The PMNCH 2014 Accountability Report

Tracking Financial Commitments to the Global Strategy for Women's and Children's Health

Executive Summary

World Health Organization

The Partnership for Maternal, Newborn & Child Health

Executive Summary

Background

This is the fourth annual report that the Partnership for Maternal, Newborn & Child Health (PMNCH) has undertaken since 2011 on analyzing commitments to the Global Strategy for Women's and Children's Health (Global Strategy) and their implementation.[1] This year's report focuses exclusively on the commitments made to the Global Strategy that were specifically expressed in financial terms. It provides (i) an update on the estimated value of financial commitments, (ii) the progress made in their disbursement and implementation, (iii) an analysis of how these commitments have affected financing for reproductive, maternal, newborn, and child health (RMNCH) more broadly, and (iv) an assessment of the degree to which financial commitments and overall RMNCH funding are aligned with the priorities spelled out in the Global Investment Framework for Women's and Children's Health (GIF), and the Global Health 2035 roadmap, published by The Lancet Commission on Investing in Health (CIH).

The analysis in this report is focused on commitments that were listed on the Every Woman Every Child (EWEC) website, and covers commitments for the timeframe of the Global Strategy (2011–2015).[2]

Core findings

This year's analysis of financial commitments shows a number of encouraging trends in the implementation of Global Strategy commitments and RMNCH financing more broadly, although it also points to important areas requiring additional focus.

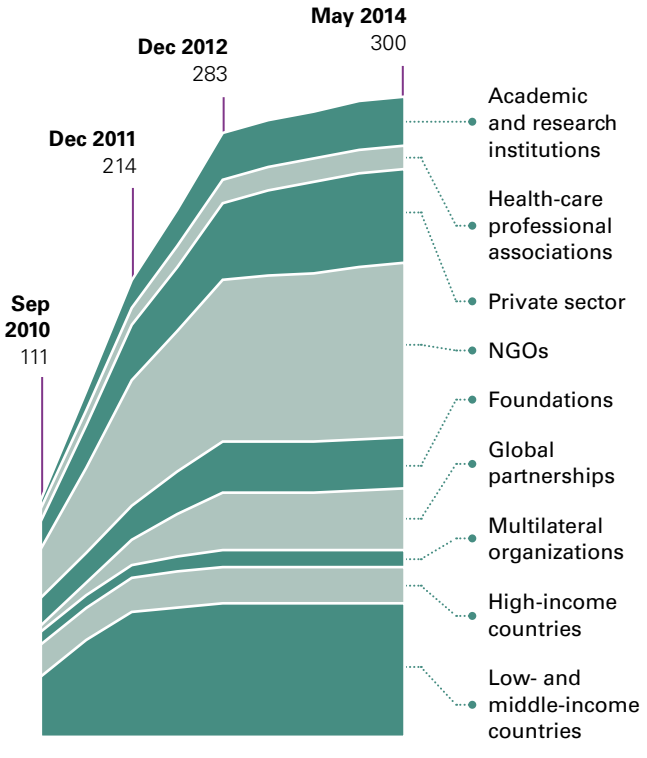
FINDING 1 → The number of commitment-makers has tripled, from about 100 in 2010 to 300 in 2014 (Figure i).[3] The capacity of the EWEC movement to attract and maintain partners over time indicates a high degree of sustained political commitment to women's and children's health. For example, many of the 40 partners making commitments to the Every Newborn Action Plan (ENAP) in 2014 were those who had made previous commitments to the Global Strategy, demonstrating a continued perception of the added value of the EWEC platform.[4]

FINDING 2 → Financial commitments to the Global Strategy have now reached almost US$60 billion (i.e. US$45 billion once doubled-counted* figures are removed). An important feature of the financial commitments is that up to US$22 billion is new and additional funding for women's and children's health. Of this additional amount, US$13–17 billion is targeted at the 49 Global Strategy focus countries, which represents 15–19% of the US$88 billion funding gap for RMNCH between 2011 and 2015.[5] If non-financial commitments were monetized, the value of all commitments would be substantially higher. However, additional financing is still needed to achieve the goals of the Global Strategy and to reach the targets outlined by the GIF and the Global Health 2035 report.

*Double-counting" relates to funding committed twice by different stakeholders: For example, there could be a bilateral donor commitment to a global health partnership that is reported as a Global Strategy commitment by both the donor and the partnership.

Figure i

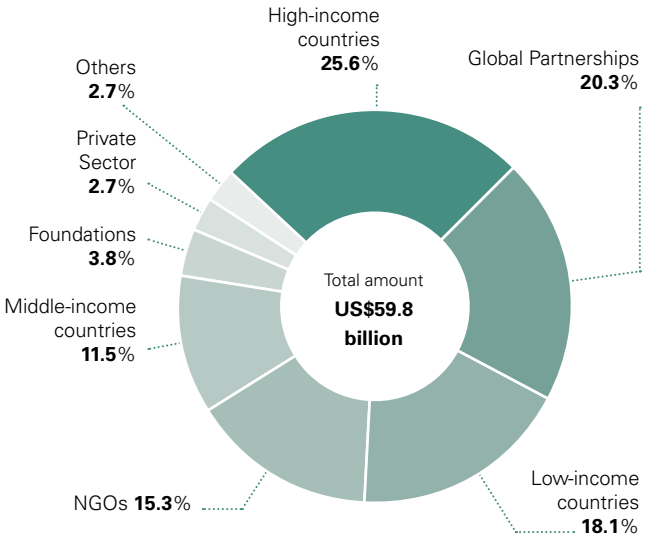
Global Strategy commitment-makers tripled to 300 in 2014 – up from 111 commitment-makers in 2010



Source: Every Woman Every Child website.

Figure ii

Financial commitments to the Global Strategy have reached almost US$60 billion

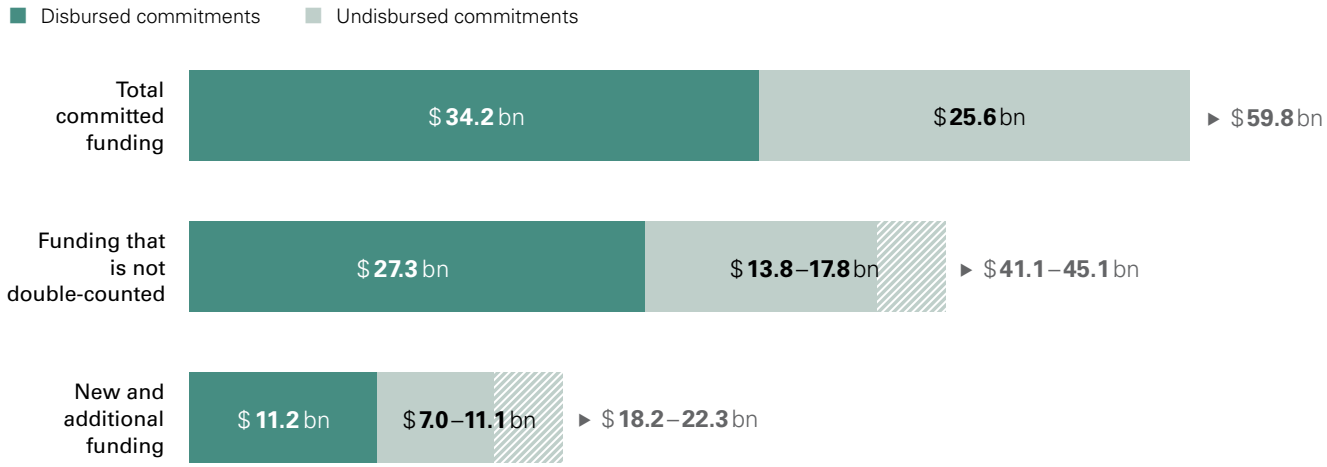


Other includes multilaterals, health care professional associations, and academic, research and training institutions.

Figure iii

Disbursements against Global Strategy commitments

(actual disbursements are likely to exceed those shown; commitment-makers provided data through either Dec. 2012 or Dec. 2013)



Note: Striped green color visualizes range of commitments. "Double-counting" relates to funding committed twice by different stakeholders. New and additional funding relates to investments that stakeholders committed in addition to their RMNCH spending levels prior to the Global Strategy.

FINDING 3 → Commitment-makers are making strong progress with their disbursements. Almost 60% (US$34 billion) of the US$60 billion committed has now been disbursed (Figure iii), and once double-counted funds have been removed; a total of US$27.3 billion has been disbursed to date. However, the true rate of disbursement is likely to be even faster due to delays in the reporting of disbursements. Figure iv shows the steady upward climb in disbursement of committed funds over time – from 20.1% of committed funds in 2012 to 57.2% in 2014 (Figure iv).

FINDING 4 → The Global Strategy has positively influenced international donors. The overall analysis of trends in donor funding for RMNCH indicates that the Global Strategy has made an impact on RMNCH donor financing.[6] Donors disbursed a total of US$6.8 billion to improve RMNCH in the 49 Global Strategy countries in 2012, an increase of 11.1% since the launch of the Global Strategy in 2010. Disbursements to the 75 Countdown to 2015 (Countdown) priority countries rose from US$8.0 billion in 2010 to US$8.7 billion in 2012, a growth of 8.4% (Figure v).[7] Donors who are also major commitment-makers to the Global Strategy drove this increase. Data provided for this report signal further growth in RMNCH donor funding in 2013.

Figure iv

Trends in Global Strategy disbursements

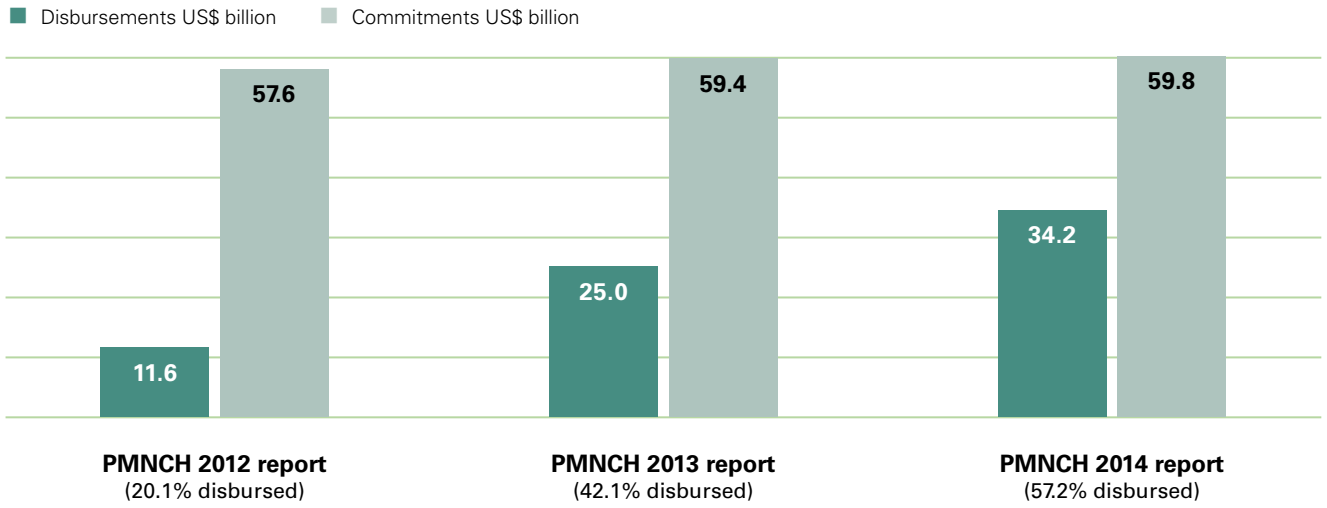
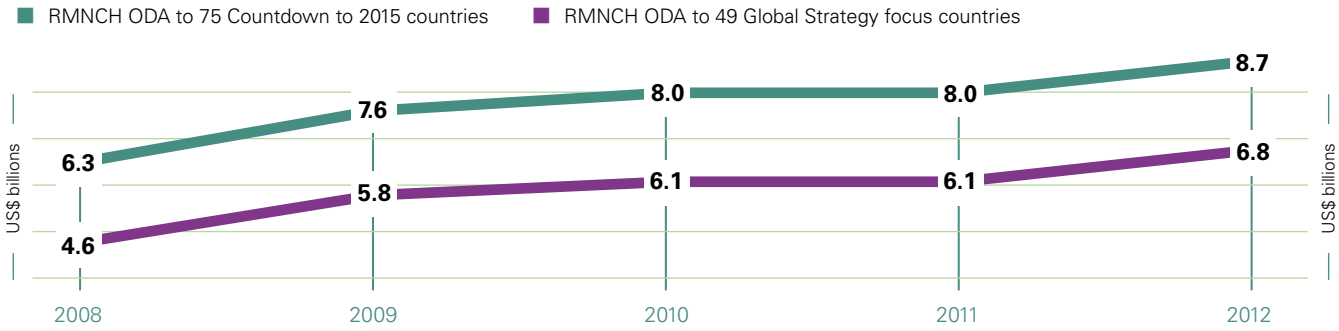


Figure v

Overall ODA for RMNCH continues to show an upward trend – but is still short of need



Source: OECD CRS.

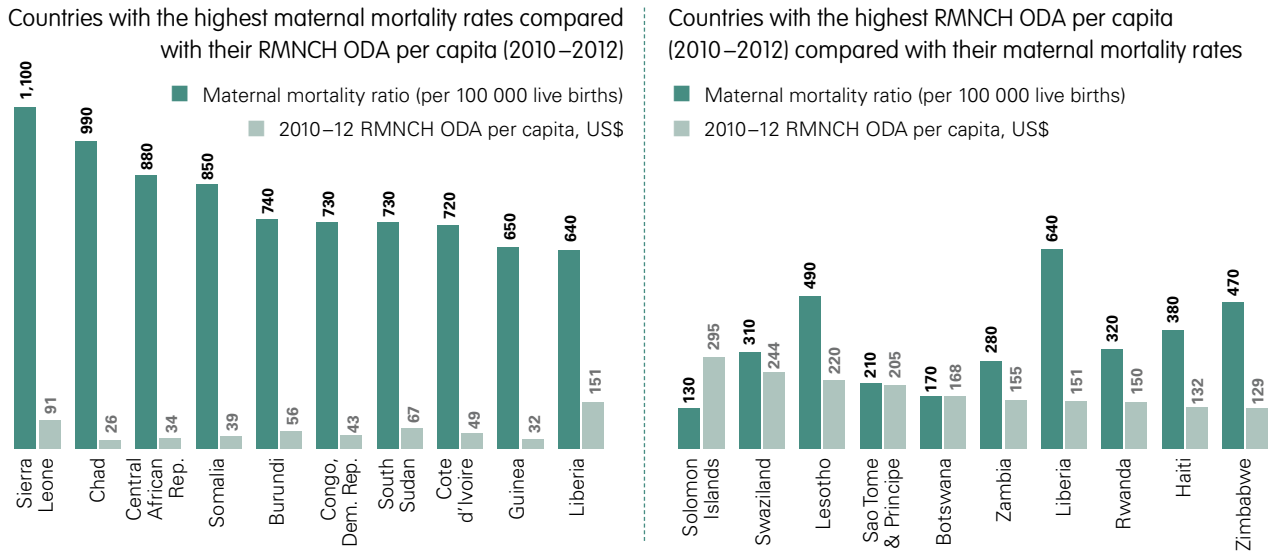
FINDING 5 → There are still inequities in the geographical targeting of donor funding (Figure vi).[8] A number of low-income countries (LICs) with very high absolute numbers of maternal and child deaths and/or very high mortality rates, and poor access to reproductive health services, including several francophone countries such as Cameroon, Chad, and Niger, receive comparatively little donor support (Figure vi). In some of these countries, such as Sierra Leone and Chad, RMNCH donor support has even fallen since 2010. This is despite the stated focus on equity in the Global Strategy and repeated references in the annual independent Expert Review Group (iERG) reports to the importance of equitable investments.

FINDING 6 → Donor funding for family planning and other key interventions has increased since the launch of the Global Strategy, but is far from sufficient to achieve agreed targets. From 2010–2012, donor disbursements for family planning increased by 47% (to US$561 million in 2012) for the Countdown countries, and by 52% (to US$451 million) for the 49 Global Strategy countries. In the same period, increases were also substantial for maternal and newborn health (MNH), which increased by 22% (to US$1.2 billion in 2012) for the Countdown countries, and by 24% (to US$904 million) for the Global Strategy countries. However, the additional MNH funding is insufficient to close the US$7.9 billion funding gap estimated by the Global Strategy.[9] HIV-related RMNCH funding continues to be the largest funding area, followed by immunization. Child health investments fell short of expectations and malaria funding declined in 2011, but was followed by an increase in 2012.

FINDING 7 → Domestic expenditures for RMNCH (including family planning) increased but fall short of need. RMNCH expenditures by the governments of the 49 Global Strategy countries increased to a total of US$2.7 billion in 2012, a 15% increase from 2010. Domestic funding for RMNCH from the 75 Countdown countries grew by 21% between 2010 and 2012.

Figure vi

There are inequities in the geographical targeting of donor funding and countries' needs



Note: There are similar geographical inequities when analysing RMNCH ODA and countries' under-five mortality burden.
Source: OECD CRS & WHO, UNICEF, UNFPA, World Bank: Trends in maternal mortality, 1990–2013

Recommendations

RECOMMENDATION 1 → Efforts to mobilize additional resources from international and domestic sources for RMNCH need to be continued and must be kept high on the political agenda. RMNCH must remain central in the post-2015 development framework. The framework should include clear realistic targets to end preventable maternal, newborn and child mortality and to improve access to sexual and reproductive information and services and ensure the realization of sexual and reproductive health and rights. Given the unprecedented support catalyzed by the Global Strategy, a new mobilization and advocacy effort similar to the Global Strategy should be considered for the post-2015 era to finance the unfinished agenda of Millennium Development Goals MDGs 4–6 and achieve a "grand convergence" in global health.

RECOMMENDATION 2 → Funding should be focused on the most cost-effective, evidence-based intervention packages that have the largest impact on reducing mortality and that are currently receiving too little attention. Donors and countries should refer to the Global Investment Framework for Women's and Children's Health to guide their investments, which should be particularly targeted at the most underfunded of its six packages and those with the highest impact. The child health, MNH, and immunization packages require the largest additional investments alongside the other packages. The family planning package has the potential to have the largest impact on reducing mortality.

RECOMMENDATIONS 3 → Funding needs to be better matched with mortality burden to achieve equitable progress among countries and healthy lives for all.[10] Funding should become more closely aligned with mortality burden so that countries in greatest need receive sufficient donor support. Stakeholders should use existing global platforms, and consider new platforms, such as the potential RMNCH Global Financing Facility, to better coordinate their RMNCH investments to increase efficiencies in their allocations to countries.

RECOMMENDATION 4 → Countries need to further prioritize and strengthen efforts to self-finance their RMNCH needs. More domestic resources from middle-income countries (MICs) are required for RMNCH to free up donor funding for the poorest countries, but LICs also need to strengthen their efforts to self-finance their RMNCH needs. Global Health 2035 also projected that LICs and lower middle-income countries (LMICs) are on course to experience very significant economic growth, which will create greater domestic fiscal space for health financing.

RECOMMENDATION 5 → Strengthen political leadership for family planning at country level to create support for contraception and sexual and reproductive health and rights. The Global Investment Framework for Women's and Children's Health and Global Health 2035 report argue that family planning deserves particularly high, early prioritization. While there is substantial global attention focused on supporting family planning, more political leadership is needed at country level. Domestic leadership should be directed at supporting interventions to increase both the supply of contraceptive information and service programs, and to address social, cultural and behavioral factors that inhibit women, girls and couples from accessing available services.

RECOMMENDATION 6 → Initiate a major final Global Strategy accountability reporting session at the UN General Assembly (UNGA) in September 2015 to ensure accountability right up to the finish line. Without such a process, there is a risk of "slippages" in accountability. The UNGA in September 2015 would be a timely high-level event for this final reporting session, although data for the entire period of the Global Strategy will only be available in 2016 at the earliest.

RECOMMENDATION 7 → To strengthen accountability for RMNCH beyond 2015, a harmonized method should be agreed on to track progress against the post-2015 targets for RMNCH. While efforts are ongoing to include RMNCH targets in the post-2015 development framework, the RMNCH community should also agree on an approach for ensuring accountability towards these goals. This approach would involve agreeing on one method for assessing progress towards closing the RMNCH funding gap estimated by the Global Investment Framework for Women's and Children's Health.

Endnotes

1 United Nations Secretary-General. The Global Strategy for Women's and Children's Health. New York, United Nations, 2010.

2 Commitments to the Global Strategy are listed on the EWEC website, http://www.everywomaneverychild.org/ (accessed 01 May 2014).

3 These numbers are based on an analysis of commitments on the EWEC website, http://www.everywomaneverychild.org/ (accessed 01 May 2014).

4 World Health Organization. Every Newborn: an action plan to end preventable deaths. Geneva, WHO, 2014.

5 The 49 Global Strategy focus countries were the 49 lowest-income countries according to the World Bank list of economies as of April 2008. These countries were in the focus of work of the Taskforce on Innovative International Financing for Health Systems and then became the focus countries of the Global Strategy. These countries are: Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Cote d'Ivoire, Eritrea, Ethiopia, The Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, Kenya, Democratic Republic of Korea, Kyrgyz Republic, Lao PDR, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, Tajikistan, Tanzania, Togo, Uganda, Uzbekistan, Vietnam, Yemen, Zambia and Zimbabwe.

6 The Muskoka methodology was used to calculate Official Development Assistance (ODA) for RMNCH. For background on the Muskoka method, refer to http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html (accessed 31 July 2014).

7 Countdown priority countries account for more than 95% of global maternal and child deaths. The 49 Global Strategy countries are a subset of the 75 Countdown countries. For a complete list of the Countdown priority countries, please refer to: http://www.countdown2015mnch.org/country-profiles (accessed 31 July 2014).

8 The PMNCH 2013 Report also found that certain countries received comparatively little support from donors. The Partnership for Maternal, Newborn & Child Health. Analyzing Progress on Commitments to the Global Strategy for Women's and Children's Health: The PMNCH 2013 Report. Geneva, PMNCH, 2013.

9 The MNH funding gap is a subset of the US$88 billion funding gap for women's and children's health. See: Global Strategy Finance Working Group. Background paper for the Global Strategy for Women's and Children's Health: Financial estimates in the Global Strategy. New York, United Nations, 2010.

10 This corresponds with the "ensure healthy lives" goal suggested for the post-2015 agenda. The Open Working Group on Sustainable Development Goals. The Proposal of the Open Working Group for Sustainable Development Goals. New York, United Nations Department of Economic and Social Affairs, 2013: http://sustainabledevelopment.un.org/focussdgs.html (accessed 31 July 2014). Please also refer to PMNCH: The 2014 Partners' Forum Communiqué. Ensuring the health and well-being of every woman, child, newborn and adolescent. 2014.

Acknowledgements

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Advisory Group

The Advisory Group of PMNCH Partners played an important role in the development of the report. Its objectives were: first, to comment and advise on the proposed methodology; second, to review any initial and emerging findings and drafts of the report; and third, to advise on how the relevance and impact of the report's analysis and findings can be maximized to improve the delivery and impact of commitments to the Global Strategy.

The members of the Advisory Group were:
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