganda's commitments related to the Global Strategy,, CARMMA and Scaling Up Nutrition (SUN) and will be monitored through a national Countdown process. Resources permitting, the coalition plans to develop a three-year costed strategic plan. The coalition currently obtains its funding from its members through a voluntary contribution mechanism.

Uganda timeline for RMNCH commitments



The coalition has conducted some successful joint advocacy. In April, 2012 the coalition and the Uganda Parliament co-hosted three side events at the 126th IPU Assembly, where they advocated for the IPU to retain RMNCH on its agenda. Delegates passed the RMNCH resolution during the Assembly. Between April and June 2012, the coalition members worked very closely with the Parliamentary Budget Committee to advocate for the allocation of more resources for health in the national budget.

Coalition aims for 2013:

- I. Continue with mobilization and awareness on RMNCH to catalyse action among key stakeholders for reducing maternal and child deaths.
- II. Health budget advocacy for investment in increasing numbers of health staff, drugs and supplies, family planning and EmOC equipment.
- III. Strengthen the coalition in terms of coordination and monitoring.
- IV. Work in collaboration with MoH to undertake a Uganda Country Countdown in 2013.

The coalition will achieve these objectives through awareness creation activities, especially at the community level; advocacy for policy change using media, parliamentarians and community actors as key strategies; building the required evidence base to influence policy (this will include supporting a national Countdown to 2015 process) and strengthening collaboration to ensure linkages between district level dialogues and national level advocacy initiatives.

Collaborating with parliamentarians to increase health budget allocation

Following the presentation of the Uganda national budget in June 2012, the CSO coalition on RMNCH organized a lobbying meeting that targeted parliamentarians. The major objective of this event was to raise RMNCH issues that required additional budget allocation to the health sector, particularly the crisis in human resources for health and supplies to health centres. A village health team representative from Kiboga district, Mr Kasirye, provided a professional testimony on MNCH realities at community level. In her closing remarks, Hon. Sylvia Namabidde, an MNCH champion and member of parliament, said: "...given the evidence on the ground, as legislators we are going to block the budget until more budgetary resource is allocated to the health sector".

In September 2012, the coalition worked with legislators to delay the budget approval process by two weeks, until an additional US\$260 billion (approximately US\$ 100 million) was allocated to the health sector. The CSO coalition provided data and evidence to parliamentarians, who championed the need for an increased health budget. The coalition also conducted a grass-roots mobilization strategy, where community members sent SMS messages to their constituency parliamentary representatives to encourage them to advocate for the well-being of mothers and children.

With sustained pressure, the Parliamentary Budget Committee allocated an additional US\$49.5 billion (nearly US\$ 20 million) for the 2013/14 financial year, primarily to recruit health workers and also to enhance staff motivation for doctors. The money for recruitment was released and to date over 6,000 additional medical workers have been recruited.

Conclusion

The CSO coalition on RMNCH in Uganda has the potential to galvanize energies and stimulate accelerated political action towards the achievement of MDGs 4 and 5. This will be achieved through establishing an inclusive and focused movement, fighting for mothers and children to enjoy their right to health.

RMNCH situation

Region

- East Africa

Population

- 3 million^{xxx}

U5MR

- 99 per 1000 live births in 2010 (175 in 1990)^{xxxii}

MMR

- 310 per 100 000 live births in 2010 (600 in 1990)^{xxxiii}

Challenges

- Coverage of key interventions to improve maternal health remains low and unequal

Health sector factors

- Limited human resources; lack of equipment and supplies; delays in release of funds; limited funding and capacity at district level

Key initiatives/commitments

- Uganda has various strategies for improved women's and children's health including the 2008 Roadmap for the Accelerated Reduction of Maternal and Child Mortality
- Uganda is a part of Scaling up Nutrition, and has also developed a cross sectoral strategy to improve nutritional status
- Uganda has also been critical in positioning women's and children's health as a global priority as seen through Uganda's leadership of the Inter-Parliamentary Union resolution on RMNCH



Asia

Bangladesh

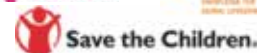
India

Indonesia



Bangladesh

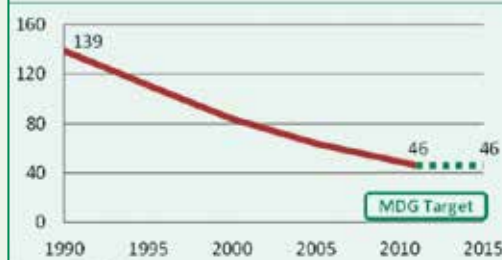
Convening CSO Partners:



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Under-five mortality rate

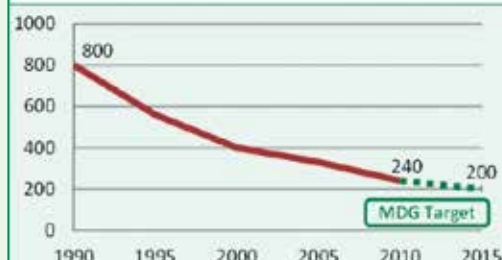
Deaths per 1000 live births



Source: IGME 2012

Maternal mortality ratio

Deaths per 100,000 live births



Source: MMEIG 2012

Source & MDG target calculation: Countdown to 2015 Report

Introduction

Save the Children Bangladesh, the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and Bangladesh Rehabilitation Assistance Committee (BRAC) have been collaborating on the development of a multi-stakeholder coalition to reinvigorate joint advocacy for RMNCH in Bangladesh.

These agencies convened a National Advocacy Stakeholder Meeting for Greater Action and Accountability for Women's and Children's Health on 5 July 2012. This was attended by a variety of health-care professionals, development partners and other stakeholders, including members of the national MNCH task group – previously formed in 2009 and chaired by the Ministry of Health and Family Welfare (MOHFW). The purpose of this meeting was to raise awareness of global processes in support of women's and children's health, and to encourage discussion on ways to better support national efforts and identify joint advocacy opportunities for RMNCH in Bangladesh.

At the meeting last July, partners agreed to build on a 2010 mapping to identify additional stakeholders to involve in coalition and subsequent advocacy strategies to improve RMNCH in Bangladesh.

The coalition has worked with the Ministry of Health and other national and international partners to finalize a Bangladesh Case Study on Reproductive, Maternal, Newborn and Child Health, and to identify future actions to address bottlenecks to improved women's and children's health and to identify related advocacy strategies. This case study was presented at the PMNCH-led Asia-Pacific Leadership and Policy Dialogue meeting for women's and children's health, held in Manila in November 2012.

Bangladesh timeline for RMNCH commitments

2010

Bangladeshi Prime Minister Sheikh Hasina makes a Global Strategy commitment to increasing skilled birth attendance and halving unmet need for family planning by 2015

2012

Bangladesh makes a commitment at the London Family Planning Summit to increasing access to family planning services with a focus on adolescents

2012

Bangladesh commits to A Promise Renewed

Coalition aims for 2013

- I. Identify initiatives working on newborn health, particularly prematurity.
- II. Strengthen initiatives to increase skilled birth attendance.
- III. Increase the use of antenatal care to reduce preterm death, and chlorohexidine to reduce deaths caused by pneumococcal neonatal infections.
- IV. Increase the recruitment, training and employment of skilled birth attendants.

Lead partners of the CSO coalition will also explore the possibility of setting up a separate CSO working group on RMNCH to provide a space for collaboration for the constituency members.

National Seminar and Collaborative Action – RMNCH Coalition meets on World Prematurity Day

On 17 November 2012, the coalition in Bangladesh, along with UNICEF, WHO, Bangladesh Neonatal Forum (BNF), Bangladesh Perinatal Society, ICDDR, the Saving Newborn Lives Program and the USAID funded Maternal Newborn Child Health Integrated Program (implemented by Save the Children), jointly organized a stakeholder consultation on the occasion of World Prematurity Day. This high-level meeting was attended by programme directors at the MOHFW, key organizational leaders, and development partners. The seminar covered a range of topics, including the country situation on prematurity and its consequences, as well as evidence for low-cost interventions to reduce preventable maternal, newborn and child deaths.

A broad consensus was reached on including interventions such as Kangaroo Mother Care and Antenatal Corticosteroid into national programming to improve RMNCH. The seminar also agreed on a set of advocacy activities, for which funding was committed and which are expected to be scaled-up across the country.

Conclusion

Despite the commitment of national government and its development partners, efforts to improve RMNCH in Bangladesh have often been hampered by a lack of regular and widespread collaboration along the continuum of care. The reinvigoration and widening of the national coalition has begun to create a more effective climate of collaboration between MOHFW and local, regional and global organizations. A diverse group of stakeholders and partners are now working closely with government to improve RMNCH in the country.



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RMNCH situation

Region

- South Asia

Population

- 14.8 million^{xxxiv}

U5MR

- 48 per 1000 live births in 2010 (from 143 in 1990)^{xxxv}

MMR

- 240 per 100,000 live births in 2010 (from 800 in 1990)^{xxxvi}

Challenges

- 60% of all U5 deaths are newborn; most causes of maternal deaths are preventable e.g. haemorrhage (35%), unsafe abortion (10%) and hypertension (17%)^{xxxvii}

Social factors

- Poverty; gender inequities; lack of women's education; child nutrition (41% children under five are underweight)^{xxxviii}

Health sector factors

- Lack of emergency obstetric and postnatal care (only 27% of women and babies receive care within two days of birth)^{xxxix}
- Health-worker shortages (only 5.7 doctors, nurses or midwives per 10 000 people)^{xl}

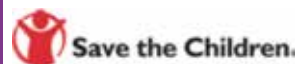
Key initiatives/commitments

- Health, Population and Nutrition Sector Development Programme 2011-2016 (20% of its budget is for RMNCH)
- Government plans to update the 2001 National Maternal Health Strategy

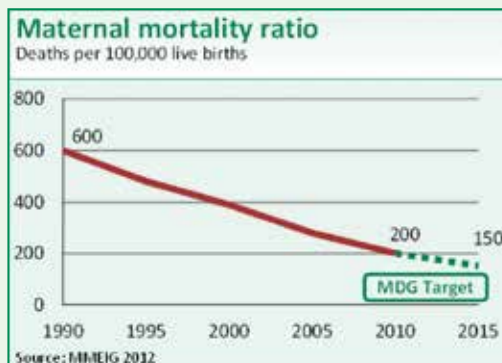
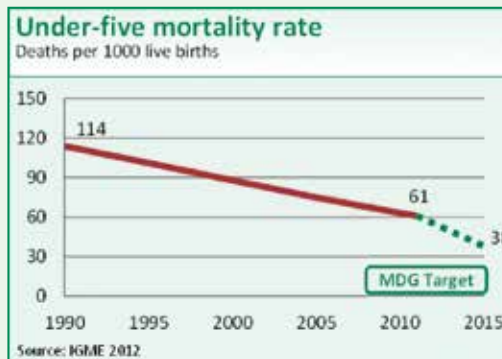


India

Convening CSO Partners:



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Source & MDG target calculation: Countdown to 2015 Report

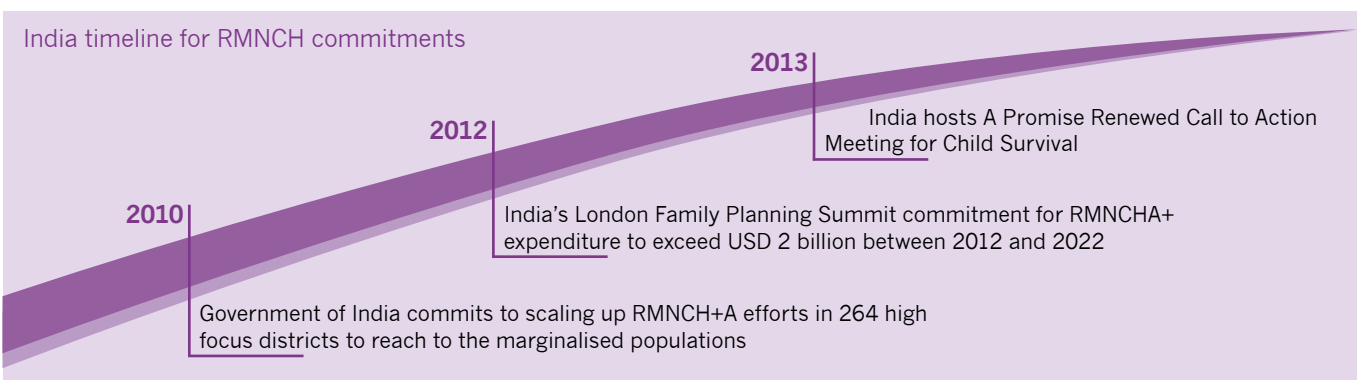
Introduction

Through an order from the Government of India, the Ministry of Health and Family Welfare (MOHFW) created a coalition for reproductive, maternal, newborn, child and adolescent health (RMNCH+A) on 1 May 2012. The objective was to “advocate for policy and programme directions towards improved reproductive, maternal, newborn and child health outcomes in India”.

The first of its kind, the coalition has authority to provide direction and advocate for RMNCH+A policy and programming. Members include central and state government agencies, academia, research and training institutes, health care professional associations, local bodies (*panchayats and nagarpalikas*), non-governmental organizations, faith-based organizations (FBOs), media, corporate organizations, bilateral and multilateral donors and United Nations agencies.

Hosted by Save the Children, the coalition aims to work more effectively with stakeholders to enhance joint action and accountability, and to support the implementation of national commitments and policies, as well as those made within the context of regional and global frameworks – such as the Global Strategy for Women’s and Children’s Health. The coalition held its first and second meetings on 21 November and 19 December 2012.

The meetings identified programming, advocacy, strategy and capacity building priorities and agreed the roles of each member organization and an immediate action plan (see below).



Coalition aims for 2013

- I. Mapping of donor partners.
- II. Mapping of RMNCH+A projects at district and sub-district level, and the selection of interventions that can be scaled to impact outcomes.
- III. Document global success stories of other countries in improving RMNCH+A outcomes.
- IV. Provide support to individual states to implement the universal screening of neonates and children programme (and once this begins post-November 2014, develop a monitoring framework).
- V. Publicize the coalition and its aims through a website, newsletter and other activities.
- VI. Disseminate The Book of Proceedings: a national consultation on the potential role of private sector providers in delivering essential neonatal care services and provisions in under-served urban and peri-urban settings.

Call to Action India

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

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

Declaration is available at:

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

Conclusion

Through the unique RMNCH+A coalition and its sub-group of NGOs and FBOs, a diverse range of different organizations and stakeholders has been formally brought together to work with government on improving RMNCH+A outcomes. The coalition, in partnership with government, possesses a clear strategy for accelerating the rate of progress on RMNCH outcomes in India.



RMNCH situation

Region

- South Asia

Population

- 1.24 billion^{xli}

U5MR

- 55 per 1000 live births in 2010 (from 115 in 1990)^{xlii}

MMR

- 212 per 100 000 live births in 2010 (from 600 in 1990)^{xliii}

Challenges

- 52% of under-five deaths are neonatal; many children under five die from preventable causes such as pneumonia (23%) and diarrhoea (12%)^{xliv}

Social factors

- Sizeable inequities between different geographical areas

Health sector factors

- Lack of skilled health practitioners
- Poor access to and training in the use of essential medicines

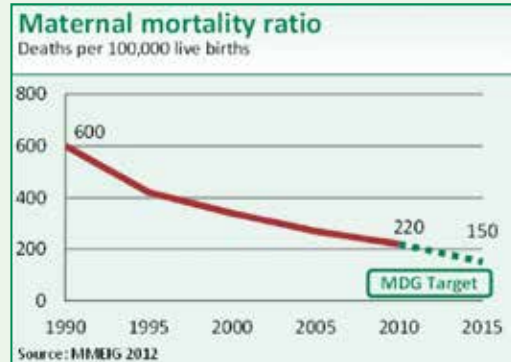
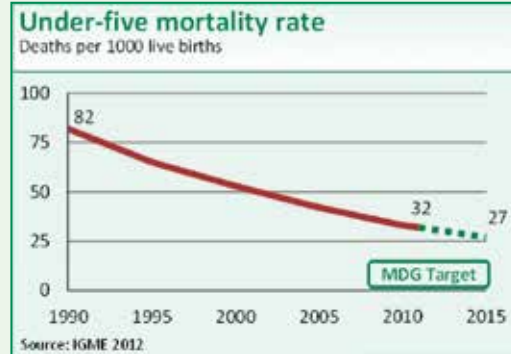
Key initiatives/commitments

- 1951 India launched first family planning programme in the world
- 1977 Maternal and Child Health became integral part of family planning programme
- 1983 National Health Policy.
- 1992-3 Child Survival and Safe Motherhood Programme (CSSM), funded by the World Bank and UNICEF
- 1997-8 Reproductive Child Health Programme incorporated within CSSM
- By 2010, India was spending over US\$ 3.5 billion on health services, including significant investments in the JSY cash-transfer program to improve facility-based delivery and maternal and newborn health outcomes
- India is expected to spend more than US\$ 2 billion from 2012 to 2020 on RMNCH and adolescent health

Indonesia



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Source & MDG target calculation: Countdown to 2015 Report

Introduction

In 2012, the Indonesian Family Planning Association (PKBI) and World Vision Indonesia utilized the catalytic funding provided by PMNCH to expand and strengthen an existing CSO coalition. The coalition conducted a mapping to identify organizations involved in RMNCH and now holds stakeholder meetings at least once per quarter to agree collaborative RMNCH advocacy workplans. The CSOs have set up a voluntary contribution mechanism that allows them to jointly fund their efforts. Through this collaboration, CSOs jointly engaged in legislative drafting of government regulations, such as the Country Accountability Framework, and national roadmap to translate the recommendations of the Commission on Information and Accountability into action in the country. The CSOs are encouraging partners at district level to engage with local UN agencies and NGOs to improve the coordination of programme implementation.

The coalition has conducted a capacity-building exercise on RMNCH indicators, and have looked at policy analysis, resource tracking and local-level advocacy. Its activities have also included research into levels of awareness of national breastfeeding legislation among health professionals, as well as a workshop on adolescent health. A media briefing was held to update national media on the status of RMNCH and to provide information on the work of the coalition. In August 2012 a second media gathering on the Mother-Baby Friendly Workplace was held, attended by more than 25 journalists and 40 I/NGOs. This resulted in the publication of at least 15 printed and online articles on RMNCH issues.

The CSO coalition builds on a network created in 2010 with support from the Ministry of Health, the Ministry of People's Welfare, the World Health Organization (WHO) and UNICEF. It followed on from World Vision's global 2009 Child Health Now Campaign, and a national workshop on the Millennium Development Goals (MDGs) conducted by the Government with support from donor agencies.



Coalition aims for 2013

- I. Mobilize and build awareness of all RMNCH stakeholders to take action on government commitments to the Global Strategy (i.e., more skilled birth attendants and increased health budget).
- II. Mobilize parliaments, media, and civil society to promote the implementation of the Country Accountability Framework.
- III. Improve the implementation of national regulation on exclusive breastfeeding and its acceleration plan for 2012-2014, International Code on Marketing of Breast-Milk Substitutes, 10 Steps to Successful Breastfeeding (Baby Friendly Hospital Initiative), and Mother-Baby Friendly Workplace.
- IV. Influence the policy on neonatal visits by community (voluntary) health workers.
- V. Advocate for the improvement of quality youth-friendly adolescent health services.
- VI. Advocate for the improvement of quality of comprehensive Emergency Obstetric and Newborn Care (EmONC) services in hospitals and health centres.
- VII. Improve the quality integrated health post services and competency of community (voluntary) health workers.

Mapping RMNCH stakeholders in Indonesia – a joint effort underpinning the development of a comprehensive RMNCH CSO advocacy network for Indonesia

Civil society partners, as part of their efforts to engage the widest range of stakeholders in their advocacy efforts, conducted a rapid mapping that yielded useful information for the Ministry of Health and other health actors. Partners contacted district health officers throughout the country and asked them to provide information on all organizations involved in RMNCH in Indonesia and specifically in their region.

This mapping identified 27 organizations operating in 27 provinces (out of 33 provinces). It noted that 62% of the organizations engaged in RMNCH at the national and provincial level are national NGOs. The mapping noted that, at provincial level, most actors are engaged in promoting awareness of infant and young child feeding, community-based integrated management of childhood illness, integrated health post strengthening and HIV/AIDS awareness. At the national level, however, some actors are engaged in advocacy initiatives.

Conclusion

Under the concept of the continuum of care, the CSO coalition in Indonesia has brought together CSOs and networks in a platform that is jointly funded, and which plans and acts together. Through this collaboration the coalition is now becoming a strong voice in shaping the RMNCH dialogue in Indonesia.



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RMNCH situation

Region

- South East Asia

Population

- 240 million^{xlv}

U5MR

- 35 per 1000 live births in 2010 (from 85 in 1990)^{xlvi}

MMR

- 220 per 100 000 live births in 2010 (from 600 in 1990)^{xlvii}

Challenges

- Reductions in MMR and U5MR in recent years have been slow; Inequity in access to services

Social factors

- Regional inequity (14 of Indonesia's 34 provinces have higher U5MR than the national average)^{xlviii}
- U5MR in the lowest wealth quintile is 3.6 times that in the highest wealth quintile^{xlix}

Health sector factors

- Unequal distribution of human resources; lack of equipment and supplies; lack of effectiveness on health spending at all levels, and limited capacity at district level

Key initiatives/commitment

- Infant and Young Child Feeding promotion
- Global Strategy commitment to increase provision of skilled birth attendants and increased national health budget to achieve quality health care and services in all health facilities'
- Universal Delivery Care Scheme to provide free birth delivery at community health services (began in 2011)

Conclusion

The increase in commitments that the RMNCH community has generated in the past three years is a testimony to the incredible momentum behind MDGs 4 and 5. These commitments also increase the need for coordination. CSOs play an important role in holding stakeholders accountable for the implementation of their commitments. Improving collaboration among CSOs and RMNCH stakeholders can strengthen their voice and improve their impact on accountability.

PMNCH support to the strengthening of CSO advocacy coalitions has generated joint advocacy platforms that operate along the RMNCH continuum of care, and in some cases tackle issues around social and environmental determinants of health; as well as undertake joint work planning and priority setting, resource mobilization and implementation. This work has already yielded some successful advocacy initiatives.

Supporting CSO advocacy collaboration in countries remains a critical component of the strategy to achieve MDGs 4 and 5. This will naturally happen at different rates in different countries, according to available resources and factors such as political will and leadership. However, more rapid advances can be made if country CSO coalitions take steps to learn from each other how best to advocate for RMNCH and greater accountability. Recommended actions for the future include increased sharing of best practices across regions and internationally. This report is a contribution to that effort.



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