# Executive Summary

This report reviews the progress made towards implementing the commitments to advance the Global Strategy for Women's and Children's Health, launched by the United Nations Secretary-General Ban Ki-moon in September 2010. A key aim of the Global Strategy is to save 16 million lives in the world's 49 poorest countries by 2015 through enhanced financing, strengthened policy and improved service delivery. The Global Strategy identified six key areas in need of urgent action to improve women's and children's health:

1. Support for country-led health plans, underpinned by increased, predictable and sustainable investment;
2. Integrated delivery of health services and life-saving interventions to enhance access;
3. Stronger health systems, with sufficient skilled health workers at their core;
4. Innovative approaches to financing, product development and the efficient delivery of health services;
5. Improved monitoring and evaluation to ensure all actors are accountable for results;
6. Promoting human rights, equity and gender empowerment.

To take forward accountability for achieving the Global Strategy, the Commission on Information and Accountability (COIA) was created to make recommendations on global reporting, oversight and accountability mechanisms for women's and children's health. Subsequently, an independent Expert Review Group (iERG) was set up in 2011 to report annually to the United Nations Secretary-General on the results and resources related to the Global Strategy, and on progress towards implementing the COIA recommendations.

This report was produced by the Partnership for Maternal, Newborn & Child Health (PMNCH) in response to a request from the iERG to inform its reporting to the United Nations Secretary-General. It reviews progress on implementation of commitments to the Global Strategy made by 220 stakeholders[1] from seven constituency groups: implementing countries; bilateral donors and foundations; civil society organizations (CSOs); multilateral agencies; private sector; health-care professional associations; and academic and research institutions. The report identifies catalysts and constraints to the delivery of commitments and provides examples of good practices and challenges to accountability for women's and children's health.

Building on the 2011 PMNCH Report on commitments,[2] the report also analyses the scope and content of new commitments. Finally, it provides recommendations on the way forward.

The report was informed by a range of data-gathering tools: an online questionnaire; key informant interviews with government officials and development partners; three country case studies (Bangladesh, Burkina Faso and Uganda); and an H4+ (UNFPA, UNICEF, WHO, World Bank, UNAIDS and UN Women) survey to track national commitments in the area of human resources for health. These tools were designed and finalized through extensive consultations with an advisory group and other experts and stakeholders. The report was also informed by desk review of relevant literature and databases in the public domain and by documentation provided by stakeholders. One hundred and eighty-one of the 220 stakeholders completed the online questionnaire. The high response rate of 82% suggests significant interest in reporting on the implementation of investments and policies to improve women's and children's health.

It should be emphasized that the mandate of this report was to review the implementation of the specific commitments to the Global Strategy. As such, the report is not a comprehensive stock-taking of all the significant ongoing efforts and investments for women's and children's health. The Global Strategy, and the commitments made to it, can never comprise the entire global effort to improve women's and children's health. It is important to recognize that key national, regional (e.g. Campaign for Accelerated Reduction of Maternal Mortality in Africa, CARMMA) and international stakeholders had also made major commitments to, and investments in, women's and children's health before the Global Strategy was launched, and since then. These commitments are outside the purview of this report.

It is worth pointing out two limitations of the report. First, the diversity of commitments and lack of baseline data and indicators have made it very challenging to assess and compare progress. Second, much of the data gathered for this report was the result of self-reporting, which often consisted of quite general statements. This has limited the level of detailed information that can be provided about progress of implementation.

The core findings of the report include:

### Finding 1: Implementation of commitments is well under way, but is also constrained by some key factors.

Responses to the questionnaire suggest that a significant proportion of commitments has been,

or is being, implemented. To illustrate, 65% of respondents reported that the implementation of policy commitments is at an advanced stage or has been achieved. Similarly, 73% of respondents reported that the implementation of commitments to service and product delivery and health systems strengthening is at an advanced stage or achieved. The report highlights several specific examples of progress on implementation.

Examples of progress were also identified in the H4+ survey of low- and middle-income countries (LICs and MICs). For example, of the countries surveyed, 84% reported that they had trained and deployed additional midwives and skilled birth attendants while 77% had carried out activities to improve health-worker performance.

While there is evidence that implementation of commitments is well under way, stakeholders also identified substantial constraints to effective scale-up. These include:

- **Insufficient funding** for RMNCH was identified as the most important constraint by most stakeholders, particularly by LICs, MICs and CSOs. This is of particular concern in countries where the implementation of their commitments depends significantly on international financing. Some respondents also perceive that the release of funds is sometimes slow.
- **Shortages of skilled health workers** are a critical barrier to implementation. Other human resource constraints include unequal geographic distribution of health workers, inadequate training and skills, migration and insufficient recruitment capacity. In addition, the potential of digital technology, which can strengthen training, remains untapped.
- **Shortages of health commodities and poor infrastructure** are another significant challenge, despite substantial efforts to strengthen health systems as part of the Global Strategy and national plans. It is expected that forthcoming efforts, including follow-up to the Commission on Life-Saving Commodities for Women and Children, will help to address this.
- **Weak governance and instability,** caused by factors such as civil conflict, natural disasters and frequent changes in government, were reported by several respondents as key impediments to implementation.
- **Sociocultural barriers**, including myths and misconceptions, gender discrimination and social taboos, continue to have a negative effect on the demand for, and use of, services in many countries.
- **Full potential for collaboration between public and private stakeholders remains untapped**. A major reason is the lack of an enabling policy environment to develop transformative and sustainable partnerships with the private sector at scale.

  These partnerships have been increasingly important to deliver solutions in a changing economic and development landscape, and are the focus of Millennium Development Goal (MDG) 8.

### Finding 2: Implementation of commitments has generally focused on high-burden countries, but important gaps remain.

The report shows that most commitments focus on the 49 countries highlighted by the Global Strategy and that stakeholders support the countries with a high burden of disease. While counting the number of commitments does not provide information on their magnitude and quality, it does provide a snapshot of the dynamics of the commitments made.

The report also highlights important gaps. Stakeholders tend to focus on the same countries, usually those receiving the most development assistance, while other countries are neglected, regardless of the number of deaths, mortality rates, income levels and progress towards MDGs. For example, five countries that are off track on both MDG 4 (reducing child mortality) and MDG 5 (reducing maternal mortality) received fewer than three commitments each. These are Azerbaijan, Congo, Gabon, Sao Tome and Principe, and Turkmenistan. Conversely, India and Nigeria – not lower-income countries – received an above-average number of commitments. However, it should be noted that India and Nigeria do represent a significant proportion of the absolute number of maternal and child deaths.

### Finding 3: Most commitments that focus on specific interventions address critical gaps, but some key interventions with low coverage still receive limited attention.

Commitments are increasingly focusing on specific RMNCH interventions that have previously received little attention, including skilled birth attendance, antenatal care and PMTCT. Family planning, a recently neglected area, also received increased attention, and this focus was reinforced during the Summit on Family Planning in July 2012.

Some areas that are recognized as major threats to maternal and child health still attract few commitments. Interventions to prevent and treat three of the major causes of death in children under five – diarrhoea, pneumonia and malaria – are the target of fewer than half of respondents. However, commitments to the Child Survival Call to Action made in June 2012 will contribute to addressing these gaps. Other areas that have received comparatively little attention to date include prevention and management of preterm birth, and management of neonatal infection and resuscitation.

### Finding 4: Financial commitments are considerable and are being disbursed, but additional resources are still needed.

The declared value of the commitments to the Global Strategy expressed in financial terms has been estimated at approximately US$ 58 billion. This figure is based on financial commitments from 98 stakeholders, almost one-third of which are LICs and MICs. However, once "double-counting" has been taken into account, the true value of the financial commitments is closer to US$ 40 billion. Of this amount, at least US$ 20 billion is new and additional funding mobilized by the Global Strategy, including the Muskoka Initiative (the G8's 2010 commitment to MNCH). Although some stakeholders, including both implementing countries and external donors, were not yet able to report on disbursements, there is evidence that more than US$ 10 billion has been disbursed to date. There are significant differences in disbursement rates by stakeholder groups, from less than 1% of the financial commitments by the private sector to more than 50% by NGOs.

These findings also show that there is a need to lever significant additional financial commitments to meet the US$ 88 billion gap in funding (for 2011-2015) for the 49 countries highlighted by the Global Strategy. As pointed out above, however, the US$ 20 billion estimate does not comprise the entire effort related to women's and children's health and other investments would contribute to reducing the funding gap. In addition, it has not been possible to estimate the significant financial value of all the policy, advocacy, service delivery and other commitments that were not expressed in explicit financial terms, and which would also contribute to narrowing the financing gap.

Finally, the analysis in this report confirms the urgency of addressing the COIA recommendations to strengthen tracking of both domestic and external resources. Following an initiative of the Canadian government to address these recommendations, a Task Team on MNCH of the OECD-DAC Working Party on Statistics has agreed on a new approach to tracking RMNCH donor funds by 2013. This is expected to give a more accurate picture of RMNCH financing in future years.

### Finding 5: There are opportunities to strengthen cross-sectoral action.

As highlighted by the Global Strategy, integration with MDG 1c on nutrition and MDG 6 on infectious diseases (AIDS, tuberculosis and malaria), noncommunicable diseases and other health, social and cross-cutting issues, is critical to achieve MDGs 4 and 5. The report shows that commitments to the Global Strategy have not adequately focused on integration with determinants of health that are traditionally perceived as being outside the domain of the health sector, such as safe drinking water, sanitation and hygiene, education, nutrition and food security.

### Finding 6: The Global Strategy is perceived by stakeholders as adding value.

Despite challenges determining the degree to which the Global Strategy has directly influenced progress on RMNCH, more than 81% of respondents stated that the Global Strategy has delivered significant benefits and catalytic support to their efforts to improve women's and children's health. Stakeholders identified the following areas where the Global Strategy has added value to existing efforts. Respondents suggested that the Global Strategy:

- **Generates high-level political support**, globally and at national level. For example, findings from the Burkina Faso country case study show there is high-level commitment from the President, the First Lady and the Minister of Health, who have endorsed and supported regional RMNCH initiatives and processes such as CARMMA, the Maputo Plan of Action and the Abuja Declaration.
- **Supports alignment between stakeholders** by catalysing consensus on key needs and principles for accelerating action; by providing a unified framework for women's and children's health that has clear buy-in and support from all key stakeholder groups and endorses and legitimizes the continuum of care; and by helping stakeholders to align their own health strategies with the focus and goals of the Global Strategy. Commitments made in Uganda through active parliamentary leadership, for example, have rallied all actors behind common goals and targets for RMNCH, and increased support for and engagement in a shared platform for planning, implementation, reporting and measuring results.
- **Raises visibility of existing RMNCH national plans** and objectives, while promoting greater alignment around interventions and approaches. The findings of the three country case studies indicated that commitments by stakeholders were generally aligned with national health plans.
- **Catalyses transformative private-public partnerships**: the emphasis in the Global Strategy on private-public partnerships has promoted innovative approaches to implementation such as Merck for Mothers and the Intel 1Mx15 initiative that aims to bring information and communications technology (ICT) training to 1 million health-care workers by 2015, through collective action and sustainable collaboration.
- **Promotes innovative approaches** to financing, product development and delivery of health services.
- **Promotes mutual accountability for delivering on commitments** to improve women's and children's health.

### Finding 7: There is great potential to strengthen national accountability mechanisms through parliamentarians, media, community participation and countries' human rights obligations.

The Global Strategy highlights the need for effective accountability mechanisms. These should be transparent and inclusive, ensuring the meaningful participation of all key stakeholders, and particularly communities, CSOs and parliamentarians. The report highlights implementing countries' low awareness of the COIA recommendations for strengthening accountability. Those countries that were aware reported mixed progress on implementing the COIA recommendations, suggesting a need for additional efforts and investment.

The report also shows that there is considerable scope for strengthening accountability for women's and children's health by building on existing mechanisms. This can be done by: using the health sector review as a platform for accountability; increasing the use of human rights instruments; building capacity for parliamentary engagement and oversight; expanding social accountability approaches to improve accountability to citizens and communities; and fully utilizing the power of the media. Examples include:

- **Parliamentarians** – a resolution by the Pan-African Parliament (PAP) in October 2011 urged the Speakers of African parliaments to prioritize the implementation and funding of MNCH policies and programmes. A resolution by the Inter-Parliamentary Union (IPU) in April 2012 called on parliamentarians to take all possible measures to achieve MDGs 4 and 5.
- **Human rights** –the Universal Periodic Review, through which states have a responsibility for reporting on human rights commitments, provides one concrete mechanism to strengthen accountability for women's and children's health. Another tool is the recently developed technical guidance to implement the Human Rights Council (HRC) resolution on maternal mortality and morbidity.
- **Social accountability** – in India and Nepal, social accountability is strengthened through public hearings where women share their experiences in accessing health services with senior officials and request action to address problems.
- **Budget analysis and public expenditure tracking** – in Mexico, the national NGO Fundar is using this tool to encourage the government to increase and earmark decentralized funds for women's and children's health.

Stakeholders are also taking action to monitor and evaluate their own commitments. For example, Save the Children has appointed an independent organization to assess progress on implementation of its commitment to the Global Strategy and World Vision International has commissioned a mid-term review of its commitment.

## Recommendations

### To improve targeting and implementation of the commitments:

- Provide additional support to countries receiving little attention, despite being either off track for MDGs 4 and 5 and/or with high-mortality rates, so as to close the remaining geographical gaps.
- Focus commitments more strongly on those interventions that are receiving less attention even though they address conditions responsible for significant morbidity and mortality; this is particularly true for interventions to prevent and treat pneumonia, diarrhoea and malaria.
- Continue the increased attention and resource allocation to previously neglected interventions, such as family planning, skilled birth attendance and PMTCT.
- Pursue development of a global partnership for development; an MDG in itself (MDG 8) but also crucial to MDGs 4 and 5.
- Provide additional technical support to countries to identify priorities and resource needs.

### To secure sufficient resources to bridge the financing gap and align commitments with needs:

- Leverage additional financial resources, including from domestic sources, to address the remaining financing gap. The financial commitments made to the Global Strategy are considerable, yet many implementing countries report that they are still insufficient.
- Allocate existing and additional funding to close the remaining geographical and intervention gaps.
- Improve value for money, not only by prioritizing cost-effective essential interventions, but also by taking action to reduce inefficiencies in resource allocation and use.
- Take action to accelerate the release of funds, and improve the ability of countries to receive and administer funds.

### To harness catalysts and mitigate constraints:

- Take advantage of the catalytic effect of the Global Strategy to maintain high-level political support and involve additional stakeholders.
- Address the critical human resources challenges, and tackle other health systems weaknesses, such as poor infrastructure and shortages of commodities.
- Consider gender and sociocultural issues when designing policies and programmes, and allocating resources. Involve men and youth in RMNCH initiatives.

### To integrate efforts with other sectors also critical to women's and children's health:

- Increase efforts in sectors that are critical to improving women's and children's health, such as agriculture, transportation, ICT, trade, education, nutrition, food safety, safe water, sanitation and hygiene.

### To advance accountability and strengthen governance for women's and children's health:

- Strengthen health information systems to enable more accurate reporting on RMNCH outcomes.
- Sustain the implementation of the recommendations of the COIA.
- Ensure alignment and consistency of reporting requirements across existing initiatives and accountability mechanisms to mitigate the reporting burden of countries.
- Reinforce efforts to track international and domestic financing for RMNCH, for example through reporting of official development assistance using the approach agreed by members of the OECD Working Party on Statistics.
- Promote the role of civil society and parliamentarians in strengthening accountability, and strengthen the links between the Global Strategy and national and regional efforts, such as CARMMA.
- Make better use of human rights instruments and frameworks to promote accountability.
- Collect more detailed information on the implementation of commitments, when possible.
- Tailor data collection tools to constituency groups, given that commitments sometimes differ in nature between different categories of stakeholders.
- Make future commitments more specific by including deliverables, time-lines and indicators to address the challenges of assessing progress on implementation.