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THE PMNCH 2012 REPORT

ANALYSING PROGRESS ON COMMITMENTS
TO THE GLOBAL STRATEGY
FOR WOMEN'S AND CHILDREN'S HEALTH





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On behalf of the Board and secretariat of The Partnership for Maternal, Newborn & Child Health (PMNCH), we are pleased to introduce *The PMNCH 2012 Report - Analysing Progress on Commitments to the Global Strategy for Women's and Children's Health*. The report was produced in response to a request from the independent Expert Review Group (iERG) to inform its reporting to the United Nations Secretary-General on progress in women's and children's health. The report builds on the PMNCH 2011 Report and reviews progress on commitments made by 220 stakeholders to the Global Strategy and in support of Every Woman Every Child.

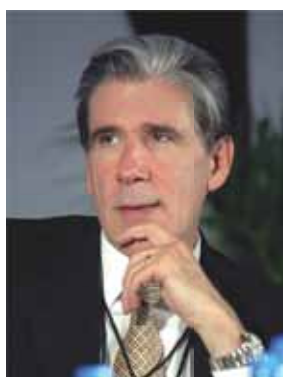
The report finds that the Global Strategy has been a catalyst for more focused and coordinated efforts for women's and children's health. It also concludes that implementation is underway but faces some constraints. Based on the report's findings, the following recommendations on the way forward are made:

- Provide additional support to countries with high mortality rates and/or off-track to reach MDGs 4 and 5 but receiving little support at present;
- Focus commitments more strongly on interventions that address major causes of death and are receiving little attention;
- Leverage additional financial resources to further reduce the funding gap identified in the Global Strategy;
- Address constraints to implementation of commitments, in particular related to financial and human resources;
- Integrate efforts with other sectors that are critical to improving women's and children's health, such as education, water and sanitation, transportation and information and communications technologies;

- Support the implementation of the recommendations by the Commission on Information and Accountability, including strengthening health information systems and tracking of international and domestic financial resources;
- Include indicators and means to track progress and impact in future commitments.

Many people and organizations have collaborated to produce this report, and they are listed in full on page 78. Here we would like in particular to acknowledge the following: all stakeholders who generously invested time to provide information on the implementation of their commitments; the coordinators of the PMNCH 2012 Report – Jennifer Goosen, Geoff Black (CIDA), Neema Rusibamayila (Government of Tanzania), Stefan Germann (World Vision International) and Lene Lothe (Norad); as well as the Advisory Group for the 2012 Report.

We hope this report helps readers to understand the progress that has been made towards implementing the Global Strategy, as well as the remaining gaps and challenges, and that it contributes to advancing accountability for commitments to women's and children's health. Moving forward, it will be important to report on progress on women's and children's health in its totality, to which the Global Strategy contributes. This is done best by countries, where accountability belongs, with active engagement of governments, communities and civil society, supported by regional and global actors, such as the independent Expert Review Group. The global community has a duty to the women and children of the world to keep its promises and to be held accountable. ■■■■



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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 stakeholders¹ 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. ■■■■

CHAPTER 1

INTRODUCTION

A platform for action

In September 2010, the United Nations Secretary-General Ban Ki-moon launched the Global Strategy for Women's and Children's Health (Global Strategy). The Every Woman Every Child (EWEC) effort was established at the same time to advance the Global Strategy and mobilize and intensify global action to improve women's and children's health. The Global Strategy aims to increase visibility and political support, mobilize resources and catalyse a renewed effort to accelerate progress towards the achievement of MDGs 4 and 5. Its ultimate aim is to save 16 million lives in the world's 49 poorest countries by 2015. The Global Strategy estimated that US\$ 88 billion in additional resources would be required from 2011-2015 to reach the health MDGs in these 49 countries.

The Global Strategy presents a roadmap showing how to enhance financing, strengthen policy and improve services on the ground for the most vulnerable women and children. It identifies six key areas for action:

- **Country plans** – country-led health plans supported by adequate investment;
- **Integration** – integrated delivery of health services and life-saving interventions;
- **Delivering services** – stronger health systems, with sufficient skilled health workers at the core;
- **Innovation** – innovative approaches to financing, product development and delivery of health services;
- **Human rights** – promoting human rights, equity and gender empowerment;
- **Results** – improved monitoring and evaluation to ensure accountability of all actors for results and resources.

The aims of the Global Strategy and EWEC are further supported by a number of initiatives (see Figure 1). In 2011, the **Commission on Information and Accountability (COIA)** for Women's and Children's Health established a framework to strengthen global and national reporting, oversight and accountability for women's and children's health and set up an **independent Expert Review Group (iERG)**.³ The **Innovation Working Group** was established to foster innovation in support of Every Woman Every Child, and has released various reports including *Private Enterprise for Public Health* in July 2012.⁴ The **United Nations Commission on Life-Saving Commodities for Women and Children** (co-chaired by Nigeria and Norway) was launched in March 2012, with its final report published in September 2012. It aims to increase access to medicines and health supplies by addressing barriers that limit access to 13 essential health commodities.⁵ In May 2012, in conjunction with the release of **Born Too Soon: The Global Action Report on Preterm Birth**,⁶ more



than 30 new and expanded commitments to prevention and care of preterm birth were made.⁷ The **Child Survival Call to Action: A Promise to Keep** was launched in June 2012 and is an initiative led by the US Government, Ethiopia and India and supported by UNICEF and partners.⁸ It aims to end preventable child deaths, putting emphasis on evidence-based country plans, transparency and mutual accountability, as well as global communication and social mobilization. The **Family Planning Summit** in July 2012, co-hosted by the UK government and the Bill & Melinda Gates Foundation, generated political commitment and financial resources to meet the family planning needs of women in the world's poorest countries by 2020.⁹

The broader agenda

While the Global Strategy and related initiatives aim to accelerate progress towards Millennium Development Goals (MDGs) 4 (reduce child mortality) and 5 (improve maternal health), the scope of this objective extends beyond reproductive, maternal, newborn and child health (RMNCH). As highlighted by the Global Strategy, integration with MDG 1c on nutrition and MDG 6 on infectious diseases (HIV/AIDS, tuberculosis and malaria), non-communicable diseases (NCDs) and other health, social and cross-cutting issues is also critical to achieve the MDGs. The critical importance of the health of women and children to the broader development and sustainability agenda is increasingly being recognized. Investment in the health of women and children is not only the right thing to do – it also brings significant political, social and economic returns.

Accountability for results and resources: the independent Expert Review Group mandate

In its report, formally released in September 2011, the COIA made 10 recommendations,¹⁰ including the creation of an **independent Expert Review Group (iERG)** to report

regularly to the United Nations Secretary-General “on the results and resources related to the Global Strategy and on progress in implementing the Commission’s recommendations”. The iERG submits its first report to the Secretary-General in September 2012 and has requested PMNCH to provide the following support to inform its reporting:

1. a review of stakeholder commitments to the Global Strategy and of the extent to which those commitments have been delivered;
2. a review of good practices and obstacles to accountability for RMNCH.

PMNCH is providing the requested information and analysis through this PMNCH 2012 report.

The PMNCH 2012 report

The goal of this report is to review the content and implementation of the specific commitments to the Global Strategy to inform the iERG’s reporting to the Secretary-General, and to report on progress to the global RMNCH community. It should be stressed that the report is *not* a comprehensive stock-taking of all the significant on-going efforts and investments for women’s and children’s health. The Global Strategy, and the commitments made to it, do not comprise the entire effort related to women’s and children’s health. Key national, regional (e.g. Campaign for Accelerated Reduction of Maternal Mortality in Africa, CARMMA, led by the African Union) and international stakeholders had made major commitments to, and investment in, women’s and children’s health before the Global Strategy was launched and since then. This caveat has to be kept in mind throughout the report.

The PMNCH 2012 report builds on the PMNCH 2011 Report, *Analysing Commitments to Advance the Global Strategy for Women’s and Children’s Health*.¹¹ This was developed to support greater accountability, and to

FIGURE 1: Time-line of events

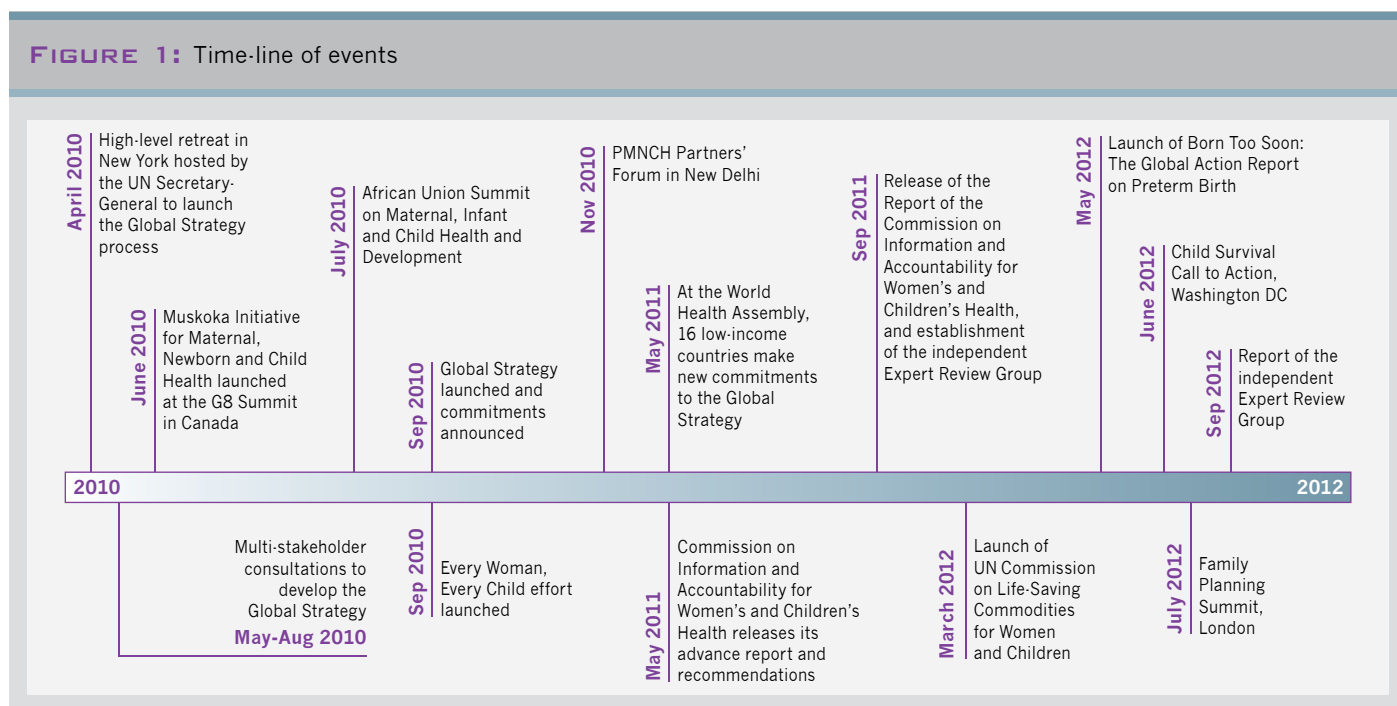
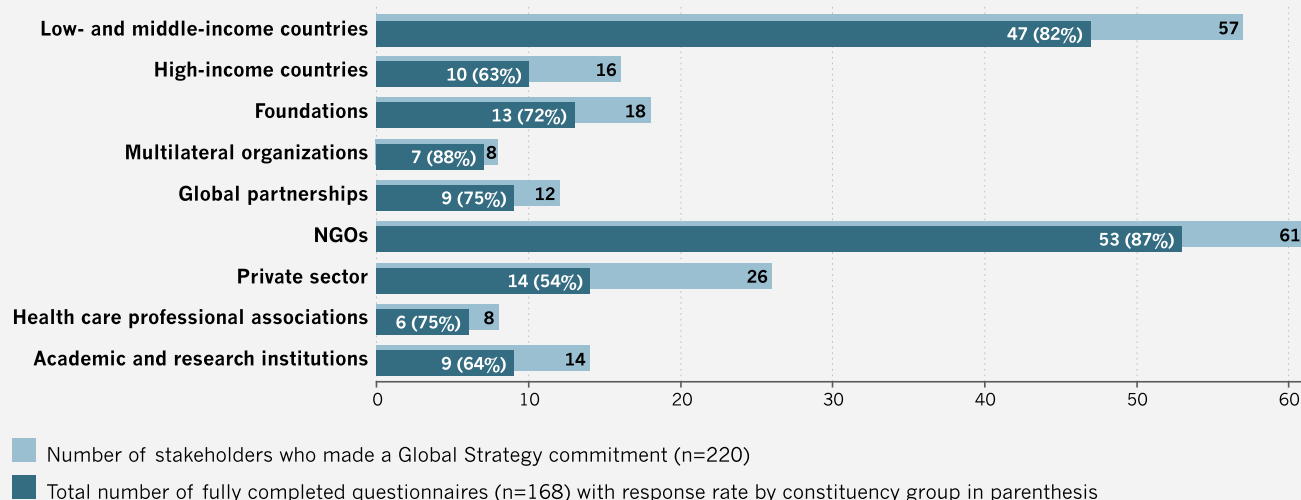


FIGURE 2: Response rates to online questionnaire by constituency group



further understanding of the more than 100 commitments made by stakeholders at the launch of the Global Strategy in September 2010 and at the World Health Assembly in May 2011.

Given that two years have passed since the first commitments were made in 2010, this report not only analyses the content of the commitments made by 220 stakeholders but also uses self-reporting data to focus on the progress of the implementation of commitments and how they support and align with national strategies and programmes. More precisely, the report includes:

- **Content analysis** – as with the PMNCH 2011 report, this analysis was conducted to determine the focus of commitments to policy, systems, service and product delivery, financing, advocacy and research, as well as their geographical distribution;
- **Implementation progress** of the various types of commitments was analysed;
- Description of **catalysts and challenges** to implementation, as reported by the stakeholders;
- **Thematic analyses** – to explore certain topics in more detail, in-depth analyses were carried out on financial commitments and commitments related to human resources, advocacy and media, and research and innovation;
- **Country case studies** – to study how commitments are aligned with national plans, addressing health and development gaps and supporting country progress towards achieving MDGs 4 and 5;
- Finally, as requested by the iERG, we reviewed **national accountability mechanisms** for women's and children's health.

The report was informed by an online questionnaire (Web-Annex 1), key informant interviews, country case studies and desk review (details on methods can be found in Annex 1). The online questionnaire was sent to all 220 stakeholders that have made commitments to the Global Strategy. At the time of writing (August 2012),

168 questionnaires have been fully completed and have informed this analysis (see Annex 2). An additional 13 questionnaires have been partially completed, but not validated and therefore not included in the analysis. The high response rates of 76% (fully completed questionnaires) and 82% (fully and partially completed questionnaires) indicate a robust sense of responsibility for reporting on the implementation of investments and policies to improve women's and children's health (response rates by stakeholder category are shown in Figure 2).¹² Only half (54%) of private sector stakeholders responded to the online questionnaire. Some countries did not complete the questionnaire due to a policy of only reporting within existing frameworks, which is reasonable and in line with harmonization and aid effectiveness efforts. In these cases, where possible, information was collected directly from the countries' existing reports.

It is worth pointing out two limitations of the report. First, the diversity of commitments and lack of baseline data and indicators has made it very challenging to assess and compare progress. Second, a large part of the data gathering for this report – self-reporting that often consists of quite general statements – has limited the level of detailed information that can be provided about progress of implementation.

How was the report developed?

The report was developed through a consultative process. A technical consultation was organized in January 2012 to seek feedback on the objectives, scope and methods of the report. A multidisciplinary, multistakeholder advisory group provided technical review, including at a face-to-face meeting in May 2012 (see Acknowledgements for a list of members). A number of PMNCH partners provided guidance and analytical inputs (see Acknowledgements). Two consultancy firms, HLSP and SEEK Development, were contracted to carry out data collection and analysis to inform different components of the report. ■■■■

OVERVIEW OF COMMITMENTS TO ADVANCE THE GLOBAL STRATEGY



This chapter provides an overview of the commitments made by a wide range of stakeholders to the Global Strategy since its launch in September 2010.^{13, 14}

The chapter analyses the geographical targeting of stakeholder commitments to determine to what extent the distribution of commitments matches the countries identified in the Global Strategy as having the greatest need. It also reviews the focus of commitments to specific RMNCH interventions along the continuum of care to assess if commitments focus on interventions with low coverage, which are in need of intensified efforts and resources.

The analysis of the geographical focus of commitments is based on the results of the online questionnaire. The online questionnaire provides information on the number of times a country was identified by stakeholders (including implementing countries themselves) as a focus country for their commitments. It is therefore important to note that the data do not provide information on the scope and programmatic focus of the activities. In addition, this analysis does not include commitments that do not specifically mention focus countries (e.g. donors such as the Bill & Melinda Gates Foundation and high-income countries, committing funds to RMNCH globally).

Finally, it is important to reiterate here that the commitments to the Global Strategy do not comprise all the initiatives aimed at improving women's and children's health. Therefore, if a country or intervention received few commitments, this may not necessarily imply an overall neglect. Stakeholders who did not make explicit commitments to the Global Strategy may be investing in that country/issue outside of the Global Strategy framework.

FINDING 1: Commitments to the Global Strategy continue to increase.

By April 2012, a total of 220 stakeholders had made commitments to advance the Global Strategy (112 in September 2010 when the Global Strategy was launched, 16 in May 2011 at the World Health Assembly, 89 in September 2011 at the time of the United Nations General Assembly and a further three until April 2012). Figure 3 shows the evolution of the number of commitments over time, and Figure 4 the distribution of commitments by constituency groups. It should be noted that there is untapped potential for additional commitments. For example, only 26 commitments are from the private sector, and among them only six from the Global Fortune 500 list of companies.

Due to the time-frame for the report's analysis, it was not possible to include commitments made in conjunction with the launch of *Born Too Soon: The Global Action Report*

Box 1: Overview of commitments made at Child Survival Call to Action and Family Planning Summit

The **Child Survival Call to Action**, an initiative led by the US government, Ethiopia and India, supported by UNICEF and partners, was launched in Washington DC on 14-15 June 2012. It aims to end preventable child deaths, putting emphasis on evidence-based country plans, transparency and mutual accountability, as well as global communication and social mobilization. More than 80 countries represented by governments and a multitude of partners from the private sector, civil society and faith-based organizations attended the launch. The aim of the Call to Action is to contribute to reducing child mortality to 20 or fewer child deaths per 1000 live births in every country by 2035. Reaching this target would save an additional 45 million children's lives by 2035. Fifty-six governments and more than 100 civil society organizations committed to supporting the Call to Action, and eight new and expanded partnerships were announced. A global roadmap was unveiled at the launch, providing a vision of how to accelerate child mortality reduction.¹⁵

The UK government's Department for International Development and the Bill & Melinda Gates Foundation hosted the **Family Planning Summit** in London on 11 July 2012. The objective was to mobilize global policy, financing, commodity and service delivery commitments to support the rights of an additional 120 million women and girls to use contraceptive information, services and supplies in the world's poorest countries by 2020. More than 20 developing countries made bold commitments to address the policy, financing and delivery barriers to this happening. Donors and the private sector made new financial commitments to support these plans amounting to US\$ 2.6 billion.¹⁶ It was announced that these commitments are above and beyond the level of funding provided for family planning in 2010, and therefore contribute to the additional funding needed. The US\$ 2.6 billion will go a considerable way towards the estimated resources needed to reach an additional 120 million women (US\$ 4.3 billion over the next eight years). The Summit agreed a methodology with donors for estimating the proportion of wider health commitments that contribute to family planning.

Born Too Soon: The Global Action Report on Preterm Birth was released in May 2012. It was developed through a joint effort of almost 50 international, regional and national organizations, led by the March of Dimes, PMNCH, Save the Children and WHO in support of the Every Woman Every Child effort. The report provided the first-ever national, regional and global estimates of preterm birth. It showed the extent to which preterm birth is increasing in most countries, and is now the second leading cause of death globally for children under five, after pneumonia.¹⁷ In response to the urgent priority of addressing preterm birth to reach MDG 4, more than 30 new and expanded commitments to prevention and care of preterm birth were made when the report was released.¹⁸



FIGURE 3: Accumulated number of stakeholders that have made commitments to the Global Strategy until April 2012

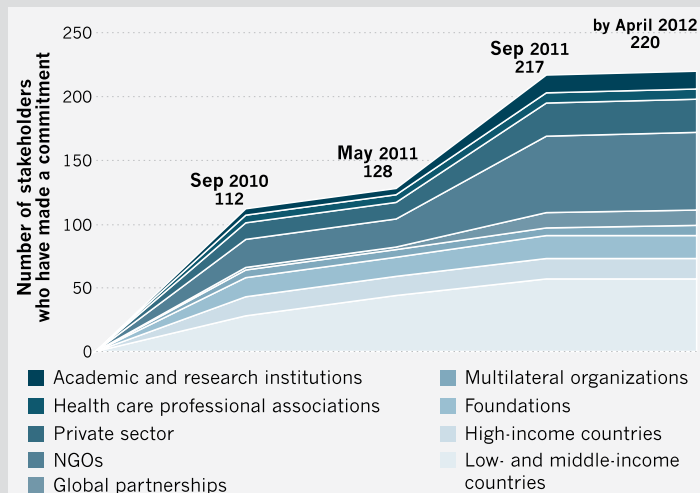
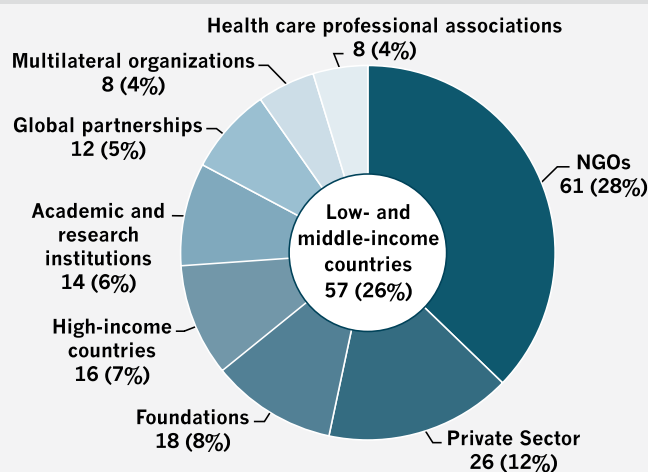


FIGURE 4: Number of stakeholders, by constituency groups, who have made commitments to the Global Strategy until April 2012



on *Preterm Birth* in May 2012, at the Child Survival Call to Action in June 2012, and at the Family Planning Summit in July 2012. For a general overview of these commitments, see Box 1.

Based on the 168 fully completed questionnaires, the analysis found that most commitments focus on support to policy, services and product delivery and advocacy (Figure 5). Almost half (45%) of the commitments specify an amount to be allocated to RMNCH. Figure 6 shows the distribution of types of support as a proportion of all commitments. More details are provided in the next chapters. No clear differences in the focus of commitments by constituency group emerged.

It is of particular importance that significant financial, policy and service delivery commitments have been made by the governments of 33 low-income and 24 middle-income countries, including 44 of the 49 countries identified in the Global Strategy as priority countries.¹⁹

FIGURE 5: Proportion of respondents indicating support for different categories of commitments²⁰

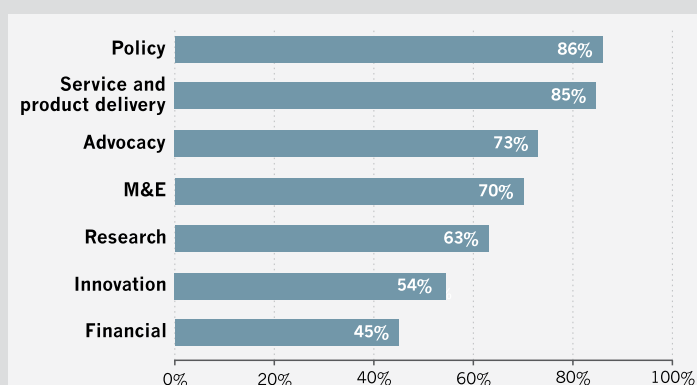
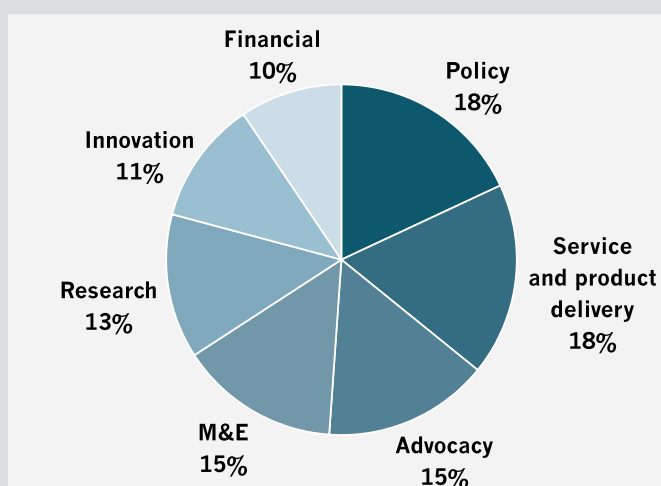


FIGURE 6: Distribution of commitments (proportion of all commitments)



FINDING 2: Focus is generally on high-burden and poorest countries.

While the Global Strategy aims to save the lives of 16 million women and children in the world's 49 poorest countries, stakeholder commitments also target other high-burden countries, such as India and South Africa. The geographical analysis thus refers to the 75 Countdown to 2015 priority countries that account for more than 95% of global maternal and child deaths. These 75 countries include the Global Strategy's 49 focus countries.²¹

Overall, several countries receive a high number of commitments: nine countries receive more than 20 commitments, and 23 more than 10. Stakeholders tend to focus on the same countries; usually those receiving the most development assistance. Not surprisingly, seven of the 10 countries being targeted by the highest number of commitments were also among the top 10 recipient countries of development assistance for MNCH in 2010.²² At the other end of the spectrum, two countries did not receive any commitments: Equatorial Guinea and Iraq. Table 1 shows the countries receiving the most commitments and the countries receiving the fewest. Annex 3 contains a full list of countries and the number of commitments received.

Stakeholders generally prioritize the 49 Global Strategy countries.

These were countries with the lowest income at the time of the Global Strategy launch in 2010. These 49 countries receive a mean of 12.1 commitments (median of 10.0) while other countries receive a mean of 7.8 commitments (median of 7.0). Eighteen of the 20 countries receiving the most commitments are all Global Strategy priority countries.

Stakeholders focus on countries with a high number of deaths.

India and Nigeria, which are now both lower-middle-income countries, but are responsible for a considerable number of maternal and children deaths, are also the first and sixth countries in terms of number of commitments (31 and 24 respectively). Globally, the 10 countries with the highest number of maternal deaths, and 15 of the 20 countries with the highest number of maternal deaths, were the focus of 10 or more commitments. Similarly, all 10 countries with the highest number of under-5 deaths, and 16 of the 20 countries with the highest number of under-5 deaths, were the focus of 10 or more commitments.

FINDING 3: Some countries are not the focus of sufficient support and inequities exist.

A closer look at individual countries reveals some gaps and inequities. Some countries with a high burden of disease do not receive as much support as others. For example, countries such as Chad, Niger and Somalia, all Global Strategy priority countries, are responsible for both a high number of maternal deaths (more than 4200 each) and child deaths (more than 70 000 each) due to very high mortality rates; each is, however, the focus of

TABLE 1: Countries receiving the most and the fewest commitments, with mortality data

COUNTRY	UNDER-5 MORTALITY RATE (DEATHS PER 1000 LIVE BIRTHS), 2010 ²³	NUMBER OF UNDER-5 DEATHS (THOUSANDS), 2010	MATERNAL MORTALITY RATIO (DEATHS PER 100 000 LIVE BIRTHS), 2010 ²⁴	NUMBER OF MATERNAL DEATHS, 2010	NUMBER OF COMMITMENTS RECEIVED
COUNTRIES WITH THE HIGHEST NUMBER OF COMMITMENTS					
INDIA	63	1696	200	56 000	31
ETHIOPIA*	106	271	350	9000	27
BANGLADESH*	48	140	240	7200	25
KENYA*	85	122	360	5500	25
TANZANIA, UNITED REPUBLIC OF*	76	133	460	8500	25
NIGERIA*	143	861	630	40 000	24
MOZAMBIQUE*	135	114	490	4300	22
MALAWI*	92	56	460	3000	21
UGANDA*	99	141	310	4700	21
PAKISTAN*	87	423	260	12 000	20
CONGO, DEMOCRATIC REPUBLIC OF THE*	170	465	540	15 000	19
GHANA*	74	57	350	2700	19
RWANDA*	91	38	340	1500	19
ZAMBIA*	111	60	440	2600	18
CAMBODIA*	51	16	250	790	16
HAITI*	165	45	350	940	16
MALI*	178	120	540	3800	16
BURKINA FASO*	176	120	300	2100	15
NEPAL*	50	35	170	1200	15
SOUTH AFRICA	57	58	300	3200	15
COUNTRIES WITH THE LOWEST NUMBER OF COMMITMENTS					
ANGOLA	161	121	450	3600	5
BOLIVIA (PLURINATIONAL STATE OF)	54	14	190	510	5
BOTSWANA	48	2	160	75	5
DJIBOUTI	91	2	200	51	5
TOGO*	103	19	300	580	5
MAURITANIA*	111	13	510	590	4
COMOROS*	86	2	280	79	3
GAMBIA*	98	6	360	230	3
GUINEA-BISSAU*	150	8	790	460	3
MOROCCO	36	23	100	650	3
UZBEKISTAN*	52	31	28	160	3
CONGO	93	13	560	800	2
ERITREA*	61	11	240	460	2
GABON	74	3	230	94	2
KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF*	33	12	81	280	2
SAO TOME AND PRINCIPE*	80	0	70	4	2
SOLOMON ISLANDS*	27	0	93	16	2
TURKMENISTAN	56	6	67	73	2
AZERBAIJAN	46	9	43	79	1
EQUATORIAL GUINEA	121	3	240	61	0
IRAQ	39	43	63	710	0

* Countries with an asterisk are among the 49 Global Strategy priority countries.

TABLE 2: Examples of differences in geographic focus of commitments

COUNTRY	UNDER-5 MORTALITY RATE (DEATHS PER 1000 LIVE BIRTHS), 2010	NUMBER OF UNDER-5 DEATHS (THOUSANDS), 2010	MATERNAL MORTALITY RATIO (DEATHS PER 100 000 LIVE BIRTHS), 2010	NUMBER OF MATERNAL DEATHS, 2010	NUMBER OF COMMITMENTS
MALAWI	92	56	460	3000	21
GHANA	74	57	350	2700	19
NIGER	143	100	590	4500	7
CHAD	173	80	1100	5300	7
SOMALIA	180	70	1000	4200	7

only seven commitments while countries with a lower number of deaths such as Ghana and Malawi were the focus of 19 and 21 commitments respectively (Table 2).

Some inequities also exist as stakeholders tend to focus on countries with a high number of deaths, putting less emphasis on smaller countries, regardless of their mortality rates and income level. Countries like the Gambia and Guinea-Bissau, both Global Strategy priority countries, have relatively high mortality rates but are targeted by three stakeholders only. Although the necessity to target countries responsible for a high number of deaths is not in dispute, increased support to small countries with high mortality rates is needed.

FINDING 4: Commitments are not closely linked to progress on the MDGs.

Figure 7 and Table 3 illustrate the degree to which the geographical focus of commitments is linked to progress towards MDGs 4 and 5a (see also Annex 3 for information on whether or not a country is on track or off track).²⁵

It should be pointed out that because the MDGs are related to the rates, the on track vs. off track analysis does not take into account impressive reductions in the absolute number of maternal and child deaths achieved by countries such as India. Because the on track and off track definition is based on the average annual mortality rate reduction in 1990-2010, it also does not reflect accelerated rates of reduction seen in the last 5-10 years in many countries.

The best targeting is represented by the large red circles, because those 23 countries are off track on both MDGs and received more than 10 commitments.²⁸ Targeting of Global Strategy commitments was not as strong for the five countries with small red circles, which are countries off track for both MDGs 4 and 5a that were the focus of fewer than three commitments.²⁹ Three countries received only one or no commitment, one country being off track on both MDGs: Azerbaijan. Seven of the eight countries on track for both MDGs 4 and 5a were the focus of at least eight or more commitments (medium or large green circles); Bangladesh was the focus of 25.³⁰

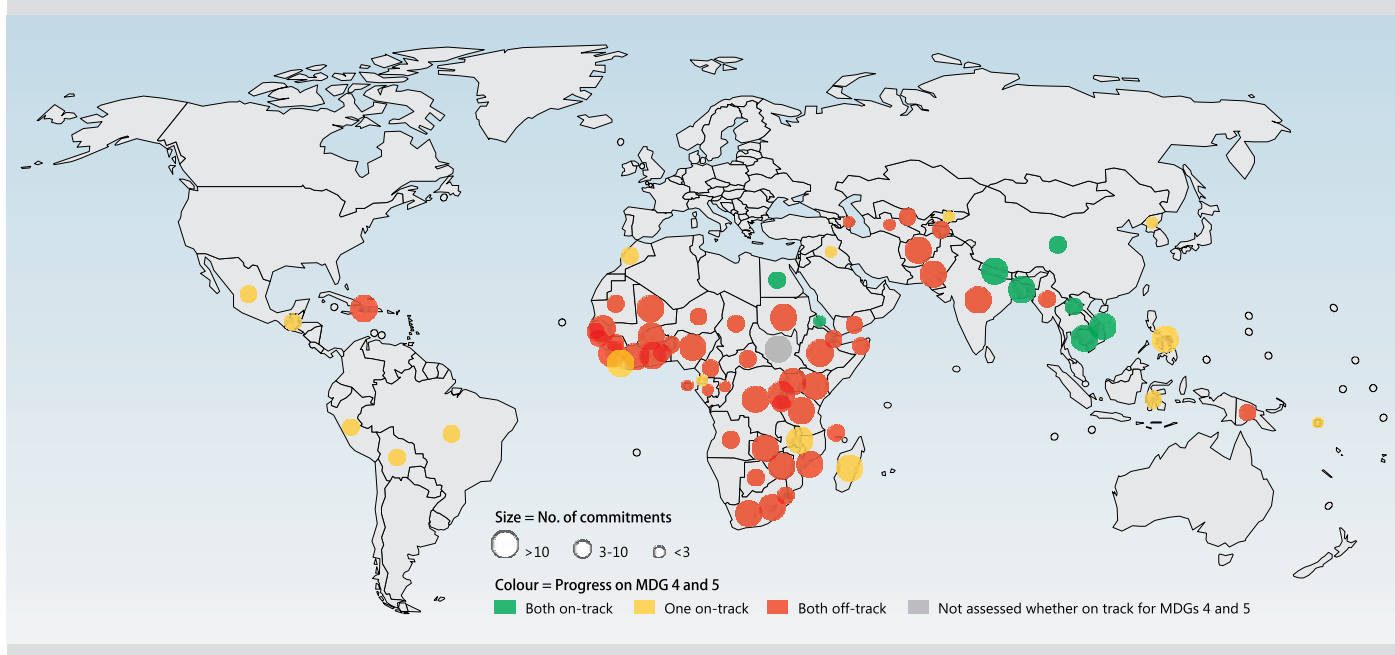
FINDING 5: Most commitments that focus on specific interventions address critical gaps, but some key interventions with low coverage still receive limited attention.

- Skilled birth attendance, with a mean coverage of less than 60%, is the area receiving most attention, with 103 respondents to the online questionnaire identifying it as a focus area;
- Antenatal care (at least four visits) is the focus of 93 respondents;

TABLE 3: Number of commitments and progress towards MDGs 4 and 5a for Countdown to 2015 countries²⁶

NUMBER OF COMMITMENTS	ON TRACK FOR BOTH MDGS ²⁷	ON TRACK ON ONE OF THE TWO MDGS	OFF TRACK ON BOTH MDGS
FEWER THAN 3	1	4	5
3-10	3	8	22
11-20	3	3	16
MORE THAN 20	1	1	7

FIGURE 7: Geographical focus related to MDG progress in the implementation of Global Strategy commitments



- Prevention of mother-to-child transmission of HIV is the third intervention reported as a priority (92 respondents). This is welcome as coverage is quite low.

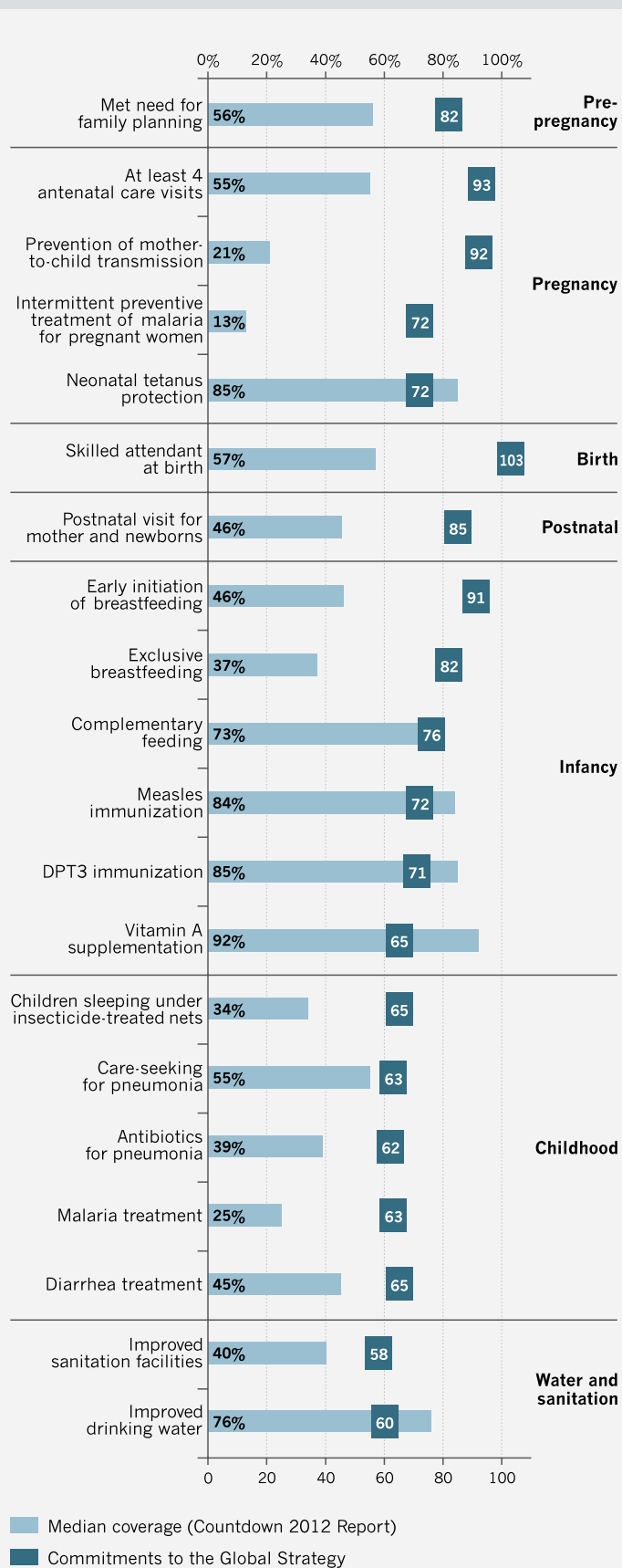
In the questionnaire, 138 respondents (84%) reported that they focus on specific RMNCH interventions in their commitments, while others provide general support to women's and children's health. Many commitments, focusing either on policy, service and product delivery, advocacy or other issues, target gaps in coverage of these essential interventions.³¹ Figure 8 relates the number of commitments focusing on specific interventions with the median coverage of these interventions.³²

Significant attention was also given to promotion of exclusive breastfeeding and early initiation of breastfeeding, postnatal visits for mothers and newborn and family planning. There is also evidence that key donors have increased their funding for reproductive health and that this trend will continue. These trends show an evolution since 2011. For example, areas such as elimination of mother-to-child transmission (EMTCT) of HIV, postnatal care visits and exclusive breastfeeding were identified as areas receiving only limited support in the PMNCH 2011 report.

However, some areas recognized as major threats to maternal and child health attracted fewer commitments: diarrhoea, pneumonia and malaria were the target of fewer than 50% of respondents. This is a finding of serious concern and in need of urgent attention. Other areas with comparatively little attention relate to specific prevention and management of preterm birth and management of neonatal infection and resuscitation. ■ ■ ■ ■



FIGURE 8: Commitments related to the median coverage of essential RMNCH interventions in Countdown to 2015 countries



FINANCIAL COMMITMENTS



This chapter provides an assessment of the financial commitments to the Global Strategy. It estimates the total value of these commitments and the amount of pledged funding that is new and additional, and analyses how these commitments contribute to bridging the US\$ 88 billion financing gap for women's and children's health in 2011-2015 estimated by the Global Strategy. It also reports on initial progress in disbursements.

It should be emphasized that this analysis is not a comprehensive stock-taking of all RMNCH-related financing. As noted throughout this report, significant other investments to improve women's and children's health are not reflected in the commitments to the Global Strategy. In addition, this analysis only includes commitments expressed in explicit financial terms. It was beyond the scope of this report to estimate the cost of the substantial policy, advocacy and service delivery commitments to the Global Strategy. The analysis therefore significantly underestimates the financial value of all Global Strategy commitments.

The analysis of the financial commitments was informed by: (i) the online questionnaire; (ii) key informant interviews with selected stakeholders and global health financing experts; and (iii) a review of literature and databases.

At the time of writing this report, just two years have passed since the launch of the Global Strategy in September 2010. This presented several challenges, which included limited data availability. For example, current data on ODA disbursements and domestic health expenditure are only available for 2010.

It is also anticipated that the eventual implementation of the COIA recommendations on tracking financial resources will provide a more complete and accurate picture of funding streams in the future (see also Finding 5).

FINDING 1: The declared financial value of all commitments to the Global Strategy is nearly US\$ 58 billion. However, once double-counting is removed, the true value is about US\$ 40 billion.

Ninety-eight explicit financial commitments, including 27 from low- and middle-income countries (LICs and MICs), have been made to the Global Strategy (Web-Annex 2). The value of these declared commitments amounts to US\$ 57.6 billion (Figure 9 provides a breakdown by constituency group).

However, the analysis finds that US\$ 14.8-17.2 billion of the financial commitments are subject to “double-counting”. Double-counting occurs when funding is reported twice by two different stakeholders. For example, a donor commitment to a global partnership (e.g. to the GAVI Alliance or the Global Fund to Fight AIDS, Tuberculosis and Malaria) is reported as a Global Strategy commitment both by the donor and by the global partnership (more details on the methods to estimate the amount of double-counting are provided in Annex 1).

Once double-counting has been accounted for, the true value of the total financial commitments is in the range of US\$ 40.4-42.8 billion.

FINDING 2: The Global Strategy has leveraged about US\$ 20 billion of new and additional funding.

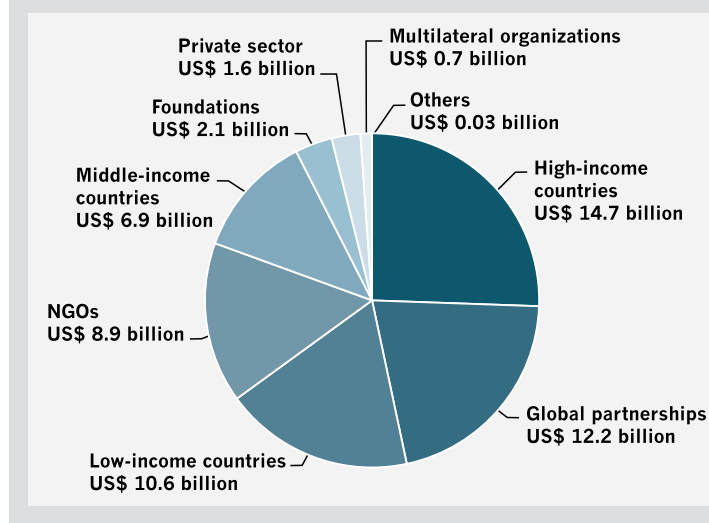
The estimated US\$ 40 billion value of the financial commitments does not distinguish new financial commitments from previously existing resources that were brought under the umbrella of the Global Strategy. The analysis shows that, out of this total amount, at least US\$ 18.2-20.6 billion (mean: US\$ 19.4 billion), including the commitments made to the Muskoka Initiative (the G8’s 2010 commitment to MNCH), can be confirmed as new and additional on top of RMNCH spending levels prior to the Global Strategy. It is important to stress that many stakeholders indicated that it was difficult to determine whether their funding was new and additional, sometimes because of lack of clear documentation of the basis of the financial commitment. When stakeholders were unable to report on whether or not their commitment is new and additional, this report did not count it as such (see Annex 1 for details on methods). The estimate of new funding is therefore significantly underestimated.

Of this US\$20 billion in new and additional funding, international donors are the source of US\$ 12.5 billion and implementing countries are the source of an estimated US\$ 5.7-8.1 billion for 2011-2015.

FINDING 3: Additional resources are still needed to meet the US\$ 88 billion financing gap estimated by the Global Strategy.

The estimated financing gap for 2011-2015 to achieve the health MDGs in the 49 countries highlighted in the Global Strategy amounts to US\$ 88 billion. Part of this gap is being filled by the close to US\$ 20 billion of additional resources mobilized by the Global Strategy to date.³⁴ In addition, as pointed out throughout the report, the commitments to the Global Strategy do not comprise the entire effort related to women’s and children’s health, and other investments would contribute to reducing the funding gap. Furthermore, as noted above, 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 contribute to narrowing the financing gap.

FIGURE 9: Declared financial commitments reported by constituency groups³³



FINDING 4: At least US\$ 10 billion of the financial commitments have been disbursed, but at varying rates by stakeholder group.

Disbursements by international stakeholders totalled US\$ 10.2 billion by September 2012.³⁵ This amount includes both existing and additional resources.³⁶ High-income countries reported that they disbursed US\$ 5.3 billion (36% of their financial commitments), foundations US\$ 652 million (31% of their financial commitments), NGOs US\$ 1.8 billion (52% of US\$ 3.4 billion, i.e. once double-counting has been removed), GAVI and the Global Fund a total of US\$ 2.5 billion (42% of US\$ 6 billion, i.e. once double-counting has been removed), and health-care professional associations disbursed US\$ 3.6 million (12% of US\$ 31 million).³⁷ The private sector disbursed US\$ 3.5 million, which is just 0.2% of the overall commitment of US\$ 1.6 billion by this sector. The low disbursement rate by the private sector could be attributed to a number of factors, including a relatively low response rate of 54% to the online questionnaire.

In addition, two MICs, India and Indonesia, reported substantial domestic health expenditures in 2011, which even exceed their Global Strategy commitments. India, for example, has reportedly spent US\$ 8 billion of federal resources on domestic RMNCH programmes since September 2010. Because this amount exceeded the Global Strategy commitment, it created a methodological challenge. It was thus assumed that one-fifth of the total commitment had been disbursed in 2011, the initial year of India’s five-year commitment (India’s and Indonesia’s disbursements do not contribute to filling the US\$ 88 billion identified in the Global Strategy because they are not among the 49 countries included in that estimate).

Only limited evidence is available on disbursements of financial commitments by LICs. The picture will become clearer as countries report on their 2011 expenditures through National Health Accounts and other means.

FINDING 5: Donors agreed upon an improved system for tracking RMNCH donor funding.

To improve the tracking of donor flows for RMNCH, the COIA recommended that, by 2012, donors should agree on how to improve the Creditor Reporting System of the OECD Development Assistance Committee (OECD-DAC) to enhance its capacity to capture RMNCH expenditures in a timely manner. Following an initiative of the Canadian government, the OECD-DAC Working Party on Statistics established an Informal Task Team on MNCH in 2011. In June 2012, Task Team members agreed to introduce a new approach to tracking RMNCH donor funds by 2013 based on quartile-scoring. Donors will indicate whether 0%, 25%, 50%, 75% or 100% of their overall funding is for RMNCH. This system should help to give a more accurate picture of RMNCH financing in future years, which is currently less precise compared to the tracking of expenditures for other health areas.

Summary

This chapter has indicated that more than US\$40 billion, after removing double-counting, has been committed to advance the goals of the Global Strategy, part of a growing trend of development assistance for health which rose from US\$ 12.3 billion in 2002 to (a projected) US\$27.7 billion in 2011.³⁸ This total of more than US\$ 40 billion combines new financial commitments with previously existing resources. Yet it is clear that the Global Strategy has leveraged a significant amount of additional funding – about US\$ 20 billion. However, additional resources are still needed to meet the US\$ 88 billion financing gap. Financial commitments are being disbursed, but LICs and MICs have indicated that they require more financial support, particularly in the context of the current global financial crisis. ■■■■



CHAPTER 4

POLICY COMMITMENTS

A cornerstone of the Global Strategy is support for country-led health policies. In this context, policies are defined as government-led decisions, plans and actions that are undertaken to achieve specific health-care goals within a society,³⁹ such as improving RMNCH outcomes. Across sectors and constituency groups, stakeholders made commitments to support government policies related to improving women's and children's health.⁴⁰ This chapter examines the types of policy support, level of policy (global, regional, national, subnational or institutional) and progress on policy implementation.

FINDING 1: All implementing country governments who made commitments to the Global Strategy made explicit policy commitments.

Other stakeholders report that they provide or would provide support to the implementation of government policies as part of their commitments, ranging from 67% among academic institutions to 100% among multilateral organizations.

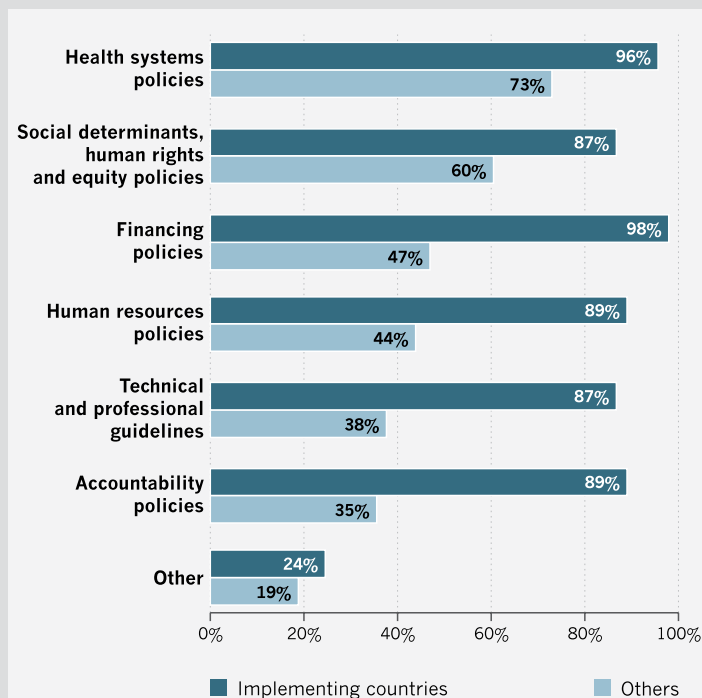
FINDING 2: While implementing countries focus on all policy areas relevant to RMNCH, other stakeholders give particular attention to health systems reform and governance, as well as to social determinants, human rights and equity issues.

The proportion of stakeholders indicating support for different types of policy is shown in Figure 10. Implementing countries address all or most policy areas, while other stakeholders focus on supporting governments in specific areas. The “non-government” stakeholders put most emphasis on supporting policies related to health systems reform and governance (73% of respondents) followed by policies on rights and equity (60% of respondents). Commitments related to policies on rights and equity primarily focused on gender and economic empowerment, non-discrimination and equitable access to health services and on citizen participation. Policies on health systems financing and on human resources for RMNCH and/or health were addressed in 47% and 44%, respectively, of the policy commitments made by other stakeholders.⁴¹

Additional information emerges when one looks at how each constituency group chose to give policy support to implementing countries: all bilateral donors and multilateral organizations focused on policies for governance and health systems reform; while 88% of bilateral donors also supported the implementation of financial policies. Accountability and technical guidelines



FIGURE 10: Proportion of respondents indicating support for different types of policy



were prioritized by 71% of multilaterals. Both foundations (78%) and global partnerships (75%) placed the strongest focus on social determinants, rights and equity, as did, to a lesser extent, NGOs (59%). Finally, academics gave priority to human resources and equity and rights policies, in addition to governance and health systems reforms.

The following sections provide examples of the implementation of policy commitments.

Health systems policies

Policies intended to strengthen health systems, and the governance of those systems, covered a wide range, from general statements of intent to very specific and focused plans.

The policy commitments of low-income countries (LICs) aim at providing the groundwork necessary to build a stronger health system. For example, the MOH of Kyrgyzstan, with the support of UNICEF, has developed a plan to improve access to perinatal services based on health services delivery levels, regionalization and timely referral of at-risk pregnant women and newborn; and Chad is creating a national policy on human resources for health.

While recognizing the importance of national policy action, commitments with international scope and reach were made by HICs, foundations and other global partners. For example, as part of the Muskoka Initiative, France committed to support national and multi-country policies and programmes to improve the development of health

systems. Many donor countries such as Australia, Japan, Norway, Sweden and the UK support the development, implementation and monitoring of national health plans in LICs and MICs. As part of its commitment, Japan launched its new Global Health Policy, with a special focus on maternal, newborn and child health. Sweden's policy for global development includes a strong focus on women's and children's health.

Foundations such as the Bill & Melinda Gates Foundation and the Elizabeth Glaser Pediatric AIDS Foundation support policy and advocacy grantees that focus their work on promoting various RMNCH policies. These include the need for sustained funding for RMNCH, the development of national HIV and RMNCH strategies and plans, and the strengthening of procurement systems and human resources.

Finally, some stakeholders focus on institution building. For example, the NGO Together for Girls is working with governments to develop and strengthen the capacity of individuals and institutions. The International Federation of Medical Students' Associations (IFMSA) collaborates with learning institutions to review the RMNCH content of medical curricula (see also Chapter 7.1).

Social determinants, human rights and equity policies

Social determinants, including gender and sociocultural issues, were identified by stakeholders as key barriers to progress in RMNCH. Gender and economic empowerment was mentioned by 56% of respondents as a focus area of their commitments. In Nepal, for example, a Gender and Social Inclusion Strategy was introduced by the MOH, including a specific focal unit to address gender issues.

Respondents indicated that considerable attention is also given to non-discrimination and equitable access to health services in the implementation of their commitments. This is reflected in a number of laws that have been passed on the prohibition of female genital mutilation, for example in Niger and Benin.

Rights to RMNCH were the focus of several global partnerships, foundations and NGOs. For example, the Global Fund for Women committed to advancing health and sexual and reproductive rights in more than 40 countries. The Elders (an independent group of eminent global leaders, created by Nelson Mandela in 2007) established Girls Not Brides: The Global Partnership to End Child Marriage. This has brought together civil society organizations, and many others, working to end child marriage. The David and Lucile Packard Foundation focuses on raising community awareness to build demand for family planning and reproductive health information, services and supplies. It has partnered with NGOs and civil society to work with local influential leaders, parents and in-laws. The work focuses on promoting the education and empowerment of girls, and women's leadership, to enhance their awareness and amplify their voices to advocate for family planning and reproductive health. In Bangladesh, an initiative called Cost of Violence Against Women (COVAW), urges policy action on domestic violence in rural areas by demonstrating its financial cost in addition to its impact on the health and well-being of women and children.

Financing policies

Stakeholders place a strong focus on RMNCH financing policy implementation in areas such as health insurance, incentive schemes and the removal of user fees; 63% support such policies in the implementation of their commitments. For example, the government of Senegal is implementing a policy on subsidies for deliveries and caesarean sections in poor rural areas – an initiative that is gradually being extended into suburban areas with high poverty rates. Bangladesh is implementing a demand-side financing programme to increase uptake of maternal health interventions (Box 2).

India has put in place a policy to provide free and cashless services to pregnant women in government health institutions in both rural and urban areas. The policy is implemented through the Janani-Shishu Suraksha Karyakram (JSSK) initiative. More than US\$ 280 million was allocated in the financial year 2011-2012 and the allocation is expected to increase each year. Services and care provided through JSSK include normal deliveries and caesarean operations with free drugs and consumables, and free food and transport. Similar entitlements have been put in place for sick newborn.

In Indonesia, funding support for a national policy to finance at least 1.5 million safe deliveries by poor women, which has been implemented and overseen by the MOH for 18 months, is being stepped up by the Ministry of Finance. Another example is the Nepalese Aama Programme, which removes user fees and provides incentives for clients and service providers. Other examples from LICs include Guinea-Bissau (ensuring that 75% of pregnant women are covered by health mutual funds); Haiti (ensuring free MNCH services); and Kyrgyzstan (100% free medical care for pregnant women and children under five). In Malawi, with government support, private sector institutions provide free maternal and child health care. In Burkina Faso, a number of NGOs have been contracted by the MOH to deliver services in specified regions and districts. In some districts of Burkina Faso, both Médecins du Monde and Terre des Hommes have been covering the 20% of fees that remain the responsibility of women under the government's subsidization programme for emergency obstetric care.

Other stakeholders also put strong emphasis on financing systems and policies (88% of bilateral donors do so). For example, Norway has been very active in the development and implementation of the GAVI/GFATM/WB Health System Funding Platform. Global partnerships such as GAVI and GFATM provide health systems strengthening support to enhance the capacity of health systems to deliver services.

NGOs are often strong advocates of RMNCH financing policies. For example, the White Ribbon Alliance for Safe Motherhood in the United Republic of Tanzania successfully deployed national- and district-level advocacy strategies to persuade the Ministry of Planning to instruct every district to include a specific budget line for maternal and newborn health. The Population Council supported policies on health financing using innovative financing schemes in countries such as Bangladesh, Cambodia, Kenya, the United Republic of Tanzania and Uganda.

Box 2: Demand-side financing for maternal health in Bangladesh

The government of Bangladesh is running a voucher scheme initiative for pregnant women, which provides incentives for facility births. Women who are eligible for this demand-side financing programme receive: three antenatal care (ANC) check-ups; safe delivery care in a health facility or at home with a skilled birth attendant; emergency care for obstetric complications (including caesarean sections); one postnatal care (PNC) check-up within six weeks of delivery; cash incentives to cover routine and emergency transport, and some food and medicine costs for the family; and a small box of gifts. The programme also provides incentives to health-care providers to identify eligible women and provide maternal health services.

An evaluation of the programme found demand-side financing to be strongly and significantly associated with higher rates of skilled birth attendance (with the likelihood of skilled birth attendance more than twice as high in intervention areas). The voucher scheme is also strongly and significantly associated with higher rates of institutional deliveries and PNC visits. This makes it much more likely that home deliveries will be attended by a qualified provider.⁴² Another study found strong evidence that demand for health services among the poor can be stimulated by demand-side financing. Poor people who receive vouchers are 4.3 times more likely to deliver in a health facility, and twice as likely to use skilled health personnel at delivery than non-poor recipients. The voucher scheme reduces inequality even in the short term.⁴³

Human resource policies

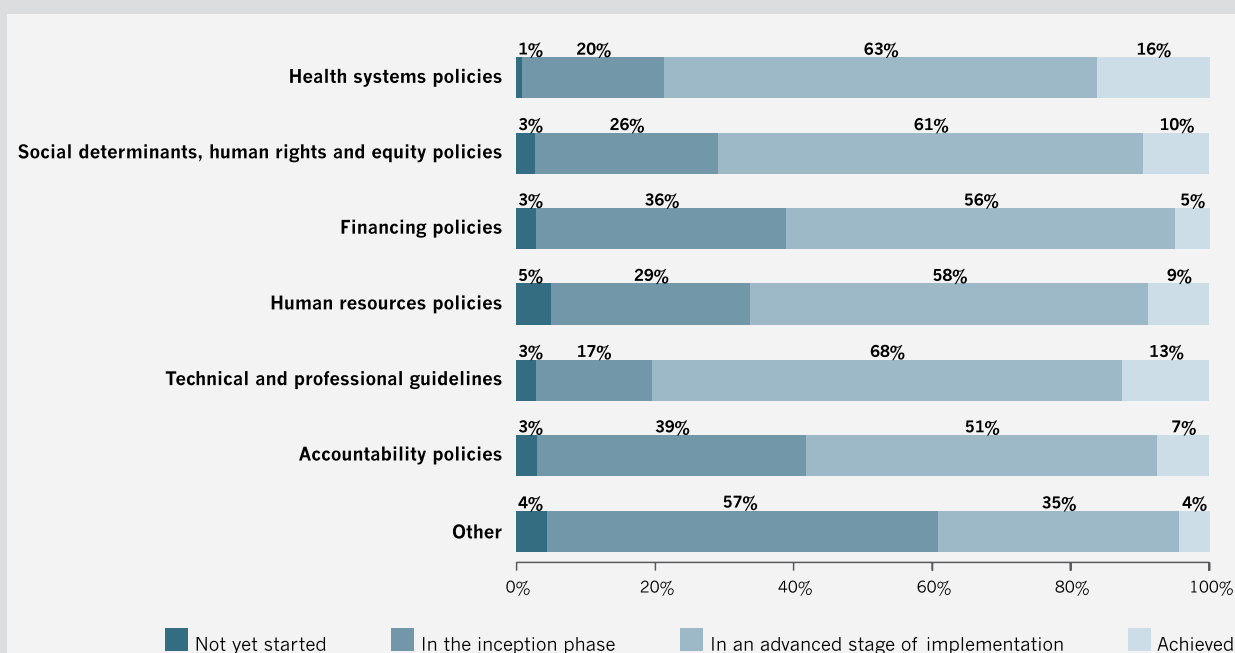
Health workforce policies are supported by 58% of respondents. More detail on the findings of the questionnaire relating to human resources, as well as findings of an H4+ survey on implementation of commitments to health workers in implementing countries, are discussed in Chapter 7.1.

Technical and professional guidelines

More than half (53%) of the policy commitments focus on policies to improve the use of evidence-based and cost-effective interventions. For example, Viet Nam introduced new technical guidelines to address one target of its commitment: to increase the proportion of pregnant women who receive at least three ANC visits. Tajikistan has committed to develop an accreditation policy for maternity institutions and to ensure that 90% of maternity hospitals are certified.

United Nations agencies such as WHO, UNICEF and UNFPA develop guidelines and training materials on evidence-based and cost-effective interventions. They also provide technical support and training to implementing countries. The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in

FIGURE 11: Progress on implementation by type of policy commitment



Human Reproduction (HRP) works to strengthen research centres, and linkages between researchers and policy-makers, in support of evidence-based national health plans. Another international organization, the GFATM, produced a tool in 2011 to provide guidance on how to include MNCH in high-quality proposals for funding.⁴⁴

NGOs and foundations are active in influencing policy changes to promote wider use of evidence-based interventions. Population Services International supported national policy change for inclusion of ORS/Zinc to be distributed by community health workers in Cameroon.

Others provide technical support to improve clinical practice. The TY Danjuma Foundation (Nigeria) has committed to providing technical support to health centres in rural communities. The Global Alliance to Prevent Prematurity and Stillbirth (GAPPS) has committed to developing and upholding a code of conduct and standards of excellence in RMNCH.

Accountability policies

Policies that aim at strengthening accountability were supported by 52% of respondents. Stakeholders are making greater and more innovative use of existing national accountability mechanisms, such as parliamentary oversight, social accountability and the media. For example, in April 2012, the Inter-Parliamentary Union (IPU) passed a resolution calling for all 120 member parliaments to take all possible measures to achieve MDGs 4 and 5 by 2015. Stakeholders emphasized that the IPU initiative represents a key opportunity to strengthen oversight for national health budgets, and to hold governments accountable for their commitments in the

context of the recommendations of the Commission on Information and Accountability (COIA). At the same time, they raised concerns about the capacity of LIC parliaments to monitor government activities and budgets effectively.

Some NGOs engage in capacity building for their partners in implementing countries. For example, World Vision is currently rolling out its Citizen Voice in Action initiative in 26 countries with plans to expand this approach to other countries in the coming years. This “uses a social accountability approach to enhance community systems towards empowerment of citizens to keep government and other health services providers accountable to deliver results and to implement commitments made by stakeholders e.g. under EWEC” (see also Chapter 9). WaterAid has created the Citizens Action Programme to empower service users to hold providers accountable. Although this is specific to water-service delivery, the community capacity developed can also contribute to citizen participation in health service access and improvement.

ICTs and social media have a promising role in efforts to strengthen accountability for women’s and children’s health. They are being used either to publicize data about policy implementation (e.g. the International Baby Food Action Network web portal) or to share accountability tools with activists and citizens. The White Ribbon Alliance (WRA) reported that it supports a number of grassroots accountability efforts from WRA organizational members (see also Chapter 7.2). For example: “In Pakistan, the Health Service Academy, an autonomous public health institute of the government of Pakistan, created a multimedia primer detailing maternal health policy and the cost of not investing in maternal health. This is being used to influence policy-makers at the federal and provincial levels.”

FINDING 3: Stakeholders report that implementation is at an advanced stage.

Analysis of online questionnaires indicates the following rate of implementation of policy commitments (Figure 11 shows progress by type of policy commitment):

- Achieved – 9%;
- In an advanced stage of implementation – 56%;
- In the inception phase – 32%;
- Not yet started – 3%.

This chapter has described support for the development and implementation of government-led policies and plans to improve women's and children's health. All implementing country governments who made commitments to the Global Strategy have made explicit policy commitments. Most other stakeholders report providing support to government policies. Most attention was paid to health system reform and governance, with significant support also provided to policies on social and cultural rights and equity, and financing. Based on responses to the online questionnaire, implementation of policy commitments is at an advanced stage. ■■■■



DELIVERING SERVICES AND PRODUCTS AND STRENGTHENING HEALTH SYSTEMS



Global Strategy commitments are providing significant support to service and product delivery and to health systems strengthening. This chapter provides an overview of progress in implementation of commitments to improve service and product delivery, and gives illustrative examples. It should be noted that many commitments to service and product delivery and health systems did not specify a financial value, so this could not be included in the estimated global total of financial commitments.

FINDING 1: Strong support for service and product delivery and health systems strengthening.

All stakeholder groups provided significant support, which averaged 85% among all stakeholders. This ranged from 69% among foundations to 100% among multilateral organizations and health-care professional associations.

FINDING 2: Most focus on the building blocks of health systems. With the exception of education, relatively little attention was given to intersectoral areas, including nutrition.

The distribution of commitments by service and product delivery category is shown in Figure 12. Training and recruitment of human resources⁴⁵ receive the most support (82% of the commitments on service and product delivery), followed by initiatives aimed at strengthening infrastructure and delivery systems, including establishing new health facilities and improving existing ones, and strengthening community systems. In addition to supporting improvements to service delivery facilities, establishing new research and training institutions and improving existing ones is supported by more than half (56%) of the respondents (data not shown in figure).

Both health information systems and initiatives to inform and educate the public about RMNCH (to promote healthy behaviours and build demand for commodities and care) are supported by a majority of the stakeholders.

With the exception of education, which was highlighted by 55% of respondents, other sectors or activities that have an impact on women and children's health and access to care, like agriculture and transportation, are given less attention. An exception comes from Liberia, where the community health service programme is being strengthened through support from partners to buttress health facilities' efforts, especially in the areas of disease prevention, water and sanitation and home-based management of major childhood diseases.

Human resources for RMNCH and/or health

Training and recruitment of skilled birth attendants, midwives and other health workers is seen as a key element by 82% of stakeholders. Commitments that address human resources issues, as well as the findings of an H4+ (UNFPA, UNICEF, WHO, World Bank, UNAIDS and UN Women) survey on implementation of Global Strategy commitments on health workers, are discussed in Chapter 7.1.

Infrastructure and delivery systems

Stakeholders aim to build new facilities and improve existing ones, and to reinforce community systems. For example, India is strengthening its public health delivery system by investing to ensure that health facilities are functional. More than 16 000 health facilities have been identified as delivery points and have been geared to provide a comprehensive package of RMNCH services and care. Resources have been channelled to these delivery points on a priority basis in order to fill gaps in areas such as infrastructure, trained and skilled human resources, drugs and supplies and referral transport. Another example is India's decision to provide incentive payments to Accredited Social Health Activists (ASHAs) to provide home-based care to all newborn up to six weeks of life, irrespective of the place of delivery. Under this scheme, ASHAs have to visit new mothers six times in 42 days to encourage safe newborn-care practices and to enable early detection and free referral of sick babies. They are paid only after the completion of the 42 days and the provision of required services such as immunization.

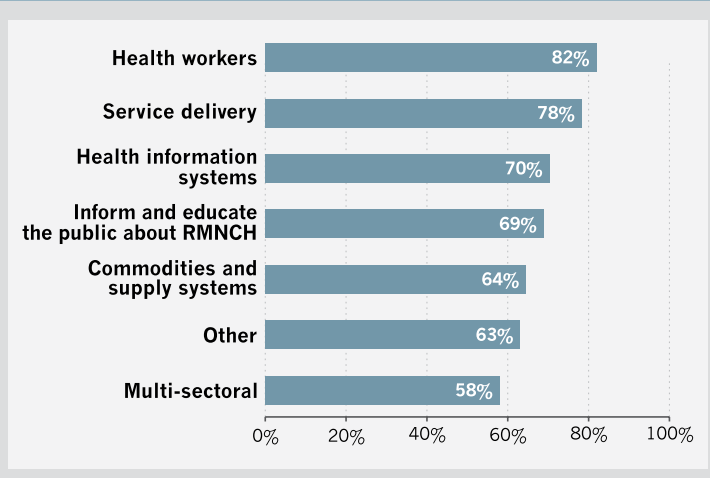
Yemen has improved the existing health facility network, including neonatal and maternal health services. In addition to improving basic and comprehensive obstetric emergency services, several main hospitals, health centres and health units have been strengthened through provision of medical equipment and appliances.

There are several examples of private sector commitments to service and product delivery; through sustainable business models and partnerships as well as philanthropic activities. For example, Novartis is addressing the lack of access to life-saving medicines among rural Indians who earn between US\$ 1 and US\$ 5 per day by reaching out to them through a pharmaceutical delivery business called Arogya Parivar (AP). Novartis is developing more affordable products by reducing packaging sizes and manufacturing locally. In parallel, it has established a distributor network of local sales teams to provide access and reduce mistrust among potential customers. In partnership with the public sector, Novartis has involved key local stakeholders in villages to educate people about disease prevention and why it is important to seek timely treatment for ailments.

Health information systems

Most stakeholders aim to strengthen health information systems and use ICT more effectively. The country case studies (see also Chapter 8) provide some examples: Bangladesh received the United Nations Digital Health for Digital Development award in September 2011 for

FIGURE 12: Proportion of respondents indicating support for different categories of commitments to service and product delivery



integrating new ICT approaches into the Management Information System for health and nutrition.

Other examples of progress include the introduction in India of a Mother and Child Tracking System (MCTS). This has enabled better tracking of pregnant women and newborn to ensure adequate prenatal and postnatal care, and encourage institutional deliveries and complete immunization of newborn. Infrastructure in states is being strengthened to ensure full coverage of new pregnancies and new births. As of August 2012, data for approximately 18 million pregnant women and 12 million children had been recorded.

The Well Being Foundation of Nigeria has developed an integrated maternal, newborn and child health (IMNCH) Personal Health Record® in partnership with the Federal Ministry of Health. It captures “store, query and retrieve” data to inform decision-making by health-care workers from the clinics, as well as strategic decisions at a higher level. In partnership with Intel Corporation, a digital platform for the WBF IMNCH Personal Health Record® is in development. This will facilitate systematic implementation of data utilization and dissemination.

One of the priorities of the Global Fund to Fight AIDS, Tuberculosis and Malaria is country monitoring and evaluation systems strengthening. It recommends that countries invest between 5-10% of grant resources for monitoring and evaluation activities, including strengthening of the health information system, surveys, operational research, programme reviews and evaluations.

Finally, the Bill & Melinda Gates Foundation supports improvement of the district-level health information management system in Ghana through cell phone technology. This improves the quality and detail of the data and saves the time of frontline health workers.

The potential of information systems and ICT in health often remains unexploited at scale and inadequately evaluated. However, more-effective use of ICT is one of the key recommendations of the COIA, so it is hoped that the picture will have changed in 2013.

Information and education about RMNCH to promote health and increase demand for commodities and care

Almost 70% of stakeholders said they supported the provision of information and education for target populations, but gave only limited details of the content. Community systems and volunteers are often in charge of providing these services. For example, the MNCH programme in Nepal uses a community network called Female Community Health Volunteers to deliver preventive, promotional and curative services. Community volunteers promote family planning services, maternal health services (such as birth preparedness) and care during and after childbirth. Similarly, Liberia is promoting RMNCH through its community health services programme.

Commodities and supply systems

Development and delivery of health products and technologies is also receiving significant attention. Collaboration with the private sector on pharmaceuticals, medical devices and diagnostics, and ICT is particularly important in this area. Some stakeholders, such as foundations and NGOs, focus on the development of new tools. Others, such as low-income countries and global partnerships, emphasize the introduction and delivery of health products, as well as supply-system strengthening.

An example of progress in developing new technologies is the John D. and Catherine T. MacArthur Foundation.

This is financing the development of a “solar suitcase” to bring light and power to maternity wards and help staff deliver babies at night. Prototypes are being piloted around the world.

In its 2011-2015 strategy, the GAVI Alliance focuses on new vaccines with the greatest potential to achieve progress towards the MDGs, and in particular MDG 4 on reducing child mortality. It intends to accelerate the introduction of routine meningitis, pneumococcal and rotavirus vaccines, and to start supporting the introduction of vaccines against rubella and human papillomavirus (HPV). Since 2010, 18 countries have introduced the pneumococcal vaccine; in 2011, Sudan became the first GAVI-eligible country in Africa to introduce the rotavirus vaccine, followed by Ghana, Rwanda and Yemen in 2012. HPV can cause cervical cancer, one of the leading causes of cancer deaths in the poorest countries. A potential side benefit of introducing the HPV vaccine is that it should help other sexual and reproductive health services reach out to adolescent girls. In addition, GAVI supports the supply, distribution and maintenance of drugs, equipment and infrastructure by funding initiatives to strengthen health systems.

Implementing countries also focus on strengthening supply chains and management of health products. For example, Liberia reports that it has constructed several warehouses, deployed regional and county pharmacists and procured supply-chain vehicles with support from global partners. In the United Republic of Tanzania, obstetric and newborn care equipment is being distributed to 780 facilities country wide.

FIGURE 13: Progress on implementation of service and product delivery commitments

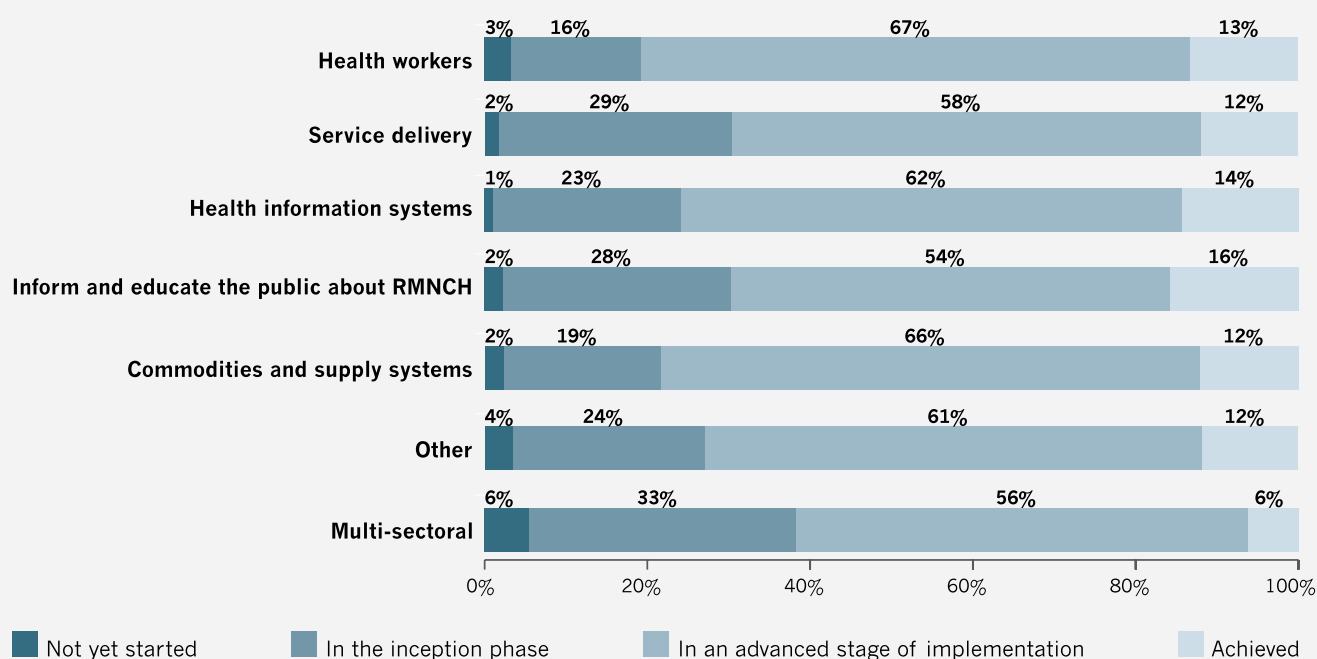
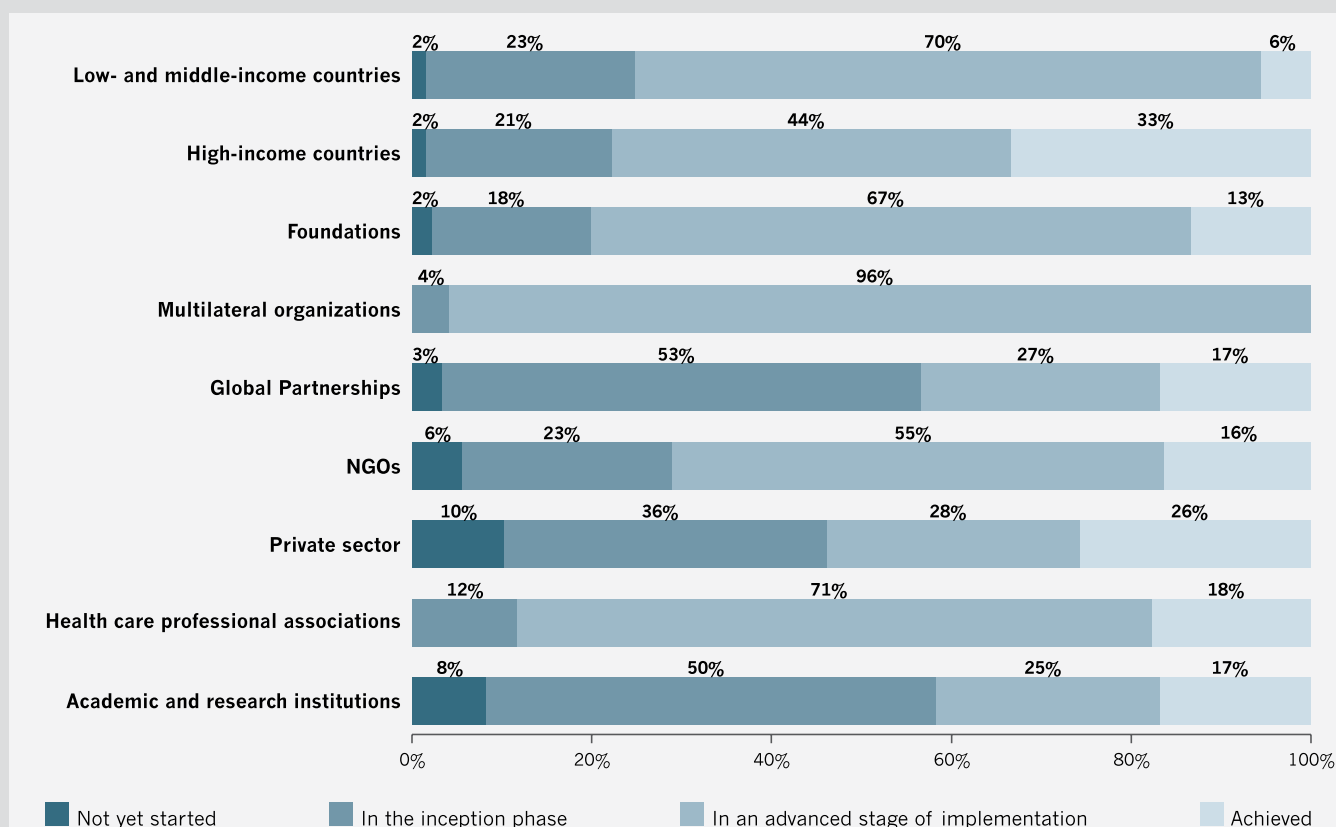


FIGURE 14: Implementation of service and delivery commitments by constituency groups



FINDING 3: Implementation of commitments is well underway.

Stakeholders' responses show the following average rate of implementation of commitments to service and product delivery (Figure 13 shows progress by type of commitment):

- Achieved – 12%;
- In an advanced stage of implementation – 61%;
- In the inception phase – 24%;
- Not yet started – 3%.

Figure 14 shows implementation rates by constituency groups.

Summary

This chapter has shown that Global Strategy commitments provide support to improve services and product delivery, as well as health systems strengthening. Based on responses to the online questionnaire, it has also shown that the implementation of these commitments is underway. Most of the commitments focus on the building blocks of the health system, in particular human resources, strengthening infrastructure and delivery systems, improving health information and strengthening community systems. Far less attention has been paid to inter-sectoral areas, such as nutrition. Constraints and challenges to implementation are discussed in Chapter 6. ■ ■ ■ ■ ■



CATALYSTS AND CONSTRAINTS TO THE IMPLEMENTATION OF GLOBAL STRATEGY COMMITMENTS



Based on responses to the online questionnaire, progress on implementation is globally on track at this stage – 10% of the commitments are reported as being achieved and 59% are in an advanced phase of implementation. Only 3% have not yet started implementation. Stakeholders report that the Global Strategy has often been an accelerator of progress, but they also encounter well-known obstacles to implementation.

FINDING 1: The Global Strategy itself is a catalyst for alignment and action.

The Global Strategy is reported by an overwhelming majority of stakeholders as having delivered significant benefits and enhanced efforts to improve women's and children's health. One catalyst most often mentioned is the increased high-level political support to RMNCH initiatives, both globally and nationally. The Global Strategy helps to mobilize political will and leadership among donors, country leaders and other high-level stakeholders.

The Global Strategy has also generated alignment by building consensus on key needs and principles for accelerating action towards the MDGs. It has created a unified framework that has clear buy-in and support from key constituency groups and that endorses and legitimizes the continuum of care. It has also helped stakeholders align their strategies and programs with the goals and focus of the Global Strategy. At the country level, it raises visibility of existing RMNCH national plans and objectives while promoting greater alignment around evidence-based and cost-effective interventions and approaches. The findings of the country case studies in Bangladesh, Burkina Faso and Uganda show that initiatives in those three countries are generally aligned with national health plans (Chapter 8).

Finally, other stakeholders stated that, by putting emphasis on public-private partnerships, the Global Strategy has promoted innovative approaches and technologies through initiatives such as Merck for Mothers and the Johnson & Johnson Strengthening Capacity for Maternal and Newborn Health project (Box 3) and Intel Corporation's 1Mx15 Health Initiative (Box 7).

The country case studies (see also Chapter 8) provide examples of the Global Strategy's catalytic role on the ground. In Bangladesh, for example, progress towards MDGs 4 and 5 is being accelerated in a number of ways. These include: strengthening the role of RMNCH within national plans; ensuring accountability for results and resources; ensuring commitment from the highest levels of the government; supporting capacity building at the district level; and increasing harmonization and coordination at policy level between the government and development partners.

Box 3: Examples of transformative public-private initiatives for RMNCH

MERCK – Merck for Mothers

In 2011, Merck committed to joining global partners to save the lives of women during pregnancy and childbirth through Merck for Mothers, a 10-year, half-billion-dollar initiative (www.merckformothers.com) to reduce maternal mortality around the world. This large scale innovative programme seeks to accelerate access to proven solutions; develop sustainable and game-changing prevention, diagnostic and treatment products and technologies; and support public awareness, improved policies and broader private-sector engagement in the area of maternal health in close collaboration with other stakeholders.

In October 2011, Merck for Mothers awarded a one-year, US\$ 2.5 million grant to PATH, a non-profit organization dedicated to advancing health technologies for low-resource settings, to identify and deliver high-impact maternal health technologies to address the leading causes of maternal mortality. In 2012, as part of Merck for Mothers, Merck committed more than US\$ 50 million to *Saving Mothers, Giving Life*, a collaboration among Merck for Mothers, the US Government, the Government of Norway, the American College of Obstetricians and Gynecologists (ACOG) and Every Mother Counts to reduce maternal mortality in selected regions in Africa where maternal mortality is high. In 2012, Merck also committed up to US\$ 25 million over eight years to increase access to family planning and reproductive health commodities in partnership with the Bill and Melinda Gates Foundation and other partners.

JOHNSON & JOHNSON – Strengthening Capacity for Maternal and Newborn Health

Johnson & Johnson with the H4+ are tackling the critical shortage of health workers in Ethiopia and the United Republic of Tanzania, as well as aiming to increase the number of facility-based births. These issues are being addressed through initiatives that train health workers (such as nurses, midwives and general practitioners), by scaling up maternal death and perinatal audits, and by encouraging the sharing of clinical knowledge among East African countries.

In addition, Johnson & Johnson is providing access to healthcare and medicines through innovative and sustainable solutions by leveraging existing and emerging technologies such as mobile phones. Through the Mobile Alliance for Maternal Action (MAMA) it brings timely and culturally relevant antenatal and postnatal information to women in 22 countries.

In Burkina Faso, service delivery has benefited from strengthened alignment of partners. The government has shown considerable leadership in spearheading initiatives that support RMNCH services. These include: strengthening of human resources; task sharing; the provision of free or subsidized maternal and child health care services; and contracting of NGOs as service providers.

In Uganda, interviewees felt that Global Strategy commitments had provided an additional “boost”, “impetus” and “enthusiasm” for existing RMNCH processes. Many respondents noted that Global Strategy commitments align and are mutually re-enforcing with past policy commitments, such as: the International Conference on Population and Development (ICPD); MDGs; Maputo Plan of Action; and the African Union (AU) Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA).

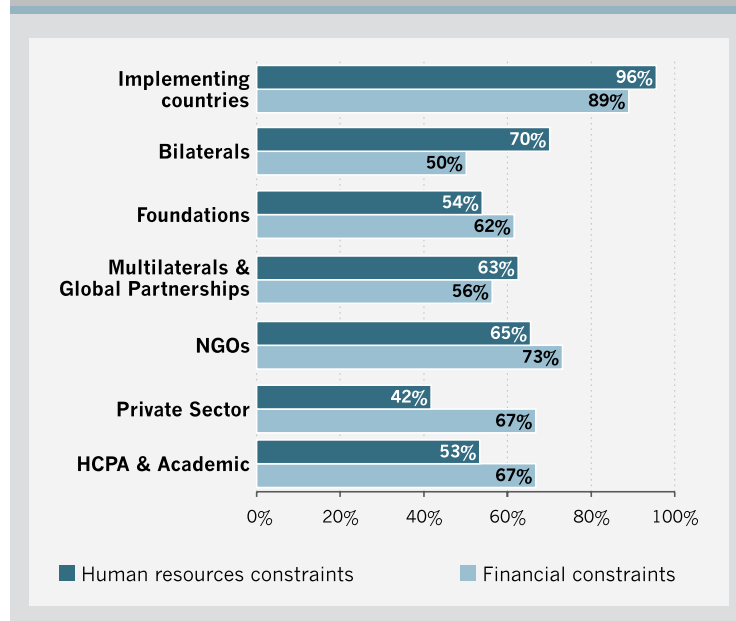
FINDING 2: Financial and human resources issues identified as major constraints.

Stakeholders consistently identified lack of funding and human resources issues as the largest barriers to the implementation of initiatives for RMNCH (Figure 15). Human resources constraints will be further discussed in Chapter 7.1.

More than 87% of the implementing countries and 73% of the NGOs reported insufficient financial resources as a major constraint. Implementing countries reported that, while they have established strategies and roadmaps, the funds available to them are insufficient to implement the

planned actions: “The main challenge we have encountered so far is that there are inadequate resources to implement the policies” (Sierra Leone); “The resources allocated [to facilities] are insufficient to cover the reimbursement of the health services provided” (Senegal).

FIGURE 15: Proportions of stakeholders mentioning financial and human resources as constraints for implementation of RMNCH initiatives



Some noted that their government's contribution to the health sector is insufficient. Others mentioned slow disbursements and lack of consistency of partners. In addition, donors often have preferences about what they fund, which leaves some priority areas underfunded in the implementing countries: "[We need] partners and donors to be encouraged to follow government priorities and plans at all times" (Kenya); "The under-financed programmes are the improvement for health facilities and improvement of human resources; in particular, in the past five years, very few donors funded medical equipment (e.g. X-rays) and none provided funding for higher education programmes such as Masters and PhDs. Donors and development partners are not very comfortable/eager to provide funding for such activities" (Indonesia).

Others stakeholders added it is unlikely they will be able to meet their own commitments in full without increased external funding.

FINDING 3: Health systems and sociocultural issues also result in significant constraints, alongside other issues.

In addition to human resources, stakeholders also highlighted other health systems components as constraints. Many mentioned the need to focus on strengthening the health system overall, as opposed to planning for, and funding, vertical or disease-focused programmes.

Scaling up access to basic and comprehensive emergency obstetric care is hindered in many countries by shortages of health equipment and commodities (e.g. products and drugs) and by poor infrastructure (e.g. operating theatres). Stakeholders also mentioned poor health-information systems as obstacles to evidence-based decision-making and monitoring of activities. In addition, a weak infrastructure beyond the

health sector (e.g. roads, transportation) often makes it difficult to reach the "rural poor".

Social determinants, including gender and sociocultural issues, are also considered key barriers to the implementation of commitments. For example, respondents from Burkina Faso and Uganda reported that myths and misconceptions had a negative effect on utilization of services. One donor stated: "When it comes to sexual and reproductive health and rights, we confront very conservative attitudes that we believe are constraining progress in maternal health. In addition, in some countries women often don't have control over utilization of health services and decisions are made by husbands or in-laws."

At the broader political and socioeconomic level, factors such as civil conflicts and natural disasters were also mentioned as a negative influence on implementation. Finally, more work needs to be done on sectors that are not directly within the health budget/sector but are critical to RMNCH improvement, such as nutrition, food safety, safe water, sanitation and hygiene.

Summary

This chapter has shown that the Global Strategy is perceived as a catalyst for alignment and action. Respondents have highlighted that it has helped to mobilize high-level political will and leadership. The Global Strategy is also appreciated for generating alignment among stakeholders and forging consensus on the key needs and principles for accelerating action towards the MDGs. The chapter has also highlighted a number of obstacles to implementation of commitments, such as lack of funding, slow disbursements, human resources constraints and broader weaknesses in health systems, including insufficient health equipment. Gender and sociocultural issues were also identified as a constraint to progress. ■■■■



CHAPTER 7

THEMATIC ANALYSES

7.1 HUMAN RESOURCES FOR HEALTH

Two years after the launch of the Global Strategy, countries and global stakeholders acknowledge more than ever that an inadequate system of health workers is one of the major constraints to improving women's and children's health. Essential health workers include community health workers, skilled birth attendants, nurses, midwives, doctors, obstetricians and other health workers with midwifery competencies.⁴⁶

The importance of supporting and strengthening human resources for health (HRH) to accelerate progress towards achieving MDGs 4 and 5 is reflected in commitments by implementing countries and other stakeholders. This chapter describes the commitments to strengthen human resources for health and progress to date. However, it should be noted that assessing year-on-year progress in implementing health-worker commitments, and their impact on the ground, can be difficult. Challenges at the policy, regulatory and financial level are complex, so a significant amount of time is required before progress can be seen. The chapter was informed by: (i) the online questionnaire; (ii) a survey carried out by the H4+ to track the implementation of HRH commitments by national governments; and (iii) the country case studies.

FINDING 1: Significant support for human resources.

Globally, 122 respondents to the online questionnaire reported support related to HRH improvement, including 44 low- and middle-income countries. Numerous respondents (82) indicated support through a policy commitment. For example, the government of Liberia introduced a new policy on Human Resources for Health and Health Financing in 2011, and made medical education free with a minimum monthly stipend for students. The Ministry of Health in Nepal is in the process of endorsing a Human Resource Strategy to alleviate challenges related to the management of health workers. Mauritania is improving the management of human resources through its commitment. At the global level, the Global Health Workforce Alliance is using a combination of advocacy and knowledge brokering activities to improve health workforce availability and capacity in priority countries.

Although implementing countries gave a lot of information about training and recruitment initiatives (see below), they provided less details on the development and implementation of policies aimed at addressing the other human resources challenges; this may imply insufficient action. Some additional challenges are extremely difficult to tackle, such as: retention problems;



low motivation and quality of health workers; and geographical disparities. However, it is critical that implementing countries aim at finding solutions with the support of other stakeholders, because these issues also represent major bottlenecks to effective delivery of RMNCH services.

More than 100 (113) respondents indicated support through their commitments to service delivery and health systems strengthening, as noted above. The majority concerned: training and/or recruitment of midwives (88 stakeholders), skilled birth attendants (76) and other health workers (102). For example, the government of Cambodia committed to enrol all graduated midwives and to allocate them to provinces and remote areas. In Guinea-Bissau, more than 90% of midwives have been trained in emergency obstetric care.

In Niger, 535 medical doctors and 1100 midwives and nurses have been recruited. In Nepal, 3071 skilled birth attendants had been trained as of January 2012. Each year in Nepal around 700 nursing staff are trained in clinical skills at various levels, and around 500 health workers receive refresher training on reproductive health. Finally, at a multinational level, the International Federation of Medical Students' Association (IFMSA) supports improving education of medical students on RMNCH in several countries (Box 4).

FINDING 2: Progress on implementation is reported to be well under way.

Based on responses to the online questionnaire, progress on implementation of health-worker-related commitments is well under way (Figure 16).

Box 4: Students focus on standards of RMNCH and adolescent health teaching in medical schools

In September 2011, the International Federation of Medical Students' Associations (IFMSA, www.ifmsa.org) made a commitment to the Global Strategy to assess the exposure of medical undergraduates to learning on women's and children health. The aims were to identify areas to strengthen and to advocate for making this learning more relevant to preparing doctors for their 21st century role within the context of global health.

With funding from the Partnership for Maternal, Newborn & Child Health (PMNCH), an IFMSA implementation team of medical students launched the Learning Project, supported by the University of Aberdeen – a member of the academic, research and training constituency of PMNCH. The project is currently in an initial scoping phase (November 2011 – October 2012) to establish the extent and nature of the learning some students have already experienced and their satisfaction with this, as well as to assess the demand in the student body of the IFMSA.



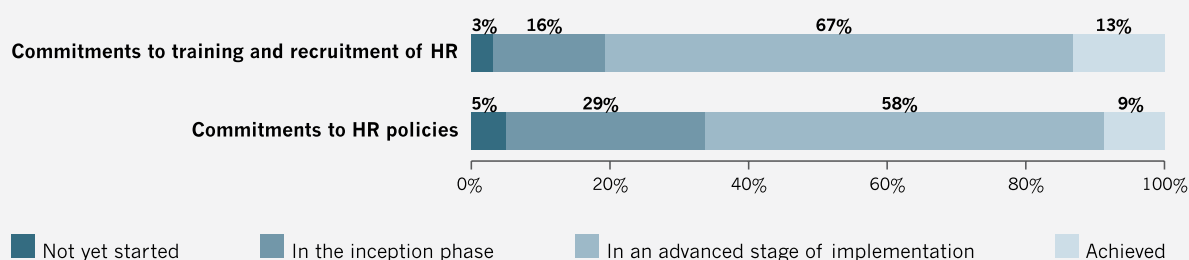
In March and April 2012, an initial small-scale questionnaire survey was conducted with 134 medical student members of the IFMSA from developed and developing countries. 80% of respondents said this was a crucial subject for all students. One respondent said: "this kind of topic should be compulsory [in curricula and training materials], but well done in order to open minds." This initial pilot work was used to refine the questionnaire and to implement a further survey at the IFMSA General Assembly in Mumbai in August 2012. Over 500 students completed the form and work is now underway to analyse the data. The findings on exposure and demand will then inform follow-on activities in a second phase of the Learning Project, such as opportunities to strengthen learning on global health alongside students from other disciplines, developing promotional material for advocacy for learning on women's and children's health, and establishing learning networks. The Mumbai conference also provided the opportunity to

hold workshops and qualitative interviews with the students and hear directly their perspectives on the challenges and opportunities for all future doctors to see health as more than a medical issue in the shared world.

The IFMSA is an NGO representing associations of medical students in more than 100 countries. Joško Miše, Director of the IFMSA Standing Committee on Reproductive Health and AIDS, articulates the importance of medical students to improving the health of women and children everywhere:

"Medical students are critical to reducing the numbers of mothers and children who die unnecessarily every day. But the health workforce needs to be educated about the problems faced. We are undertaking this project to ensure that the next generation of health workers are well equipped to play their part – along with others beyond the health sector – in helping to tackle these issues."

FIGURE 16: Progress on implementation of policy and service delivery commitments focusing on health workers



This finding from the online questionnaire is in line with the results from the H4+ survey. Of the countries surveyed by the H4+, 84% reported that they had trained and deployed additional midwives and skilled birth attendants, 76% had taken action to build or strengthen midwifery/nursing schools, while 77% had carried out activities to improve health worker performance.

Other questions in the H4+ survey attempted to assess the degree to which countries acted on commitments to train providers on specific issues. For example, 94% of countries surveyed reported some training of providers in adolescent and reproductive health issues during the past year. Additionally, 82% of countries surveyed

reported action to train providers on broader sexual and reproductive health issues, including domestic violence and prevention of female genital mutilation.

Specific examples of progress on the implementation of HRH commitments are provided in Boxes 5 and 6.

South Sudan, the world's newest country, came into being with a paucity of health infrastructure and few trained health professionals. The H4+ partners are supporting the country by helping to recruit and place 18 international midwifery advisers in hospitals across the 10 states of South Sudan. A mid-term review of the project in 2011 found that the midwives had: provided 7000 safe deliveries in hospitals and facilities; treated more than 2000 complicated pregnancy cases; and provided clinic-based antenatal care to more than 10 000 women. Through the 18-month programme, 47 people were trained as community midwives. These advances are helping the country make progress on its Global Strategy commitment of training 1000 enrolled/registered midwives by 2015 and establishing six accredited midwifery schools or training institutions.

Box 5: Implementing the health worker commitment in Bangladesh

The country case study carried out in Bangladesh included an analysis of how human resources are addressed by the government and its partners. In particular, the health sector plan acknowledges that skills shortages and poor staff retention are critical constraints to scaling up delivery of programmes and services. In response, in 2008-2009 the Ministry of Health and Family Welfare prepared a comprehensive reproductive health action plan that addressed issues of promotion, transfers and training to increase the number of staff in various cadres and to provide incentives for those working in remote areas.

The government's commitment to addressing human resource gaps was demonstrated at the launch of the Global Strategy in 2010, when it pledged to train and deploy an additional 3000 midwives in the country by 2015. Promising progress has been made. Bangladesh approved a six-month course for nurses who wished to go beyond basic midwifery training to obtain a midwifery certificate, as well as a three-year direct-entry education programme. In 2011, on the International Day of the Midwife (5 May), the government graduated its first group of 60 certified midwives. By the end of the year, an additional 140 midwives had completed the programme.

Box 6: Delivering safe motherhood in the world's newest country

South Sudan, the world's newest country, came into being with a paucity of health infrastructure and few trained health professionals. The H4+ partners is supporting the country by helping to recruit and place 18 international midwifery advisers in hospitals across the 10 states of South Sudan. A mid-term review of the project in 2011 found that the midwives had: provided 7000 safe deliveries in hospitals and facilities; treated more than 2000 complicated pregnancy cases; and provided clinic-based antenatal care to more than 10 000 women. Through the 18-month programme, 47 people were trained as community midwives. These advances are helping the country make progress on its Global Strategy commitment of training 1000 enrolled/registered midwives by 2015 and establishing six accredited midwifery schools or training institutions.



United Nations organizations and other development partners are supporting countries implementing Global Strategy initiatives. For example, in 2011 the H4+ and CIDA began offering targeted support to strengthen evidence-based policy in a group of countries where the problem of maternal and newborn mortality is most acute. This represents the first country-level collaboration of the H4+ in support of the implementation of the Global Strategy, with an emphasis on supporting health system strengthening across the full continuum of care. Through the provision of joint support to five countries (Burkina Faso, Democratic Republic of the Congo, Sierra Leone, Zambia and Zimbabwe), the H4+ is supporting catalytic programming to accelerate existing country-level efforts by targeting implementation bottlenecks and gaps, and prioritizing specific interventions and innovations.

Specifically, the 2011-2016 initiative provides: joint support for national scaling up of integrated RMNCH interventions; strengthening of national health systems (in partnership with other stakeholders and guided by national health plans); and collection and analysis of data to identify, document and support innovative

approaches and provide evidence of what works (for adaptation and roll-out in other high-burden countries). Achievements to date include: development of country-level workplans with specific actions to accelerate meeting their commitments; development of joint H4+ plans for global-level activities; baseline assessments of the current RMNCH status in all five countries; and a common monitoring and evaluation framework and its application to five country workplans.

In addition, UNFPA followed up on the 2011 State of the World's Midwifery Report and the National Assessments referenced above by launching a knowledge-management platform in November 2011. This is a repository for all available information on midwifery and a tool for knowledge sharing among countries. Coupled with the endorsement of global competencies and standards for midwives at the International Conference of Midwives (ICM) Congress in June 2011, this serves to strengthen the midwifery profession globally. It empowers country governments and other actors to deliver quality training and elevate the level of care provided to women and children.

FINDING 3: Human resources are still a constraint to implementation of other commitments.

Human resources were identified by respondents as a constraint to implementation and most stakeholders mentioned shortages of skilled health workers. The Global Strategy appears to have led to increased attention being given to the training and recruitment of skilled health workers, particularly skilled birth attendants. However, the lack of qualified personnel is currently still perceived as a significant barrier to implementation. In addition, regional disparities that favour urban areas seem to be the norm in countries as different as Indonesia, Kenya, Sudan and Yemen. For example, as described by Kenya: “We have many policies in place but inadequate number and distribution of health workers make it very difficult to implement [them]”. The shortage of health workers is not only true for service delivery but also for other aspects of the health system, such as monitoring and evaluation and research.

Other common problems include low-quality care and insufficient motivation and retention due to low salaries and difficult work conditions, particularly in rural and hard-to-reach areas. Some respondents said there were not enough training institutions, and that uneven distribution of those that existed hampered adequate enrolment and training of health workers (e.g. Liberia). Finding employment for newly qualified health workers was also difficult: “a large part of the problem is the government’s incapacity to absorb the [examined health workers] of training institutions” (Senegal).

The problems of human resources were mentioned extensively, not only by implementing countries but also by others such as donors, NGOs and the private sector, because the issue limits their ability to implement initiatives. Pfizer notes: “In working to fulfil our commitment, one of the toughest challenges is the lack of trained health-care workers and skilled partners on the ground”. The Elizabeth Glaser Pediatric Aids Foundation (EGPAF) highlights human resources management issues: “One important issue that EGPAF frequently comes across is the constant rotation of health-facility staff at every level. These rotations make it impossible to improve service quality, because as soon as a person is trained and establishes experience in an area he/she is rotated to another part of the facility.”

As financial and human resources constraints are reported by an overwhelming majority of stakeholders, there is an apparent contradiction with the self-reported advanced progress on implementation of commitments as described in Chapters 4 and 5. One explanation may be that achieving the current stage of implementation required a large up-front investment of resources by stakeholders, who then did not have the means to continue their action.

FINDING 4: The Global Strategy has promoted the development of public-private partnerships to strengthen human resources for health.

The business community has played a critical role in efforts to advance commitments to human resources for

health. By working with United Nations partners and implementing-country governments, several private sector partners have enabled more efficient and effective pre-service and in-service training. They have also advised on task shifting among cadres and offered ways for service providers to provide more targeted support to areas of high need.

Since 2010, Johnson & Johnson has helped the H4+ increase their support to countries such as Ethiopia and the United Republic of Tanzania. In the United Republic of Tanzania, this support has already had measurable impact by training more skilled birth attendants with midwifery competencies. In addition to supporting the long-term training of midwives and tutors, and strengthening the quality of pre-service midwifery training, the programme will also support policy issues related to midwifery – including the review of the National Midwifery Scope of Practice. Thirty-five medical professionals are expected to receive varied training in maternal and newborn health through the programme, and two hospitals are expected to be equipped for clinical training.

Another example is provided by Intel Corporation’s 1Mx15 Health Program (Box 7).

Another public-private collaboration is the MDG Health Alliance. Formed by Ray Chambers, the United Nations Secretary-General’s Special Envoy for Malaria, the Alliance has been pivotal in recruiting new partners to train, equip and deploy human resources for health. The group’s Frontline Health Worker pillar is spearheaded by eminent business leaders, such as Jeff Walker and Austin Hearst, and by Merck. It aims to deploy one million new community health workers by 2015. The group is working closely with Save the Children’s Frontline Health Workers Coalition. This is a dynamic coalition among NGOs, international organizations and business, working together to urge greater and more strategic US investment in frontline health workers in low-income countries.

Box 7: The 1Mx15 Health Program

1M x 15 is a new public-private partnership announced in 2011 between Intel, the H4+ through UNFPA, several governments, and other partners. The program has bolstered efforts to training of frontline health workers. The partnership’s objective is to strengthen access to, and the quality of, midwifery training in Bangladesh, Ethiopia, Ghana, India, Kenya, and other countries by using ICT through sustainable business models, creating shared value and collective impact. Intel, in collaboration with UNFPA and WHO, has developed 10 educational modules, in several languages, and is expanding the reach of the program working closely with governments in other countries including China, Nigeria and Rwanda.

7.2 ADVOCACY

Based on the online questionnaire and country case studies, this chapter provides an overview of the focus of commitments related to advocacy, highlights examples of implementation and reports on constraints and catalysts to implementation identified by respondents.

FINDING 1: A significant number of respondents to the online questionnaire made a commitment to support advocacy.

Advocacy is one of the most common focus areas for commitments, featuring in more than three-quarters (78%) of the commitments to the Global Strategy. As shown in Figure 17, advocacy for accountability received the most support (72%), followed by advocacy for policy support (64%) and advocacy for human rights and RMNCH financing (61%).

Most stakeholders' advocacy work focuses on more than one area of advocacy: in fact, 89% of respondents said that their advocacy commitment(s) support two or more areas of policy.

The following sections provide examples of support provided for the different types of advocacy.

Accountability for women's and children's health

The advocacy commitments of many civil society organizations (CSOs; see Box 8), as well as those of many foundations, aim to increase public accountability for women's and children's health. These commitments highlight a variety of ways in which these organizations are seeking to hold policy-makers accountable for their actions and pledges to improve women's and children's health. Accountability is discussed further in Chapter 9.

BOX 8: White Ribbon Alliance for Safe Motherhood

The White Ribbon Alliance for Safe Motherhood (WRA) is an international network dedicated to ensuring that RMNCH is a priority issue for governments, and to holding them accountable for their commitments. At the global level, the secretariat of the WRA has been working to raise the profile of Every Woman Every Child, while each of its 15 national alliances has developed specific advocacy and accountability plans. For example, WRA Tanzania works with the media and develops advocacy materials to inform citizens and policy-makers about their government's commitment to Every Woman Every Child. It has also successfully deployed national- and district-level advocacy strategies to persuade the Ministry of Planning to instruct every district to include a specific budget line for maternal and newborn health. As a result, new budget templates have been developed and any budget that leaves this detail out will be rejected by the MOH. WRA Nigeria has worked with UNFPA and other member organizations to set up a score card development committee, which has developed success indicators to track government commitments to women and children.

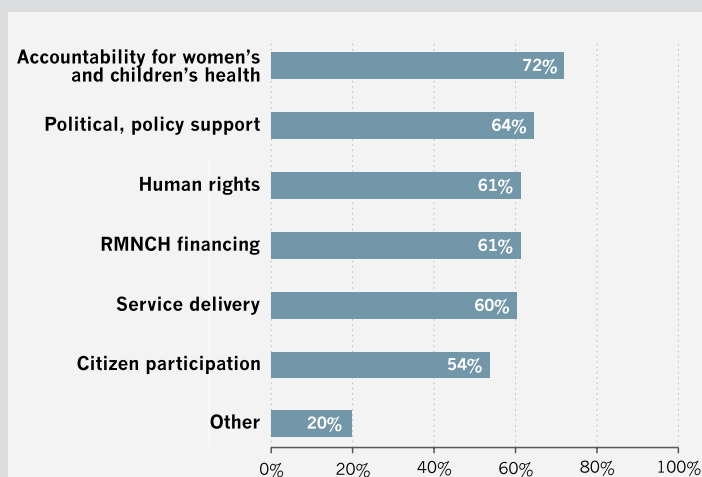
The work in Nigeria echoes that of WRA India, and the WRA of Orissa State, where a community score card framework has been developed and piloted to: (i) measure the supply of health-care resources against what should

An important area for accountability is that of monitoring public spending for maternal and child health. To facilitate this type of budget work by civil society and citizens, the International Budget Partnership (IBP) supports local CSOs in different countries to implement health-budget monitoring activities. By providing financial, mentoring and technical support, the IBP aims to strengthen local capacity to influence governments to improve spending for maternal health. In Indonesia, the IBP provided an additional grant to INISIATIF in Indonesia to monitor Indonesia's commitment to the Global Strategy, with a particular focus on monitoring the budget-related commitments.

Advocating for policy support

A large proportion of the advocacy commitments aimed at garnering political support and at improving the policy environment for RMNCH. This includes advocating with donors and national and local governments, as well as community leaders. For example, the Advance Family Planning (AFP) project is supported by the Bill & Melinda Gates Foundation, in partnership with Johns Hopkins University. The project has made impressive progress in educating policy-makers in support of policies favourable to reproductive health and family planning in Indonesia, the United Republic of Tanzania and Uganda. In Uganda, this work contributed to government approval of guidelines for community-based distribution of injectable contraceptives to ensure greater access to family planning across the country.

FIGURE 17: Proportion of respondents indicating support for different types of advocacy focus



be available according to government policies; (ii) assess experiences in health facilities; (iii) provide self-evaluation job aids that give health providers the opportunity to assess their own performance; and (iv) provide the basis for a public discussion between service providers, administrators and community members to discuss results and solutions.

Checklists were developed on the basis of Indian Public Health Standard guidelines and state-specific policy directives and health entitlements. They were focused on providing insights into progress made in providing the mandated maternal health services. Public hearings were organized with women and media representatives to increase community awareness of available health services and women's entitlements and to facilitate dialogue with government officials. Maternal death audits were conducted to gather data on the causes of maternal deaths. According to an evaluation of the program, service provision in local health centres increased significantly in the districts where the checklists were employed. The program has been successful in strengthening engagement with district and state government, and have improved accountability for implementing health policies and improving the health system. For example, use of the community score card resulted in efforts to strengthen health facilities and to regular monitoring of health facilities by elected representatives from the respective areas.

At a regional level, the Africa MNCH Coalition engages with the African Union, the Pan-African Parliament and national ministers and other policy-makers to prioritize policy and budget action for overall RMNCH at the continental, regional and country levels. With other partners, the Coalition has led advocacy interventions at the Pan-African Parliament that, in October 2011, resulted in a landmark commitment by the Conference of Speakers to prioritize policy and budget action for RMNCH.

Human rights

Some respondents focus their advocacy commitments on human rights, or take a rights-based approach when advocating for RMNCH issues. EngenderHealth committed to protecting the ability and right of women and adolescents to make free and informed decisions about their sexual and reproductive health, by building the capacity of health-care professionals. As part of this commitment, the NGO is organizing two global consultations in 2012-13 on expanding contraceptive choice. It will also publish data to help advocate for more resources and support to help women and couples access their right to control the number, spacing and size of their families.

Planned Parenthood Global has also adopted a rights-based approach in its RMNCH efforts. It is supporting its local partners to use human rights standards and mechanisms to hold their governments accountable to commitments

to women's and children's health, including reproductive health and rights. Planned Parenthood Global staff provide technical assistance to partners on subjects such as how to: engage civil society; provide input to United Nations bodies; and plan, draft and submit shadow reports. Recently, Planned Parenthood Global staff have also been collaborating with the United Nations Special Rapporteurs on Human Rights Defenders and on the Right to Health, to provide them with information about specific situations in countries and communities where they work.

The United Nations Committee on the Right of the Child, in close collaboration with WHO, UNICEF, World Vision and Save the Children, is currently developing a General Comment on Article 24 on the right to Child Health to provide an extensive and authoritative interpretation of this article to ensure countries have better guidance on how to implement the right to Child Health.

Service delivery

Some advocacy commitments are about service delivery, and pushing for better and more efficient health services. The American NGO Every Mother Counts committed to raising public awareness of the barriers to improved maternal health, and to giving citizens opportunities to engage in solutions. Health systems strengthening is implicit in all of its work in favour of such aims as more health-care workers and better transport, communications and referral systems. In 2011, it ran campaigns to raise resources for projects with partner organizations; for example, training midwives in Afghanistan with Save the Children and purchasing motorcycles for transport with Riders for Health.

For the past three years, the International Federation of Gynecology and Obstetrics (FIGO) has taken part in the LOGIC project (Leadership in Obstetrics and Gynecology for Impact and Change). Working through national health-professional associations in Burkina Faso, Nigeria, Cameroon, Uganda, Ethiopia, Mozambique, Nepal and India, it has collaborated with Ministries of Health to improve practices for maternal and newborn health. The policies adopted in a number of countries include implementation of maternal death audits.

RMNCH financing

Funding and financing of RMNCH is a key element of many stakeholders' efforts. This includes the campaigning carried out by ONE in support of the GAVI pledge drive in early 2011, in which ONE lobbied donors to finance the roll-out of pneumococcal and rotavirus vaccines in addition to GAVI's portfolio of basic child immunizations. The campaign lasted for eight weeks in more than a dozen countries, and the main petition page generated more than 300 000 signatories in support. The campaign also included the use of the social network Twitter, the production of two new videos, government-relations work and outreach to prominent media outlets. Donors came together in June 2011 and contributed US\$ 4.3 billion in pledges to GAVI, surpassing its US\$ 3.7 billion target.

The Bill & Melinda Gates Foundation has a number of grantees that focus their work on educating governments in donor and developing countries about the need for dedicated budget lines for RMNCH. For example, the Euroleverage project of the German Foundation for World Population (DSW) used a Bill & Melinda Gates Foundation grant to generate support for a range of global health issues in Germany, and to leverage European funds for reproductive health and family planning in developing countries.

Citizen participation

Advocacy commitments are not just directed at policy-makers and funders. Some stakeholders also strive to increase citizens' knowledge and to influence their attitudes and behaviours in relation to health – as well as to encourage increased participation in public health issues. Some of these efforts deal with preventative health. For example, in Burkina Faso, Development Media International and the London School of Hygiene and Tropical Medicine are collaborating on the design, implementation and evaluation of a national radio project to promote health-related behaviour change in communities across the country. This series of ads promotes exclusive breastfeeding, one of the most efficient interventions for reducing child mortality. It will be evaluated for impact and cost efficiency in what its lead investigator describes as the largest, most rigorous evaluation ever conducted of a mass-media intervention.

FINDING 2: The implementation of advocacy commitments is at an advanced stage.

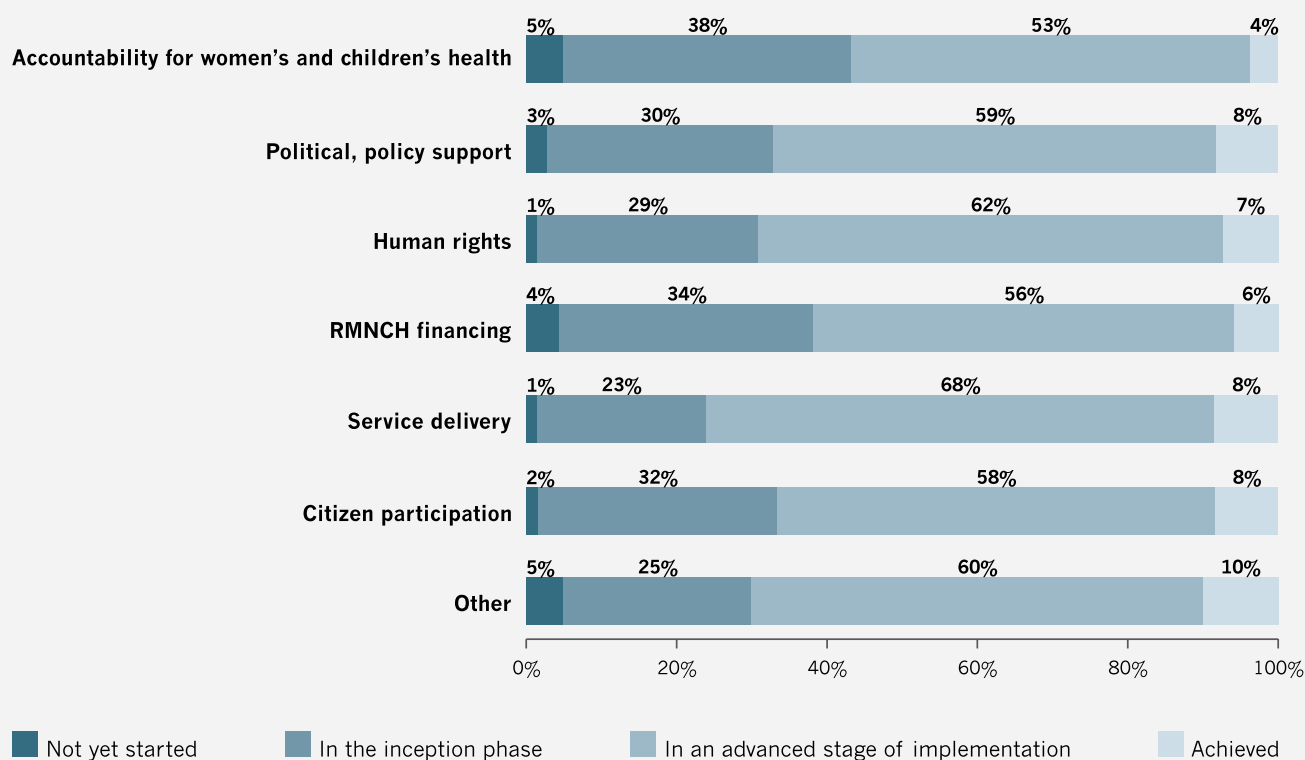
While different stakeholders are at different points in the realization of their commitments, most are well under way. Answers to the questionnaire reveal that advocacy commitments were:

- Achieved – 7%;
- In an advanced stage of implementation – 59%;
- In the inception phase – 30%;
- Not yet started – 3%.

Progress on implementation according to type of advocacy commitment is shown in Figure 18.

Among those stakeholders who are still in the inception stage of implementation, 38% of their commitments related to advocacy for accountability and 23% to advocacy for service delivery. The US-based NGO Every Mother Counts, for example, was establishing relationships with programmes but had not yet finalized the list of recipients it was going to fund. The Global Alliance to Prevent Prematurity and Stillbirth was, at the time of answering the online questionnaire, at the evaluation stage of a Grand Challenges grant. This led in July 2012 to the announcement of US\$ 15 million in research grants to help develop solutions around preventing preterm births.

FIGURE 18: Progress on implementation of advocacy commitments





Most, however, report that they are either at an advanced stage of completion of an ongoing project, or have fulfilled their commitment. The percentage varies from 57% among commitments to advocate for accountability, to 76% among commitments to advocate for service delivery. Many projects are ongoing and pre-date the Global Strategy, such as the advocacy of the International Baby Food Action Network for exclusive breastfeeding, or the technical assistance provided by the International Planned Parenthood Federation to country teams. Some commitments have been completed on schedule, such as the ONE campaign to finance pneumococcal and rotavirus vaccines through pledges to GAVI.

FINDING 3: Questionnaire respondents identified several catalysts and constraints to the implementation of advocacy commitments.

Catalysts: High-level advocacy events promote greater collaboration and partnerships

Many advocacy specialists reported that high-level events in 2012 have been instrumental to advancing progress. For example, the United Nations Foundation highlighted the Child Survival Summit in June 2012, and the Summit on Family Planning and the International AIDS Conference, both in July 2012. The Global Health Workforce Alliance identified the ICPD+20 (marking 20 years since the International Conference on Population and Development in Cairo) as an opportunity to renew attention and focus on population issues – embedding this agenda in the current push for health systems strengthening. The media coverage generated by such large events garners global attention for RMNCH from a variety of audiences.

Another advantage of such meetings is the opportunity to bring together stakeholders who might otherwise work

separately. The extensive collaborative work around the launch of the *Born Too Soon* report and the London Summit on Family Planning, for example, created new alliances between like-minded organizations. The Planned Parenthood Federation of America saw a great opportunity in bringing together service providers, advocates of women's rights, legal specialists, communicators and other stakeholders, because this helps generate informed, strategic campaigns that support governments in creating the best possible policies and practices.

Constraints: Restrictive funding environment, weak technical capacity and a conservative political context in some countries

According to respondents, even those organizations with relatively high levels of funding are affected by the current economic climate, because their partners may face difficulties in securing funds and disbursements of committed funds. According to the March of Dimes, the weak economic recovery in the US and persistent financial instability in the global economy are further barriers to increasing investment in health systems and delivery. Shrinking budgets make for a challenging environment in which to advocate for sustained or increased funding for maternal and child health.

Many organizations are engaged in capacity building, but face difficulties finding partners with sufficient organizational capacity and staff trained in advocacy in the countries where they work. Often, the partner organizations are understaffed and have low capacity for advocacy activities. FIGO, for example, explained that in many countries the FIGO affiliate has weak organizational capacities to carry out its tasks – in part because of the small number of gynaecology and obstetrics professionals.

Some respondents also mentioned that a conservative political climate make it difficult to conduct some advocacy, especially in sexual and reproductive health. The Packard Foundation, for example, found that changes in the composition of the American Congress, and the rise in social and political conservatism, have impacted the debate on women's health care. This is seen particularly in relation to removal of funding and the introduction of regressive policies that increase barriers to women's reproductive health. This domestic debate in the US around women's reproductive health and family planning puts foreign aid assistance for international reproductive health at risk of funding cuts, and can negatively influence US support for international reproductive health assistance. Amnesty International listed, as an obstacle to its advocacy work, the groups that deny women's sexual and reproductive rights and undermine gender equality at the domestic, regional and international levels.

FINDING 4: Many stakeholders make use of innovative media for their advocacy commitments.

Using new media to promote an organization's work has become part of most advocacy campaigns. Websites, videos, podcasts, webcasts, webinars and electronic newsletters are all ways for organizations to extend their reach. Every Woman Every Child stakeholders are no exception, and many of them have produced innovative, high-quality advocacy using new media. This was not included on the questionnaire, but a quick web search revealed that most NGOs who have made commitments

to the Global Strategy, as well as many foundations and even bilateral aid agencies, use new media to promote their work and raise awareness.

The global launch of *Born Too Soon: The Global Action Report on Preterm Birth* in May 2012 resulted in more than 1 billion media hits. These included coverage on the front page of the *New York Times*, and 70 million Twitter impressions – the most media exposure ever received in a single day for an event or publication addressing women's and children's health.

Many organizations have a channel on either YouTube or Vimeo, two of the world's leading video-sharing websites, where they present short films that showcase their work in different projects. These videos, which usually last between two and five minutes, can easily be shared via social networks.

The White Ribbon Alliance creates "Citizen News" videos live from key policy events, such as the Inter-Parliamentary Union assembly in April 2012 in Kampala, Uganda. At the meeting, WRA produced a daily video blog on the events of the day, including interviews with parliamentarians and representatives from civil society about maternal and child health. This experience was repeated at the July 2012 Summit on Family Planning in London.

The International Budget Partnership went a step further in using innovative technologies for advocacy with its Open Budgets Game. This interactive web-based game takes the player into Polarus, an imaginary country where he or she becomes an intern with the country's leading civil society organization on a mission to promote budget transparency. It is available to anyone with an internet connection.



7.3 RESEARCH AND INNOVATION

The Global Strategy emphasizes the critical role of research and innovative approaches to policy, service delivery and financing in accelerating progress towards MDGs 4 and 5. This chapter provides an overview of the focus of commitments related to research and innovation, and the progress that has been made on their implementation. It also reports on constraints and catalysts to implementation identified by respondents.

FINDING 1: In all, 63% of stakeholders support research through their commitments.

Proportions are highest among implementing countries: 82% of LICs and 83% of MICs reported that they support research through their commitments. They also reported that the implementation of their commitments is in turn informed by research, for example by using information from large-scale surveys to inform policy and allocate resources. For example, Burundi uses the information from the national needs assessments for emergency obstetric and newborn care, assessment of health care costs and household surveys to correct imbalances in resource allocation. Yemen informs implementation of its commitment by conducting an assessment of basic and comprehensive emergency obstetric care services and by surveying the number of community midwives and their distribution and qualifications.

A majority (80%) of bilateral institutions support research, mostly by funding research institutions. An example is Norway's funding for the Programme for Global Health and Vaccination Research (GLOBVAC) to conduct research that can contribute to sustainable improvements in health and health equity for poor people in LICs and MICs. DFID funds hundreds of scientific research publications, which are available on its website. Like some other bilateral organizations, DFID also conducts its own research and has produced four RMNCH evidence papers and four systematic reviews since 2010.

Research by academic stakeholders is sometimes linked to health systems strengthening. For example, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is working with the Pacific Society for Reproductive Health (PSRH) on a project to introduce research skills into the Pacific. Another academic stakeholder, the Institute of Tropical Medicine in Antwerp, is involved in Sustainable Nutrition Research for Africa in the Years to come (SUNRAY). Through this, participants from 13 African countries have provided the building blocks for a new nutrition research agenda.

In all, 42% of stakeholders have developed publications, policy briefs and/or programme evaluations in relation to their commitments. These publications cover a wide range of types of literature, from articles in reputable scientific journals to small-scale programme evaluations. For example, the government of Uganda published an evaluation of attainment of the targets set for the MDGs, while Indonesia's National Institute of Health Research and Development published policy briefs based on its research.

NGOs, especially the larger international ones, also conduct their own research. For example, as part of its

commitment to EWEC, Amnesty International conducts qualitative research on the impact of denial of sexual and reproductive rights. In 2012, World Vision launched with John Hopkins University a multicountry child health implementation research study. Another NGO, the Global Alliance to Prevent Prematurity and Stillbirth (GAPPS), has produced a wide array of publications, from articles in *The Lancet* to annual reports, including the landmark report *Born Too Soon: The Global Action Report on Preterm Birth*.

In all, 44% of stakeholders are taking part in research networks in connection to their commitments, and respondents gave many examples of research networks, large and small. Among the larger networks mentioned were the Alliance for Health Policy and Systems Research, which has over 300 partners, and the Evidence-Informed Policy Network (EVIPNET), both linked to WHO.

Finally, 77 stakeholders have committed to establish new research and training institutions or to improve existing facilities. For example, Mauritania reported that prior to 2011 there were only two schools of public health in the country, but that now there are four.

FINDING 2: Development and implementation of RMNCH innovations and innovative approaches is a key focus for 89 stakeholders across the constituency groups.

More than half (55%) of stakeholders reported that they support and promote innovation through their commitments, for example with financing and catalytic support. Respondents reported that they contribute to innovation in several areas: innovation in service delivery; pharmaceutical innovations; innovation in the development of other products; innovative approaches to stakeholder coordination; and innovative financing.

Innovations in service delivery

Many of the innovations mentioned as examples by respondents focus on service delivery. Such innovations include kits and packages, such as the Mama and Baby kits given to new mothers who deliver in a health facility in Liberia, and other tools to enable skilled attendance at birth. Other innovations focus on organizational restructuring, task shifting and other ways of restructuring the workload. For example, Guyana has increased the coverage of health workers by implementing community outreach to remote areas. In Rwanda, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) developed an innovative approach that provides various services to women living with HIV, and their children, at each facility visit. This approach has both improved the quality of service and reduced the workload of health personnel.

Another type of innovation for service delivery deals with health systems, and more specifically with supply chains. The Reproductive Health Supplies Coalition, through its Innovation Fund, is awarding grants to a number of organizations. For example, it is funding the Asociación Benéfica PRISMA to develop educational tools to improve procurement of reproductive health supplies in Latin America. This is done by translating, adapting and using an existing Procurement Capacity Toolkit.

Finally, training and the development of technical and delivery guidelines are also required to implement innovative service delivery approaches. Several countries and stakeholders have developed such guidelines and training materials and have implemented training programmes. For example, following a successful pilot project, the Packard Foundation worked in partnership with the government of Ethiopia, training health workers to insert contraceptive implants, and promoting this long-acting intervention. The US\$ 250 000 Foundation investment leveraged US\$ 1 million in government funds; 1500 health extension workers have been trained to date, and more than 7500 women have received long-acting family planning services.

Pharmaceutical innovation

A number of stakeholders are developing innovations related to pharmaceutical products. This is an important area in which the private sector contributes. Pfizer, for example, is developing a new combination product for intermittent preventive treatment of malaria in pregnant women. Two of the large foundations, the Bill & Melinda Gates Foundation and the Packard Foundation, are supporting grantees who work with the drug misoprostol. The Concept Foundation developed and registered Medabon (registered trademark), a pre-packaged set of misoprostol and mifepristone to increase access to safe abortion and provide a non-invasive method. Medabon was approved by 12 European Union member states. The Bill & Melinda Gates Foundation grantee has also demonstrated the effectiveness of misoprostol for the prevention and treatment of postpartum haemorrhage at the community level, instead of exclusively in referral facilities. This could increase access to this life-saving drug, which is easy-to-use and low-cost and can be easily distributed and stored. Another stakeholder, the Population Council, is developing new contraceptives and microbicide products.

Innovation in product development

Non-pharmaceutical products are being developed for RMNCH use. For example, the MacArthur Foundation has funded the development by WE CARE Solar of a “solar suitcase”. This is an economical, easy-to-use portable power unit that provides health workers with highly efficient medical lighting and power, where the electricity supply is unreliable. It can bring light and power to maternity wards to make it safer and easier for staff to deliver babies at night. Prototypes are being piloted at sites around the world. Although evaluation data will only be available in 2013, anecdotal evidence suggests that the suitcases are providing positive benefits to the clinics where they are being used.

In the area of preventive measures, the Global Alliance for Clean Cookstoves (a grantee of the United Nations Foundation) promotes the use of innovative cookstoves. These reduce the exposure of children to cooking fumes, which can contribute to pneumonia. It has also developed indoor air-quality guidelines and standards in partnership with WHO, and is in the process of developing ISO guidelines.

Innovations in financing

There are many ways to fund health services, and some stakeholders are experimenting with them and adapting them to the local context. Many countries are using performance-based financing or vouchers, providing free services or implementing various insurance schemes. For example, Guinea has established mutual insurance specifically to cover pregnancy and childbirth risks. Other examples include the implementation of voucher systems (Kenya, Myanmar, Ethiopia and Uganda); cash incentives designed to safeguard choice and rights (Afghanistan and Zimbabwe); and social health insurance (India, Kyrgyzstan and Sudan).

FINDING 3: Innovative use of information and communication technologies (ICT) was a focus for many stakeholders.

The use of ICTs is generating a lot of enthusiasm, and is being adopted by a large variety of stakeholders. A key player in this area is the global mHealth Alliance, which is funded by the United Nations Foundation. It champions the use of mobile technologies to advance health and well-being throughout the world, with a focus on LICs. Other key aims include: assembling evidence for the effectiveness of mHealth to improve health and strengthen health systems; increasing technology integration and interoperability; identifying and promoting sustainable financing for mHealth; advocating for and facilitating global and national policies that support the use of mobile technologies for health; and enhancing the capacity of the health community to design and deploy mobile technologies.

Many respondents report using internet and mobile technologies, either to reach patients with health messages or to improve patient attendance and follow-up (a strategy used by EGPAF). Some stakeholders mentioned using mobile technologies for mHealth, without being specific about how they were used (e.g. Sierra Leone, D-tree International, WHO and Norway).

Mobile technologies are also used to train health workers (as is done by the BBC Media Action in the implementation of their commitment) and to support health workers in their jobs (as is the case for many World Vision projects). World Vision has more than 40 mHealth programmes and works to develop consortia to bring mHealth for RMNCH to national scale. An example is KimMNCHip, a programme in Kenya delivered in partnership with Safaricom, the private mobile provider. The Novartis Foundation has supported the development of an innovative e-learning tool for IMPAC (Integrated Management of Pregnancy and Childbirth) to help scale up training of health workers in maternal and child health.

ICTs are also used to improve information systems and data gathering. A number of implementing countries (Yemen, Uganda, Sierra Leone, Niger, Mauritania, Malawi, Madagascar, Nepal, Liberia, Indonesia, Guinea-Bissau and Afghanistan) commented on new electronic health information systems. Nepal reported a net reduction in stock-outs of maternal and child health commodities. These dropped from 23% for the year 2005-2006 to only 5% for the year 2010-2011 following improvements in

logistic management systems. Better information systems can also improve reporting. Liberia's health-monitoring information systems have evolved from the use of calculators and typewriters to the use of modern ICT equipment. This has resulted in a dramatic reduction in erratic reporting by health facilities, with more than 70% of facilities now achieving consistent monthly reporting.

Other types of stakeholder can play a pivotal role in the development and implementation of information systems. For example, Hewlett-Packard has set up five data centres in Kenya, in partnership with the Ministry of Health and the Clinton Health Access Initiative. These have the computing and storage power to connect more than 1500 health facilities and 20 000 health-care workers. Academics can also play a role. For example, the University of Aberdeen has developed a new phone-based tool for real-time monitoring of the quality of care in health facilities that care for pregnant women. This is being piloted in Ghana and Ethiopia.

Another example of ICT use is provided by WaterAid, which has developed a simple, low-cost tool to map the provision of water and sanitation services, as well as water quality. The Water Point Mapper generates maps showing the distribution and status of water-supply services across the world. It is free to use and is an efficient way to identify and monitor which services are working, and where new ones are needed. This tool replaces expensive software tools based on geographical information systems, and can be used without an internet connection. In some instances, this tool has been used to support district authorities in developing sustainable management information systems.

FINDING 4: Catalysts and constraints to research and innovation have been identified.

In terms of catalysts and constraints, most comments related to funding. Funding can be a catalyst, as is the case with Grand Challenges: Saving Lives at Birth. This is a partnership between Grand Challenges Canada, USAID, the Bill & Melinda Gates Foundation, Norway and DFID. Saving Lives at Birth aims to identify and support innovative approaches to the health of women and their babies. In July 2012, 15 recipients were awarded seed grants for developing their innovations.

Another key catalyst for research and innovation is the Innovation Working Group (IWG) in support of Every Woman Every Child. This promotes cost-effective innovation and partnerships between public and private organizations to scale up effective and sustainable interventions that can enhance the implementation of the Global Strategy.

However, lack of funding or rigid funding rules can constrain research. Often, government budgets focus on service delivery and may not have a dedicated budget line for research. Indonesia, for example, reported that its strict national budget meant there were no funds for research, which requires dedicated funds from donors. Moreover, good-quality research projects, including those focusing on rural, hard-to-reach populations, are very expensive. The NGO Pathfinder International reported it was very expensive and time consuming to collect data in very remote areas, due to transportation issues. Yemen reported that donors hesitated to support research due

to its cost. In addition to lack of funding, implementing countries sometimes have difficulty recruiting skilled researchers. This is also the case for other stakeholders who must identify research partners in the field.

When donors do support research, it is usually for very precise projects, which leave little scope for the research priorities of implementing countries. Senegal reported that the potential areas of research were numerous, but that resources were unavailable and research capacities weak. Therefore, most research is conducted with financial support from partners, who then determine what is covered by the research.

In the area of medical research, the Bill & Melinda Gates Foundation reported that the problem is not only to find qualified personnel, but also facilities that have the laboratory capabilities to collect, process and store samples. This bottleneck is even more severe for studies that need to recruit pregnant women and subsequently follow-up with their babies. As a consequence, the few sites that can perform these studies are overburdened, and initiation of new studies can be slow.

Finally, when research is conducted it is not always properly linked to policy-making, which makes governments reluctant to fund more research. For example, when asked about research constraints, Uganda explained that, aside from the lack of funding, there was a serious failure in making proper use of previous research findings. The lack of proper linkages between the research institutions and the policy-makers and programme managers means that policy-makers don't always recognize the importance of research, and are therefore reluctant to fund it. ■■■■



SUPPORT FOR COUNTRY-LED HEALTH PLANS – EVIDENCE FROM CASE STUDIES



Three case studies were conducted – in Bangladesh, Burkina Faso and Uganda – to provide a holistic picture of how commitments support countries' efforts to improve women's and children's health. These case studies analysed the extent to which the implementation of the commitments to the Global Strategy supports country progress towards achieving MDGs 4 and 5 through aligning with national plans, addressing health and development gaps and ensuring accountability for results and resources. Summary findings of each case study are presented below.

8.1 BANGLADESH

FINDING 1: Commitments to the Global Strategy are well integrated in the national health sector plan.

Twenty-five commitments to the Global Strategy included specific support to Bangladesh. Figure 19 includes a breakdown by stakeholder category, while Web-Annex 3 lists the commitments.

Analysis shows that the Global Strategy has led to commitments being placed at the core of the country's reproductive, maternal, newborn and child health (RMNCH) policy and investments. Commitments are well embedded in the new Health Population and Nutrition Sector Development Plan (HPNSDP) 2011-2012, and highlighted in the foreword by the Minister of Health. The plan includes new or added value elements for addressing maternal and newborn health and nutrition. Individual or partial commitments in these areas are stated.

The HPNSDP also includes interventions that are intended to add value to the plan. Among those most relevant to the Global Strategy are:

- Mainstreaming gender, equity and voice in core programmes such as MNCH and nutrition;
- Improving management information systems with information and communication technology (ICT) and establishing monitoring and evaluation (M&E) systems;
- Increasing coverage and quality of services by strengthening intersectoral coordination and private sector collaboration.

Implementation of these commitments has resulted in progress towards achieving MDGs 4 and 5 through alignment with national plans and by addressing health and development gaps. Against the backdrop of the accelerated efforts to achieve the MDGs, key informants found it difficult to gauge accurately the role of the Global Strategy in driving the emerging emphasis on RMNCH at country level.

FINDING 2: Political leadership and support has been an important factor.

High-level leadership from the Prime Minister has been crucial in ensuring that line directors and programme managers in the Ministry of Health (MOH) actively engage with the implementation of commitments. The fact that country commitments were made at the highest level, by the Prime Minister, was seen to “drive the government machinery into action” (quote by government key informant and endorsed by others). Those interviewed showed a clear understanding of strategies and implementation challenges.

An intensive consultation process among the government, development partners and other stakeholders has resulted in increased harmonization at the policy level. Ongoing collaboration takes place through several forums, such as the health consortium (government and donors), local consultative groups, task groups and working groups (all stakeholders).

Stakeholders perceive that the Global Strategy has been particularly effective in accelerating efforts to achieve MDG 5. The government has facilitated stakeholder dialogue and technical input on commitments. This has generated evidence for commitments – for example, the calculation of the number of midwives required to meet a specific service delivery need by 2015.

FINDING 3: The Global Strategy is perceived as adding value, but respondents also identified a number of constraints.

The launch of the Global Strategy was seen as the event that gave extra momentum to existing RMNCH efforts and kept them at the forefront of attention. There has been an increased willingness of the government to collaborate with the many NGOs delivering services and supporting service delivery, which has helped to offset weaknesses in government capacity. In addition, the forums mentioned above are effective for identifying

programmatic gaps and weaknesses, and for sharing information on successful innovations. The culture of Bangladesh was also seen as a driver of innovation, illustrated by women activists who are a force within community groups.

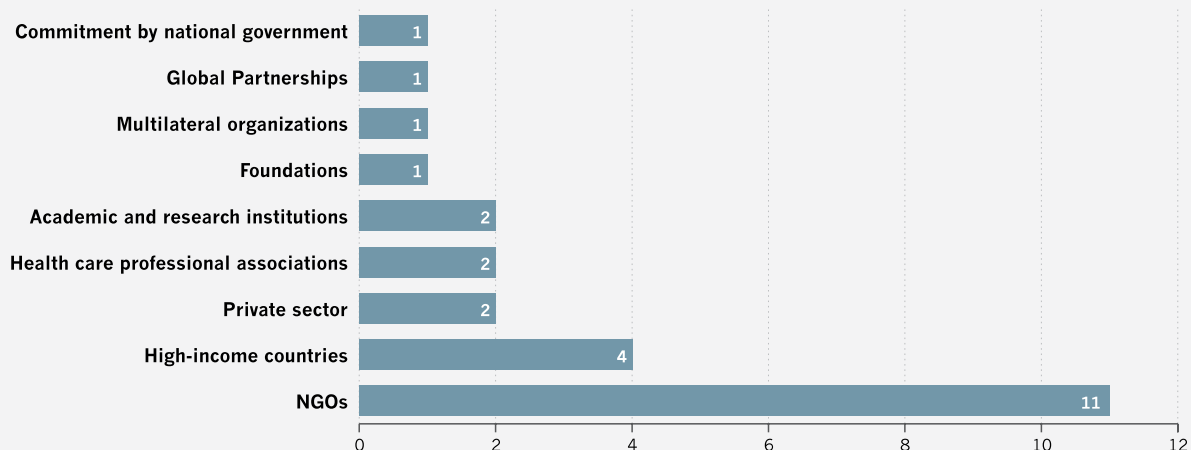
Respondents also identified a number of constraints, including slow release of funds (but not lack of them) due to inefficiencies, bureaucracy and over-tight regulations. This is illustrated by the large amounts of unspent funds, which are detailed in the annual health sector programme reviews. Another key constraint is the lack of skilled staff and unwillingness of medical staff to work in rural areas (both are related to broader health system weaknesses, including poor pay and constraints on service delivery).

FINDING 4: Commitments made to the Global Strategy are accounted for through national policies and plans.

There is no separate or distinct accountability framework for commitments made to the Global Strategy and the embedding of commitments in the HPNSDP contributes to promoting accountability for results and resources, for example through the mechanisms of the Sector Wide Approach (SWAp). The majority of donors have pooled resources in a multi-donor trust fund governed by the SWAp process. Annual Programme Reviews (APRs) involve multiple stakeholders and help to generate accountability on both the operational and financial aspects of implementation. The APR process includes monitoring, review and remedial action.

Ten of the 11 core indicators for RMNCH recommended by the COIA are already reflected in the evaluation framework of the Health Sector Strategy 2011-2016, and are included in the Demographic and Health Survey. However, the HPNSDP identifies an urgent need to strengthen the monitoring capacities within the MOH and the directorates to use the routine data for decision-making efficiently. It states the need for an overall M&E strategy and workplan to guide the improvement of the system.

FIGURE 19: Commitments to Bangladesh by stakeholder category



A number of organizations make specific commitments to holding the government accountable for results, including the H4+. The White Ribbon Alliance, for example, commissioned an historical analysis study on *Allocation of Funds for Maternal Health in Bangladesh*, published in January 2012. This has been presented to the government as an advocacy tool to hold government accountable for commitments made.

FINDING 5: The Global Strategy promotes the use of innovative solutions.

The analysis shows that the Global Strategy is giving leverage to the implementation of innovative approaches. For example, in September 2011 the country received the United Nations Digital Health for Digital Development award for its outstanding contribution to successfully using ICT for development of health and nutrition. Examples of innovative approaches include a mobile messaging service (called Aponjon) for new mothers, pregnant women and their families. It sends weekly messages timed to pregnancy stage or age of newborn, on topics such as care during pregnancy, warning signs, breastfeeding practices, nutrition, immunization reminders, and connecting with local health services. Another example is the MaMoni project, which is a partnership of several organizations working with the government of Bangladesh on an integrated package of services (maternal, newborn, family planning and nutrition package). Its activities place community action groups at the heart of the rural health services. NGO workers liaise with frontline health workers to raise awareness and identify and address health issues with their own resources.



8.2 BURKINA FASO

Fifteen commitments to the Global Strategy included specific support to Burkina Faso. Figure 20 includes a breakdown by stakeholder category, while Web-Annex 4 lists the commitments. The commitments made to the Global Strategy in Burkina Faso cover most elements of the continuum of care. Although the government's specific commitments to the Global Strategy were rather vague, these are complemented by the specific objectives and strategies in the National Health Development Plan (PNDS), which include specific targets for maternal and child mortality reduction.

FINDING 1: Commitments to the Global Strategy are well integrated in the national health sector plan and there is high-level political leadership and support.

The general impression is that maternal and child health was high on the agenda before the launch of the Global Strategy in 2010. High-level initiatives – such as the 2006 Maputo Plan of Action, and the 2010 African Union Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) – were mentioned as key influences that have led to increased commitment to maternal and child health by senior decision-makers in the government. The Global Strategy was not intended to replace existing initiatives, but rather to build on, and to consolidate, regional and national initiatives that are driving progress in RMNCH. The commitments to the Global Strategy were drawn from the PNDS and are therefore well aligned.

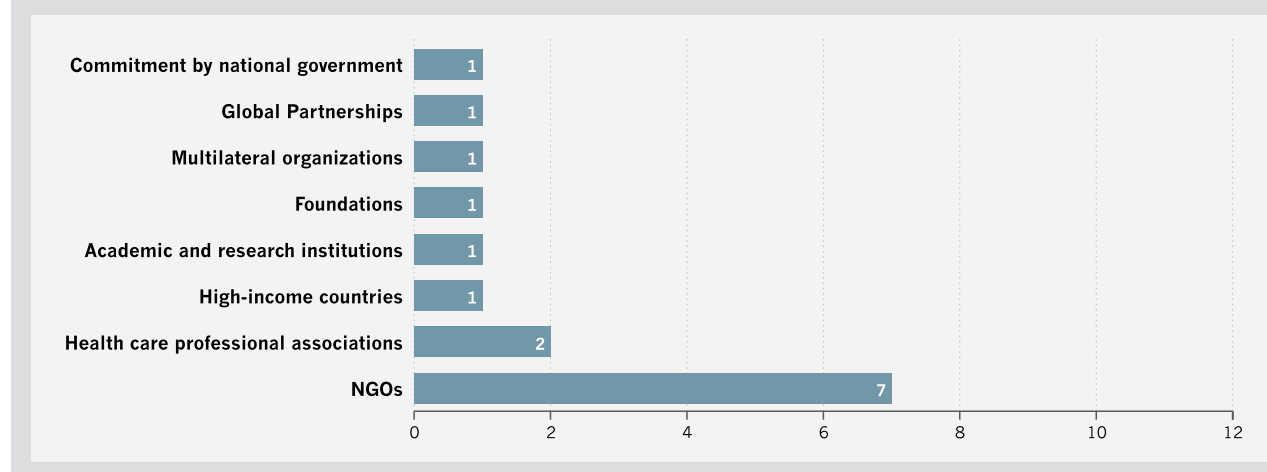
Most respondents noted that the level of coordination and cooperation is unique in Burkina Faso. There is high-level commitment from the President, the First Lady and the Minister of Health to better coordinate the sector and align the various actors. A number of thematic working groups have been set up, both with the government and between the development partners (including on nutrition). A monitoring committee for implementation of programmes and strategies for RMNCH was created in January 2012. It includes broad representation and is presided over by the First Lady and the Minister of Health. The committee's purpose is not only to monitor the implementation of programmes and strategies, but also to make suggestions to strengthen different interventions (see also Chapter 9).

Despite this, some development partners expressed concern that, while all these mechanisms exist on paper, their implementation is sometimes poor. Development partners did not all agree on the degree to which health sector planning, implementation and evaluation processes are participatory.

FINDING 2: The Global Strategy is perceived as adding value, but there are some constraints to implementation.

Burkina Faso, which remains one of the world's poorest countries, has made considerable progress on RMNCH over the last two decades. Key informants suggested that the benefits of the Global Strategy were:

FIGURE 20: Commitments to Burkina Faso by stakeholder category



- Reminding the government and other actors of the promises they made, reinforcing the obligation to improve maternal and child health, and ensuring that it stays high on the agenda;
- Contributing to increases in funding, particularly through the Muskoka Initiative and the H4+ initiative, and with particular benefits for reproductive health;
- Improving coordination between development partners, in particular among H4+ partners;
- Reminding key stakeholders of the importance of cross-cutting themes, such as integrated health care and health systems support.

In addition, many see the introduction of subsidized emergency obstetric and newborn care (EmONC) in 2006 (to complement free antenatal and neonatal care) as probably the biggest contributor to the drop in maternal and neonatal mortality that Burkina Faso has seen over the last 10 or so years. Geographical barriers to care have also been reduced through decentralization of the health sector and the creation of health clinics in all districts. However, it is not clear how or whether the Global Strategy has contributed to this.

Despite this progress, Burkina Faso remains off track for both MDG 4 and 5. Respondents identified several bottlenecks to implementation of commitments, which include:

- **Lack of quantity and quality of human resources for health** – a bottleneck raised by all key informants. Overall, the number of health workers is far below the minimum WHO recommendations. In particular, there is a shortage of skilled birth attendants, midwives and obstetricians/gynaecologists. Concerns were also raised about the quality of training and education, as well as motivation and mobility of health workers.
- **Financial resource constraints.** Almost all key informants raised the issue of financial resource constraints. This seemed to be largely related to the intention of expanding the 80% subsidy of EmONC to make it completely free. However, there were also calls for

increased funding to enhance capacity both at the national and peripheral levels. Some informants insisted that what is needed is more efficient management of existing funds and argued that the 80% subsidy would probably be enough to cover almost all maternal health services if it were efficiently managed.

- **Access to care.** Geographical distance and financial access to care were identified as two key bottlenecks for improvements to RMNCH.
- **Lack of equipment and medication.** The number of stock-outs of the essential package of 20 medicines has increased over the last few years in Burkina Faso. Similarly, lack of equipment is an issue even at the referral level at the University Hospital.
- **Limited coordination and collaboration.** Multisectoral and inter-ministerial collaboration and coordination form a major bottleneck for continued improvement in RMNCH. Improvements in health require coordinated efforts between the education, finance, women's promotion, social action, transport and infrastructure and water and sanitation sectors, among others. Vertical initiatives and fragmentation within the health sector further constrain implementation. There are many different international initiatives and partnerships in Burkina Faso, all of which require reporting to different bodies and compliance with a range of obligations.
- **Social norms and practices.** Several key informants indicated that social norms and practices remain an obstacle to health improvements. The first of the "three delays",⁴⁷ namely the decision to seek care, is often significant, particularly in the case of pregnancy and childbirth. Similarly, care is often only sought for children when they are very ill.
- **Poor communication.** Communication between all key stakeholders could be improved, as poor communication leads to duplication and fragmentation, causing unnecessary complications. For example, some NGOs are proposing to train more auxiliary midwives, even though the government has decided to remove this cadre of health workers.

- **Limited knowledge of the Global Strategy.** Few informants outside of the United Nations organizations and the government were able to identify any of its detail. There was limited awareness of Burkina Faso's commitment to the Global Strategy and many organizations had little knowledge of each other's commitments.

At the same time, a number of initiatives have been used to overcome the above bottlenecks. These include: ensuring a skill mix and enhancing the role of health workers; recruitment of additional health workers; contracting and coordination of NGOs to deliver services in specified regions and districts; provision of selected free health services; subsidizing EmONC; and strong leadership of the government.

FINDING 3: Commitments made to the Global Strategy are accounted for through national policies and plans.

Burkina Faso's commitments to the Global Strategy were drawn from the national plan PNDS. Most interviewees said they are accountable for reporting against this. The perception among respondents of the level of accountability varied significantly. Some stated it as an area of strength while others said accountability, monitoring and reporting was a key weakness within the MOH that needed to be addressed.

Analysis shows there was essentially no knowledge of the recommendations of the COIA; either the content or the time frame. However, a number of the recommendations are in the process of being implemented. Burkina Faso is making good progress with the incorporation of the 11 key RMNCH indicators and on transparency. For example, across all the different surveys and databases, all but one

of the indicators is included. Furthermore, Burkina Faso is making progress with reviews of spending and resource tracking and the government is in the process of developing a registration system and a health information database, which will make valuable contributions once completed.

However, a number of problems affect the quality of data collection, which is carried out by different agencies at different times, and the data reported are often stored in different locations, making them difficult to synthesize and analyse. Different definitions and methods are used, and data are therefore often not compatible or comparable. While there is some evidence that efforts are being made in Burkina Faso to bring the different data collection mechanisms in line with each other, accountability mechanisms need further alignment and strengthening.

FINDING 4: Innovations are underway and are being tried out.

A number of innovations have been tried and implemented in Burkina Faso to accelerate the improvement in women's and children's health. Innovations and best practices include the use of radio entertainment to broadcast educational messages about daily activities that can affect health and to encourage people to use health services. In addition, some NGOs have piloted free health-care initiatives for mothers and children under five (including EmONC and antenatal and neonatal care), with promising results. This has led to significant lobbying of the government to remove the remaining fees paid by mothers. Similarly, Population Council International has started to create safe spaces for women and girls, where they can meet and get to know other girls of their own age, share experiences and receive information on options for contraception, as well as sexual and reproductive health and rights.



8.3 UGANDA⁴⁸

Twenty-one commitments to the Global Strategy included specific support to Uganda. Figure 21 includes a breakdown by stakeholder category, while Web-Annex 5 lists the commitments. Uganda made eight commitments to the Global Strategy in 2011 focusing on issues including EmONC, skilled birth attendants, family planning and the three major causes of death for children under five – diarrhoea, pneumonia and malaria. Although these commitments were already priority intervention areas before the launch of the Global Strategy, the Global Strategy has provided an additional “boost” to already ongoing RMNCH processes.

FINDING 1: Global Strategy commitments have added impetus to progress on RMNCH targets in Uganda, but there are also constraints.

Information by government representatives suggest that Uganda is on track to achieve the four core recommendations of the COIA at country level for 2012. A positive output from the commitments is, for example, that it has rallied all actors in the RMNCH subsector behind common goals and targets, and increased support for and engagement in a shared platform for planning, implementation, reporting and measurement of results. In addition, Uganda has initiated action on a number of other COIA recommendations that have a 2013 and 2015 time target. These include using information technology innovations in national health information systems, and creating Reproductive Health and Child Health subaccounts within National Health Accounts. Uganda is also collecting data on all 11 Global Strategy Indicators, most of which are core indicators in its Health Sector Strategic and Investment Plan 2010/11 – 2014/15.

This study also documented many examples of progress made on RMNCH. For example, Child Days Plus (outreach events) has contributed to the increase in immunization coverage, and coverage of other preventive health interventions such as vitamin A supplementation,

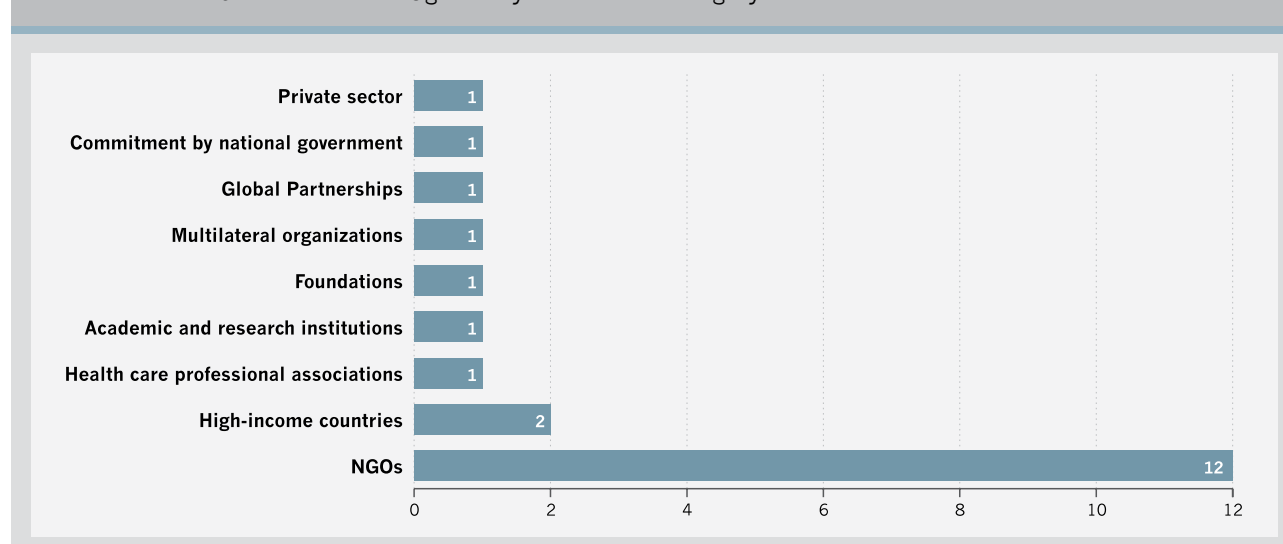
deworming and distribution of insecticide-treated nets. Also, infant and young child feeding has been integrated into different programmes such as prevention of mother-to-child transmission (PMTCT), reproductive health and the expanded programme on immunization. These country-level programmes have contributed to a significant reduction in under-five and infant mortality rate.

Other examples include the engagement of local leaders, the introduction of insurance schemes, and the introduction of maternity waiting homes or birth shelters. At the latter, mothers close to giving birth are sheltered to ease the pressure of transportation once labour pains begin and to reduce the negative impacts of obstetric emergencies.

Despite the fact that Uganda is on track to achieve a number of core commitments, there are also constraints to implementation of commitments. These include:

- **Major gap in human resources.** The majority of respondents mentioned a severe shortage for all critical cadres of health workers. Current estimates are that about 2000 more midwives are required to fill existing gaps. Besides numbers, prevailing HRH gaps pertain to an adequate “skill mix”, particularly the clinical specialization required for Comprehensive EmONC, and the knowledge and skills required for various management roles at both national and district levels.
- **Inadequate funding for RMNCH** and associated difficulties translating RMNCH policies into effective programmes.
- **Supply chain management** especially as it affects the lower levels of health care and commodity distribution.
- **Gender inequalities.** While Uganda is a signatory to various international commitments to gender equality, including MDG 3, and has a Gender Policy that provides a framework for gender-responsive development, gender inequalities still remain and consistently contribute towards stalling progress on many MDGs. These include high levels of sexual and gender-based violence, limited access to justice for victims of violence, and weak prevention and treatment services. It is particularly worrying that the first sexual encounter of 25% of girls is associated with the use of force.

FIGURE 21: Commitments to Uganda by stakeholder category





- **Low coverage of HIV counselling and care services**, including limited access to EmONC. Respondents also noted marked disparities in coverage of interventions across geographical settings, between rural and urban populations and within wealth and education quintiles.
- **Limited access to and utilization of bed nets** (despite gains in coverage of PMTCT services).

FINDING 2: Strong parliamentary engagement with the RMNCH agenda has proven effective.

Prominent parliamentary figures have been effective champions of the RMNCH agenda, especially a core group within the Uganda Women's Parliamentary Association (UWOPA). This includes influential personalities such as the Ugandan First Lady and the Speaker of Parliament. Examples of high-level involvement with maternal and child health include a presidential directive made in 2008 that obligates notification of all maternal and perinatal deaths within 24 hours of occurrence, as well as a recent presidential directive that called for recruitment of midwives to staff all health centres. Furthermore, Uganda is the lead sponsor of the ground-breaking Inter-Parliamentary Union (IPU) resolution on MNCH, adopted in Kampala in April 2012. The IPU itself made a commitment, of which this resolution was a concrete outcome. The exemplary parliamentary effort on the RMNCH agenda is to a great extent a result of a sustained advocacy push from multiple players over the past few years. Parliamentary engagement has also involved a few male MPs and also

traditional institutions, and especially the Queen of Buganda. Data collected also shows challenges in parliamentary advocacy on RMNCH, such as the need to sustain the political commitments made and build an economic case for RMNCH as an investment in health.

FINDING 3: CSOs and the media make a strong contribution to the RMNCH agenda in Uganda.

There have been several CSO campaigns in Uganda between 2010 and 2012 in support of RMNCH. Many of these seek to draw the attention of the government to cases of preventable maternal deaths, caused by capacity constraints, medical negligence, lack of supplies at health centres, or lack of midwives. Examples include the petition in September 2011 by the White Ribbon Alliance for Safe Motherhood Uganda and others to urge the government to commit to the Global Strategy, and the Child Health Now campaign, launched by World Vision Uganda in 2010. The latter is an integrated campaign model that links grassroots voices to national policy engagements.

The media has contributed greatly by constantly keeping track of activities and incidents around RMNCH. A recent examples of media coverage includes an article in *The Daily Monitor* of 9 May 2012 highlighting the increasing incidence of fistulas due to prolonged or obstructed labour. Some NGOs have focused on training journalists, and this has increased their understanding of the issues and their ability to cover maternal health issues comprehensively.

FINDING 4: There are a number of structures in place for accountability.

There are a number of accountability mechanisms in Uganda, although it is important to underscore that many of these were in place before Uganda signed commitments to the Global Strategy. For example, a country compact was signed by the government and health partners in June 2010 based on principles that include ownership and leadership by government, alignment of all partner programmes to the priorities of the Health Sector Strategic and Investment Plan (HSSIP), and a common management and accountability platform. It contributed significantly to coordination of health sector activities (including RMNCH), ensuring effective use of all available health sector funds from all sources – thus avoiding duplication of efforts and wastage of resources – and to providing ownership of the programme and common targets by all actors in the health sector. Furthermore, a monitoring and evaluation plan for HSSIP was developed in close consultation with stakeholders in May 2011. This provides overall guidance for the health sector and a platform for all stakeholders to report, review progress and plan jointly. In addition, a country accountability assessment and score card meeting was held in February 2012, which was attended by the MOH, WHO and UNFPA.

Summary

The three country case studies suggest that although the Global Strategy has in many cases contributed to increased funding, more funding is needed to ensure effective scale-up of RMNCH efforts, while the main issue in Bangladesh is slow release of funds. Other constraints to the implementation of commitments highlighted by all three case studies include: major gaps in human resources for health; lack of equipment and medication; social norms and practices (as well as gender inequality); and lack of access to counselling and care services, particularly in rural areas. In addition, key informants found it difficult to estimate the level of progress in the field of RMNCH that can be directly attributed to the Global Strategy.

The case studies also demonstrate that the Global Strategy has rallied actors working on RMNCH behind common goals and targets and has given a boost to ongoing RMNCH processes. The Global Strategy has served as a reminder to governments and other actors of the promises they made, thereby reinforcing the obligation to improve RMNCH, and ensure that it stays high on the agenda. It has also leveraged the use of innovative approaches to RMNCH. The country case studies further show that commitments made to the Global Strategy are well aligned with national health plans and that they are accounted for through national policies and plans – which were in most cases already in place before countries signed commitments to the Global Strategy. ■■■■



STRENGTHENING ACCOUNTABILITY FOR COMMITMENTS



The Global Strategy highlighted the need for an effective accountability mechanism to track progress on women's and children's health. Subsequently, the Commission on Information and Accountability (COIA) developed a framework to strengthen reporting and oversight as outlined in the 10 main recommendations of its report (see Box 9). In response to the final recommendation of the COIA, the independent Expert Review Group (iERG) was established to report annually to the United Nations Secretary-General on progress on women's and children's health.

The COIA defined accountability as a process encompassing three inter-related ideas: *monitoring*, *review* and *action*. It is a cyclical process that assesses progress, recognizes success, identifies challenges, takes action where indicated and holds all parties to account. Accountability should be a constructive and balanced process. An effective accountability mechanism should be transparent and inclusive, ensuring the meaningful participation of all key stakeholders, and particularly affected communities, civil society and parliamentarians.

The chapter draws its information from the online questionnaire, the country case studies and a commissioned review of accountability mechanisms.

Box 9: Recommendations of the Commission on Information and Accountability

Better information for better results

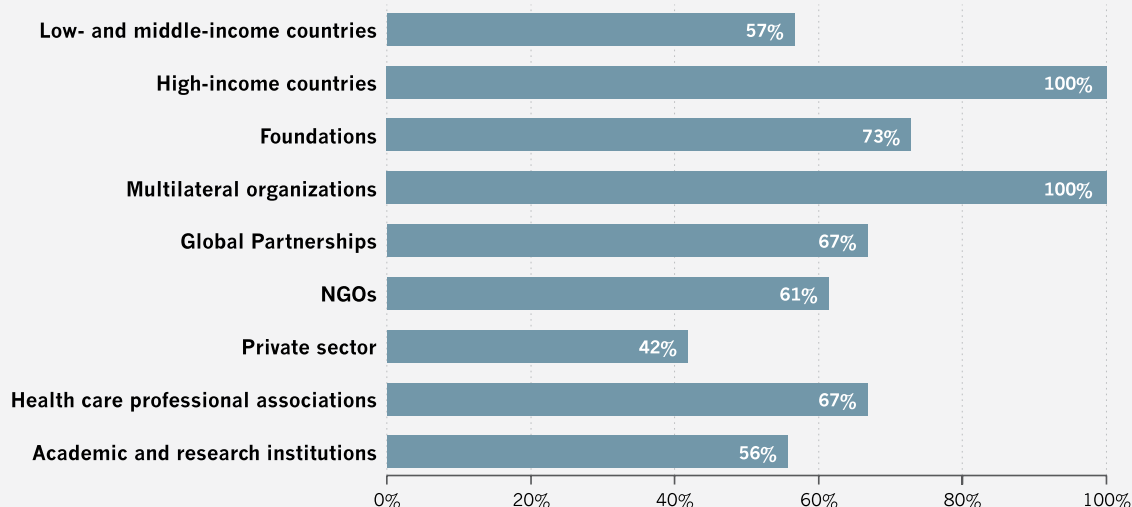
1. Vital events: By 2015, all countries have taken significant steps to establish a system for registration of births, deaths and causes of death, and have well-functioning health information systems that combine data from facilities, administrative sources and surveys.
2. Health indicators: By 2012, the same 11 indicators on reproductive, maternal and child health, disaggregated for gender and other equity considerations, are being used for the purpose of monitoring progress towards the goals of the Global Strategy.
3. Innovation: By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.

The latter was informed by key informant interviews and desk review, in response to the request of the iERG request for more information about existing accountability mechanisms. The chapter analyses awareness of and progress on the implementation of the 10 COIA recommendations, highlights examples of how countries and development partners are attempting to strengthen accountability for commitments to women's and children's health by building on existing mechanisms, and suggests additional mechanisms that could be considered.

FINDING 1: Relatively low awareness of the COIA recommendations among implementing countries.

The online questionnaire asked implementing countries and other stakeholders about their awareness of the COIA recommendations. Of the 46 implementing countries that responded, 26 (57%) indicated awareness of the COIA recommendations. By contrast, all high-income countries (HICs) and multilateral organizations indicated they know about the recommendations (Figure 22).

FIGURE 22: Level of awareness of the COIA recommendations



Better tracking of resources for women's and children's health

4. Resource tracking: By 2015, all 74 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: (i) total health expenditure by financing source, per capita; and (ii) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.
5. Country compacts: By 2012, in order to facilitate resource tracking, "compacts" between country governments and all major development partners are in place that require reporting, based on a format to be agreed in each country, on externally funded expenditures and predictable commitments.
6. Reaching women and children: By 2015, all governments have the capacity to regularly review health spending (including spending on reproductive, maternal, newborn and child health) and to relate spending to commitments, human rights, gender and other equity goals and results.

Better oversight of results and resources: nationally and globally

7. National oversight: By 2012, all countries have established national accountability mechanisms that are transparent, that are inclusive of all stakeholders, and that recommend remedial action, as required.
8. Transparency: By 2013, all stakeholders are publicly sharing information on commitments, resources provided and results achieved annually, at both national and international levels.
9. Reporting aid for women's and children's health: By 2012, development partners request the OECD-DAC to agree on how to improve the Creditor Reporting System so that it can capture, in a timely manner, all reproductive, maternal, newborn and child health spending by development partners. In the interim, development partners and the OECD implement a simple method for reporting such expenditure.
10. Global oversight: Starting in 2012 and ending in 2015, an independent "Expert Review Group" is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission's recommendations.

FINDING 2: Mixed progress on implementation of the COIA recommendations.

The countries that were aware of the COIA recommendations reported the following average rate of implementation:

- Achieved – 20%;
- In an advanced stage of implementation – 41%;
- In the inception phase – 33%;
- Not yet started – 6%.

As shown in Figure 23, there were considerable differences in progress of implementation by recommendation. More than one-third of the countries reported they had achieved recommendations related to country compacts and registration of vital events. However, progress was much slower on the recommendations related to resource tracking and innovation. Almost 90% of respondents mentioned financial and human resource constraints as the main barriers to implementation of the COIA recommendations.

FINDING 3: A majority of implementing countries have taken specific action to monitor the implementation of their commitments to the Global Strategy.

Almost two-thirds of countries (63%) reported that they monitor and assess the impact of their commitments to the Global Strategy. In Afghanistan, for example, a report on the main achievements, challenges and recommendations is presented to the parliament and,

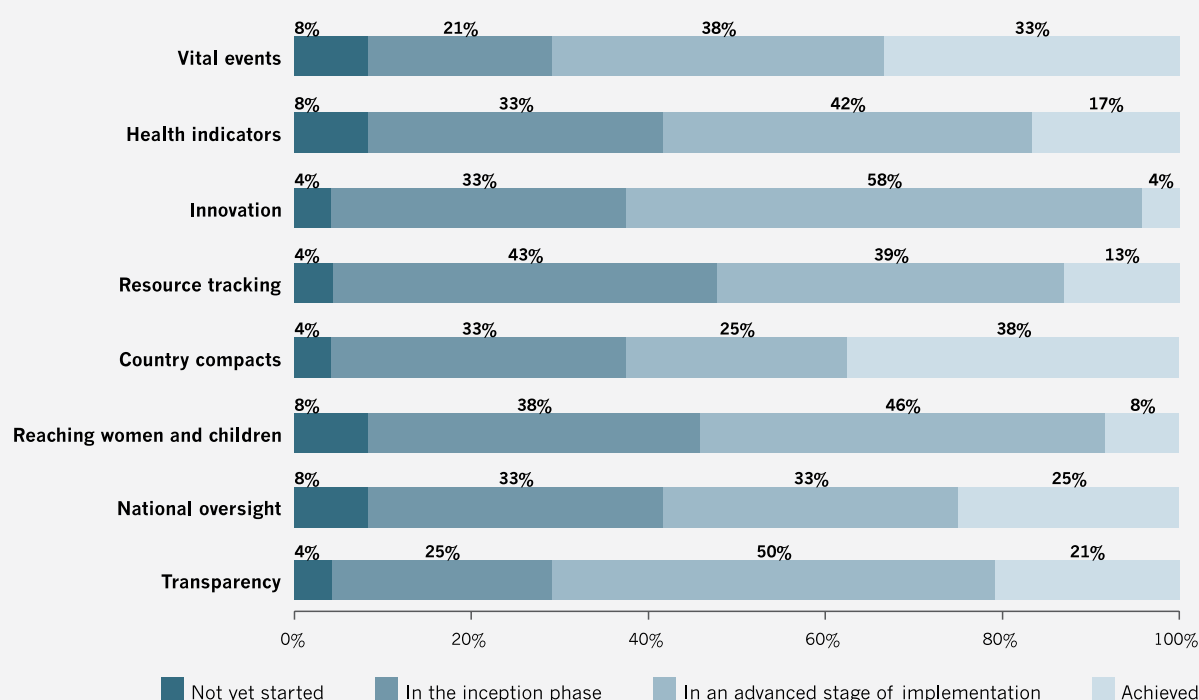
through the media, to the people. Another example is provided from the Burkina Faso country case study (see Box 10).

In addition to implementing countries, other stakeholders are also taking action to monitor the implementation of their own commitments. One example is provided by Save the Children (Box 11). Another NGO, World Vision International, has commissioned a mid-term review of its commitments. The private sector is also taking steps to monitor its commitments to the Global Strategy. Johnson & Johnson is developing a reporting system to capture the outcomes of its commitment and Merck plans to use an independent organization to monitor and evaluate its efforts.

FINDING 4: Existing national and regional mechanisms can provide a platform for strengthening accountability for women's and children's health.

The review of existing accountability mechanisms commissioned for this report found that the health sector review (HSR) may be the most appropriate starting point for accountability for RMNCH. However, the importance of other sectors in improving RMNCH outcomes should be recognized, and meaningful participation ensured to promote greater legitimacy of the process. HSRs are most often conducted by the Ministry of Health (MOH) with development partners, and involve an annual or biannual review of progress on implementation of the national health plan. These are most often developed in countries that have adopted a

FIGURE 23: Progress on implementation of the COIA recommendations by implementing countries aware of the recommendations⁴⁹



Box 10: Monitoring of RMNCH programs in Burkina Faso

In Burkina Faso, the MOH has demonstrated both political will and leadership to achieve better coordination of the health sector and alignment of the various actors. The existence of a national structure of the health sector operating under the leadership of the MOH and a single National Health Development Plan (PNDS) lends itself well to the implementation of various commitments for RMNCH. A number of thematic working groups exist within this structure, involving both the government and development partners.

A monitoring committee for implementation of programmes and strategies for the reduction of maternal, newborn and child mortality was inaugurated in May 2012. It is presided over by the

First Lady and the Minister of Health. It includes representatives from 20 government departments, as well as development partners, NGOs, professional associations, research centres and schools. It is funded by the MOH, and its purpose is to monitor the implementation of programmes and strategies, make suggestions to strengthen different interventions and support new initiatives. The committee, which will meet once a year, is assisted by a technical secretariat. The secretariat is composed by representatives from government, professional associations and a number of local non-governmental organisations, as well as UNICEF, WHO and UNFPA.

While some partners have expressed concern that health-sector governance is sometimes poor, most partners noted that the level of coordination and cooperation demonstrated in Burkina Faso is more advanced than in many other countries.

sector-wide approach (SWAp) to health, which stresses the importance of country leadership, a single sector policy, expenditure and monitoring framework, and use of common approaches across the sector. These principles are in line with the International Health Partnership (IHP+), which is another existing mechanism that can be used for accountability.

There are some challenges with using the HSR as an effective accountability mechanism. The process would

gain greater credibility and legitimacy by ensuring the meaningful inclusion of all RMNCH stakeholders as full partners in the review process, including communities, civil society, parliament and other government departments. This will require greater efforts to strengthen systems that enable communities to be active participants in health and development. The outcome and recommendations of HSRs should be shared with the head of state and parliament. Compliance with recommendations of the review can be strengthened.

Box 11: Promoting mutual accountability - monitoring Save the Children's commitment to the Global Strategy

In 2010, Save the Children committed to Every Woman, Every Child to be (i) a significant investor in MNCH programming; (ii) a global leader on newborn health; (iii) a direct participant in supporting health workers to save lives; (iv) an innovator in community mobilisation for behaviour change and advocacy; (v) a pioneer of innovative and effective partnerships; and (vi) a vocal advocate for children's rights and equity.

The organization has stated that it wishes to lead by example and demonstrate to others that it is prepared to hold itself to account and to present its progress against its targets. To support this, an independent organization was appointed by Save the Children to perform an independent assessment of the NGO's progress towards meeting these commitments to date, and a report is being made public, also including recommendations. Some of the findings include:⁵⁰

- Regarding the first commitment of reaching an annual target of US\$ 500 million, the assessment concludes that, while there was a significant increase in expenditure on MNCH programmes between 2009 and 2010, current projections suggest that the first commitment may not be met by 2015 without a sustained focus on resource mobilization. Strategies are being developed to close this gap, including a more coordinated approach by Save the Children's members towards institutional donors, and a joined up investment in programme evaluation and learning.
- An extrapolation of the results from the first year suggests that the NGO will reach the target of training and supporting 400 000 health workers in developing countries by 2015 to ensure better availability of life-saving services. However, the organization should have a breakdown of how this figure is going to be reached by the country programmes.
- As Save the Children is performing a significant amount of advocacy and community mobilisation across the globe, the auditors conclude that the organisation is continuing to address the commitment of helping to mobilize communities in the countries with the highest child mortality, to hold governments to account.
- In addition, findings show that Save the Children has developed and implemented a range of effective partnerships across the globe. In this way, it is actively and successfully working to address the commitment of engaging with partners from the corporate sector, governments, media, academics, sport, entertainment and civil society at a national and international level, to help deliver life-saving programming and engage hundreds of millions in the movement to end needless deaths of mothers and children.

Accountability can also be strengthened by linking with regional mechanisms and processes, such as the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), the African Leaders Malaria Alliance (ALMA), the Abuja Declaration, and the Joint Declaration on the Attainment of the Millennium Development Goals in the Association of Southeast Asian Nations (ASEAN).

The online questionnaire asked respondents to suggest opportunities to strengthen accountability for women's and children's health. A few countries, such as Mauritania and Senegal, highlighted the need to develop networks or frameworks to engage civil society formally in accountability mechanisms. Others, like Afghanistan and Indonesia, noted that media and information systems create opportunities and should be better used. Chad mentioned the importance of gender-focused strategies to improve the education of girls and the autonomy and leadership of women.

FINDING 5: Countries' human rights obligations and international and regional human rights mechanisms provide opportunities to strengthen accountability.

Outside the health sector, there are other mechanisms and processes that should be utilized to promote accountability for women's and children's health. For example, countries' human rights obligations provide opportunities for improved accountability. The COIA built its accountability framework on the right to health, equity in health and gender equality. The right to health is one of the fundamental rights of every human being and has been defined as "the enjoyment of the highest attainable standard of health" (International Covenant on Economic, Social and Cultural Rights, Article 12). Rights to sexual and reproductive health are vital components of the right to the highest attainable standard of health.⁵¹

Every country in the world is now party to at least one international human rights treaty that addresses health-related rights and some of them explicitly establish obligations in the area of maternal health.

States are responsible for reporting on their human rights commitments periodically to the treaty monitoring body (for example, parties to the International Covenant on Economic, Social and Cultural Rights report every four years on its implementation to the Committee on Economic, Social and Cultural Rights). The right to health is also recognized in regional human rights treaties. Examples are the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights and the Maputo Protocol on the Rights of Women in Africa. States also report to other bodies such as the United Nations Human Rights Council through the Universal Periodic Review, which provides an opportunity to promote accountability for women's and children's health.⁵²

Many States also have obligations to realize the right to health under national legislation and policy and there are many national human rights institutions with the mandate to look at women's and children's health (Box 12 provides an example from Kenya). The right to health is also enshrined in some national constitutions worldwide, for example Ecuador, Kenya and South Africa. Realization of the right to health involves devoting the maximum available resources to the health system and investing to address the health needs of the population. While the state remains ultimately accountable for guaranteeing the realization of the right to health, it is important to engage civil society as supportive but critical friends and contributors to a collective process of constructive accountability.

When national accountability mechanisms do not provide satisfaction, people may turn to the courts as a last resort. Some national courts have made rulings on cases related to RMNCH awarding redress for victims and have

Box 12: Promoting accountability for reproductive and maternal health – the Kenya National Commission on Human Rights

The Kenya National Commission on Human Rights (KNCHR) is an independent national human rights institution established in July 2003 and enshrined in the constitution. It has two roles: to act as a watchdog in monitoring and documenting perceived violations of human rights, and to act in an advisory role to government and parliament on issues related to legislation. Reports and recommendations are submitted to parliament and made widely accessible. Among key achievements of the new constitution is the guarantee of the right to health including the right to reproductive health.

KNCHR has acted on a complaint by the Federation of Women Lawyers on alleged violations of women's reproductive human rights in Kenyan health facilities. Their investigations into Pumwani Maternity Hospital and other facilities were described in the report "Failure to Deliver".⁵³ Pumwani Hospital is in the centre of Nairobi and its clients are mostly the very poor and vulnerable. The report pointed to under-funded services and a government failure to provide quality health care as factors that contributed to high maternal mortality.

A review concluded that such violations were common in many government hospitals and institutions. KNCHR initiated a national public enquiry covering all regions of Kenya. This will provide a forum to raise public awareness and debate, identify root causes of poor quality and inadequate services and seek practical solutions to address the issues. Findings will be compiled into a report with clear analysis and recommendations and submitted to the President of Kenya and to parliament.

ordered States to improve the health care services they provide. This is the case of some state-courts in India that set important precedents and help strengthen health systems.

International mechanisms can enhance accountability where national mechanisms are inaccessible, ineffective or absent. Some United Nations treaty monitoring bodies, such as the committee of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee and regional bodies such as the Inter-American Commission of Human Rights, can also review and make rulings on individual complaints.

In September 2011, the United Nations Human Rights Council (HRC) passed Resolution 18/2 on *Preventable maternal mortality and morbidity and human rights*.⁵⁴ To implement the resolution, the Office of the High Commissioner for Human Rights (OHCHR) coordinated the development of technical guidelines on the application of a human-rights-based approach (see Box 13).

FINDING 6: Parliamentarians have a crucial role to play in holding the government and other stakeholders to account and giving a voice to women, children and their communities.

Parliamentarians are widely recognized as being central to the accountability process for RMNCH, through their role in allocating resources through the budget process, enacting laws, overseeing implementation and reflecting the views of citizens about their health services. They potentially play a crucial role as advocates for women's and children's health, in partnership with communities, civil society and the media.

There are many examples of the positive results of strong engagement by parliamentarians in RMNCH. For example, in Viet Nam and Rwanda, the parliaments have passed legislation to remove financial barriers that prevented universal access to health care and have introduced legislation to ensure free care for children under six. In Uganda, the parliament held up the budget until the RMNCH allocation was increased.⁵⁵

A resolution by the Pan-African Parliament (PAP), the legislative arm of the African Union, adopted in October 2011, urges speakers of Parliament in Africa to prioritize the implementation of MNCH policies and programmes, supported by adequate budgets. Presiding over the adoption of the resolution, the Pan African Parliament President Hon. Dr. Moussa Idriss Ndélé emphasised that "parliamentary support is crucial for successful implementation of African Union Summit Decisions and African development priorities".

In April 2012, delegates to the Inter-Parliamentary Union (IPU) in Kampala passed a resolution calling for members of parliaments to take all possible measures to achieve Millennium Development Goals (MDGs) 4 and 5 by 2015 (Box 14). Delegates called upon parliamentarians to scrutinize all government health interventions to ensure they are evidence-based, conform to international human rights standards and are responsive to regular and transparent performance reviews. They stressed the need for strengthened partnership between parliamentarians, CSOs, media, the private sector and all other relevant actors.

Box 13: Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality⁵⁵

In 2011 the United Nations Human Rights Council requested the Office of the High Commissioner for Human Rights (OHCHR) to elaborate this tool to provide guidance to policymakers and other relevant actors on how to design, monitor and implement policies and programmes to reduce maternal mortality and morbidity in accordance with human rights principles and standards.

The technical guidance is based on the premise of the full respect and protection of women's sexual and reproductive rights, as recognized in international human rights law and political commitments, particularly the Programme of Action of the International Conference on Population and Development (ICPD).

The technical guidance highlights the importance of addressing maternal mortality and morbidity through comprehensive interventions that focus not only on the medical causes but also on the underlying causes and the fulfilment of women's economic, social, cultural, civil and political rights. The document establishes that any effort to reduce maternal mortality should promote women's empowerment, which entails treating women as active agents who are entitled to participate in decisions that affect their health. It also highlights that applying a human-rights-based approach requires strengthening the capacities of both rights-holders to make their claims and duty-bearers to meet their obligations, as well as paying particular attention to marginalized groups of women.

This document stresses that the accessibility, availability, acceptability and quality of sexual and reproductive health goods, services and information should be understood by health care providers and policymakers as human rights and not as charity. A very important part of the technical guidance is devoted to the issue of accountability as a critical element of every stage of human-rights-based interventions. It establishes that accountability should include appropriate monitoring mechanisms based on human rights indicators (qualitative and quantitative). It addresses the type of accountability mechanisms that can be established to identify obstacles, hold institutions, providers, donors and other actors accountable and provide effective remedies.

The technical guidance emphasizes the need to adopt a national health plan, which should include a sexual and reproductive rights strategy encompassing maternal health. This plan should be elaborated with the participation of the affected communities and based on a situational analysis. The plan should have appropriate budget based on the human rights principle of maximum available resources. The design of this plan should be followed by the repeal of all laws and policies that undermine access to sexual and reproductive health services.

The technical guidance could be a very useful tool for policy-makers, health care providers, parliamentarians, judiciaries, inter-governmental agencies, national human rights institutions and donor states. Its application could have a very positive impact on the effectiveness and sustainability of policies and programmes aimed at reducing maternal mortality and morbidity.

FINDING 7: Civil society and media have a powerful accountability role to play; their capacity needs to be reinforced.

Social accountability is a bottom-up approach in which citizens as service users can change the behaviour of service providers through their collective voice and influence.

While recognizing the necessary participation of men in promoting women's and children's health, giving voice to women is particularly important; 40% of implementing countries report that they have feedback mechanisms that allow women to assess the implementation of commitments.

In recent years, scorecards, social audits and new information technologies have been used increasingly to contribute to social monitoring. Participation may include campaigns to inform citizens about their rights and what services they are entitled to, and performing third-party monitoring through processes such as social audits and analysis. Box 15 provides an example of the use of scorecards, social audits and other elements of social accountability.

Other powerful accountability tools used by civil society are budget analyses and public expenditure tracking surveys to "follow the money" from central government

budgets through to service providers, or surveys to monitor attendance of service providers in health facilities. Box 16 illustrates how the power of budget monitoring was used in Mexico to ensure that maternal and newborn health services were included in the benefit package of the national health insurance scheme.

Social accountability can be reinforced through partnership with the media, which has an important role to play in increasing awareness of RMNCH and disseminating information to inform the population and stir debate. It can present a human face to statistics and provide a public platform for citizens. It can be an important ally in holding government to account for meeting commitments and a powerful advocate for social change.

Through their commitments to the Global Strategy, and other initiatives, stakeholders can invest in building the capacity of parliamentarians, the media and CSOs to better monitor and use more effectively the evidence for advocacy, and to hold governments to account on RMNCH commitments. By strengthening parliamentary oversight and building partnerships with the media, stakeholders can improve accountability to citizens, expand social accountability and improve monitoring of human rights treaty obligations.

Box 14: The power of parliamentary action – the Inter-Parliamentary Union resolution on women's and children's health

The Inter-Parliamentary Union (IPU), an international organization bringing together national parliaments of 157 countries and nine regional parliamentary assemblies, is playing an increasing role in promoting the health of women and children. In April 2012, the IPU adopted a resolution entitled "Access to Health as a Basic Right: The Role of Parliaments in Addressing Key Challenges to Securing the Health of Women and Children".⁵⁷ The resolution places parliaments at the heart of national accountability efforts. It calls on parliaments to monitor the national implementation of commitments made at national, regional and global levels to improve health through the development of expert committees, requests for annual reports, budgetary oversight, organization of constituency meetings and field visits. The resolution also explicitly calls on parliaments to ensure that all commitments made to the Global Strategy are fulfilled, and that the recommendations of the Commission on Information and Accountability are implemented.

Hon. Safia Nalule Juuko, Member of Parliament from Uganda, illustrates the contribution of the IPU resolution to fostering accountability, using exclusion as an example: "The exclusion and marginalization of women with disabilities is a critical problem in many countries. The IPU resolution urges parliaments to pay special attention and make budgetary provisions for the sexual and reproductive health needs of women and children with disabilities. I believe that by so doing, the IPU resolution goes a long way towards ensuring the well-being of women and children with disabilities and, ultimately, accountability for their inclusion."

The IPU resolution is already making a difference. Hon. Kyei Mensah-Bonsu, President of the IPU Third Committee and Member of Parliament in Ghana, notes that: "In Ghana we have already begun to see the value addition of the IPU resolution. Parliament shared the resolution with the new Ministry for Women's and Children's Affairs. The ministry responded by setting up a committee to peruse the IPU resolution and identify opportunities for collaborating with parliament to promote accountability for improved maternal, newborn and child health."

The resolution has also galvanized attention to women's and children's health in regional parliamentary bodies, as illustrated by the Speaker of East Africa Legislative Assembly (EALA), Rt. Hon Abdirahin Abdi: "The IPU resolution has placed the issue on the radar of EALA for urgent action and provides EALA with a renewed mandate to tackle the issue of accountability for maternal, newborn and child health."

The resolution is the result of sustained and committed efforts by the IPU, over several years, to place women's and children's health at the centre of the development agenda and as a key priority of parliamentarians.

Box 15: Giving children and communities a voice – social accountability in action

World Vision has developed a social accountability methodology that seeks to improve services such as health and education by transforming the dialogue between communities and government. Citizen Voice and Action (CVA) mobilizes citizens, gives them tools to monitor government services and facilitates a process to improve services that directly affect children and their families. It is designed to sustain a long-term working relationship between communities and governments. CVA combines several elements of social accountability into one package: civic education, community score cards, social audits and an interface meeting, which brings all stakeholders together.

World Vision launched CVA in Brazil and Uganda in 2005, and has since scaled up implementation across other countries, including India. CVA has become World Vision's primary approach to local-level advocacy in more than 20 countries.⁵⁸

Impact in Uganda and India

In Uganda, CVA is used to monitor health clinics in 20 districts across the country, where people use score cards to record the most pressing health needs in their communities. Feedback at the local and district levels has led to measurable improvements in the delivery and quality of health care services. Although other factors may have contributed, the health workers and district government staff at these clinics credit CVA for significantly improving outcomes.

In India, CVA enables children to assess their local health and education facilities. An example is the Fully functional school or Anganwadi campaign, which involved over 20 000 children and allowed them to give feedback using pictorial score cards designed for easy use by children. CVA gives Indian children a voice at local and national level. It has empowered them and their families with knowledge about their entitlements in areas such as the quality of infrastructure in schools and nurseries and the quality and availability of food for children.

Summary

This chapter has highlighted implementing countries' low awareness of the COIA recommendations for strengthening accountability. It also shows mixed progress on implementing the COIA recommendations, suggesting a need for additional efforts and investment, both from the international community and the implementing countries' decision-makers.

The chapter has also shown that there is considerable scope for strengthening accountability for women's and children's health. This can be done by: building on existing mechanisms, including health sector reviews and human rights obligations; expanding social accountability approaches to improve accountability to citizens and communities; building capacity for parliamentary engagement and oversight; and fully utilizing the power of the media. ■■■■

Box 16: Maternal health and budgets in Mexico⁵⁹

From 1998-2002 the Mexican government implemented several targeted programmes to offer maternal and newborn health (MNH) services to poor communities. However, the budget was insignificant and per capita expenditure was lowest where the concentration of poverty was highest, so failed to address inequality. Targeted programmes did not contribute to improved infrastructure nor increase the number of available physicians in poor states. Using budget analysis supported by the national NGO Fundar Center for Analysis and Research, civil society put pressure on the government to increase and earmark decentralized funds for MNH. When the government created the Popular Insurance, a health protection scheme for unemployed and poor people, emergency obstetric care (EmOC) was initially not covered. The Fundar Center for Analysis and Research costed the provision of EmOC and demonstrated the financial viability of its inclusion. It was included in the benefit package of the health insurance scheme in 2005.

CONCLUSIONS AND RECOMMENDATIONS



Conclusions

Although it is premature to identify the impact on health outcomes of commitments to the Global Strategy, this report has attempted to assess the added value of the Global Strategy and progress on implementation of the commitments. The findings are encouraging, but challenges and gaps remain.

There is evidence that the Global Strategy has been a catalyst for more focused and coordinated efforts for women's and children's health. It has generated high-level political support and built consensus on the key needs and principles in accelerating action towards achieving MDGs 4 and 5. In addition, it has provided a platform for action, contributed to aligning disparate efforts of national, regional and global actors, and promoted public-private partnerships. As reported by stakeholders, implementation of commitments is well underway but constraints have been identified, in particular financial and human resources.

Although significant new and additional funding – at least US\$ 20 billion – has been mobilized as a result of the Global Strategy, 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 previously, 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.

While the report demonstrates that most commitments are focused on the 49 Global Strategy countries, there is still concern about geographic targeting – with some countries with high mortality rates and/or off-track on MDGs 4 and 5 receiving relatively little attention. In addition, some key intervention areas recognized as major threats to maternal and child health – such as those related to the prevention and treatment of diarrhoea, pneumonia and malaria – have as yet received relatively little support.

Awareness of the COIA recommendations for strengthening accountability is low among implementing countries, and countries that were aware reported mixed progress on implementing the COIA recommendations. The report has shown that there is considerable scope to improve accountability for women's and children's health by building on existing mechanisms, strengthening health information systems, increasing the use of human rights instruments, and fully realizing the potential of parliamentary engagement and social accountability approaches.

Improving the health of women and children cannot be resolved by the health sector alone, and needs to become part of a much larger intersectoral and political agenda. However, actions to address determinants of health that are traditionally not perceived as being within the domain of the health sector – such as safe drinking water, sanitation and hygiene, nutrition and food security, transportation and ICT – are under-represented in the commitments to date.

Recommendations

To improve targeting and implementation of the commitments:

- Provide additional support to countries receiving little attention although being either off-track for MDGs 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 against pneumonia, diarrhoea and malaria.
- Continue the increased attention and resources to previously neglected interventions, such as family planning, skilled birth attendance and PMTCT.
- Pursue development of partnerships for development, an MDG in itself (MDG8) but also crucial to achieving 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. 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 around the key needs and principles of the GS framework.
- Address the critical human resources challenges, not only shortages but also geographical disparities, retention problems, low motivation and inadequate skills.

- Tackle other health systems weaknesses, such as poor infrastructure and shortage of commodities, by supporting the implementation of the recommendations of the Commission on Life-Saving Commodities for Women's and Children's Health.
- Consider gender and sociocultural issues when designing policies and programs, 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:

- Focus efforts more strongly on other sectors that are critical to improving women's and children's health – such as agriculture and trade – and on the integration of nutrition, food safety, safe water, sanitation and hygiene with health.
- Improve enabling infrastructure – for example transportation and ICT – which, in addition to health infrastructure, is critical to improved access.

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 by the Commission on Information and Accountability.
- Ensure alignment and consistency of reporting requirements and mechanisms across existing 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, for example through PAP and IPU, in strengthening accountability. In addition, the Global Strategy effort should strengthen and embrace national and regional efforts, such as CARMMA, more profoundly.
- Make better use of human rights instruments and frameworks as they can promote accountability for women's and children's health and should be an integral part of tracking commitments.
- Collect more detailed information on the implementation of commitments, when possible, for example disbursement of financial commitments to specific countries and interventions.
- 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 track progress. The lack of such information has presented serious challenges in assessing progress on implementation so far. ■■■■



ANNEX 1

METHODS

Methods development was overseen by the coordinators of the PMNCH strategic objective on accountability for results and resources. A technical consultation with researchers was organized in Geneva in January 2012 to seek feedback on the objectives, scope and methods of the report. A multi-disciplinary, multi-stakeholder advisory group provided on-going technical review and met in Geneva in May 2012 (see Acknowledgements for a list of members). Data collection and analysis were carried out by consultants selected through a Request for Proposals. Methods are summarized in the sections below.

Online questionnaire

Based on lessons learned from the PMNCH 2011 report,⁶⁰ an online questionnaire (Web-Annex 1) was used to collect data on progress on implementation of the commitments. Development of the draft questionnaire was informed by the technical consultation in January 2012 and technical review by the advisory group. The draft questionnaire was pilot-tested, revised and subsequently uploaded onto the questionnaire website (Cvent). Invitations were sent to the 220 stakeholders that had made commitments as of September 2011.

The online questionnaire generated both quantitative and qualitative data and information. The quantitative data was analysed in Excel and SPSS. The qualitative analysis consisted of analysis of the open-ended questions, using Hyper Research software. The objectives of the qualitative analysis were to triangulate the findings of the quantitative analysis and to provide examples to enrich the report. It is worth noting that the nature of data gathering – self-reporting that often consists of quite general statements – has unfortunately limited the reliability and level of detailed information that can be provided about progress of implementation.

Key informant interviews

To inform the analysis of financial commitments, national accountability mechanisms and the country case studies, semi-structured interviews were conducted. Key informants were selected through purposeful sampling to ensure inputs from a broad range of relevant stakeholders. Interviews were conducted by phone or face-to-face. The interviews used a semi-structured questionnaire. Informed consent was obtained from all key informants.

Country case studies

The objectives of the country case studies were to analyse how the implementation of the commitments to the Global

Strategy supports country progress towards achieving MDGs 4 and 5 through aligning with national plans and programs, and ensuring accountability for results and resources. Three country case studies were carried out: Bangladesh, Burkina Faso and Uganda. Countries were selected based on the following criteria: the country has made a commitment to the Global Strategy and is the focus of several commitments from other stakeholders; the country has a high burden of maternal and child mortality, and unmet need for family planning; and achieving regional balance to the extent possible.

An analytical framework and data collection tools were developed and pilot-tested by representatives of multiple stakeholders and disciplines. Data and information were collected through key informant interviews with government officials and development partners, and review of documentation provided by interviewees as well as documentation available in the public domain. Key informants were selected through a purposeful sampling in order to interview representatives of the government and development partners that have made commitments to the country through the Global Strategy.

Analysis of financial commitments

A “mixed methods” approach was used to collect and analyse data for the financial analysis, including: (i) the online questionnaire conducted for this report included a section on financial commitments; (ii) interviews with 24 stakeholders with sizable financial commitments; (iii) interviews with four technical experts to understand progress in tracking financing for RMNCH; and (iv) desk review of relevant literature and databases. The following sections explain how the financial estimates were calculated.

Approach to estimating overall financial commitments to the Global Strategy

In line with the methods of the PMNCH 2011 report, the starting point of the analysis of financial commitments to the Global Strategy was an analysis of the commitment statements from the Every Woman Every Child website. Only commitments that are explicitly expressed in financial terms were included. A database on financial commitments to the Global Strategy, established by PMNCH in 2011, was updated.

To estimate the financial commitments made by 24 LICs, the methods of the PMNCH 2011 Report, which already estimated the amount for 16 of these countries, was used (see Figure 24):

1. Unless otherwise specified, and following the method used by Countdown to 2015, it was assumed that 25%

of government health spending will benefit RMNCH. Where a specific proportion was specified in the commitment, this figure was used instead; for example, 30% for the Central African Republic.

2. Based on trends of annual government health spending in 2006-2009, total government health spending on RMNCH in US\$ in 2011-2015, if the commitment to the Global Strategy had not been made, was estimated. This means that spending would increase at the current rate until 2015.
3. Total government health spending on RMNCH in 2011-2015, if spending would increase to meet the government health spending target in the Global Strategy commitment, was estimated. Unless another target year was specified in the commitment, a linear rate of increase in government health spending until 2015 was assumed.
4. The total additional government health spending on RMNCH in 2011-2015 is the estimated value of governments' financial commitments. Figure 24 also shows the expected share of funding that is potentially subject to double-counting ("share of additional funding potentially coming from external resources").

Approach to estimating double-counted commitments

Controlling for double-counting in Global Strategy commitments is critical to avoid an artificial increase of overall funding figures. Double-counting occurs when a source of international financing, for example, a bilateral agency or foundation, channels funding through multilateral organizations, global health partnerships, and NGOs, and when both – source and channel – count this funding as part of their commitment.⁶¹

One particular challenge in this context was to estimate the funding channeled through NGOs. While decent data was available for global health partnerships and multilateral agencies, only a small number of NGOs were able to estimate the extent to which their commitment relied on financial resources from international donors (and donors were also unable to specify the proportion of their commitment channeled through NGOs). As described in Table 4, we thus needed to use a different approach to estimate the extent to which the commitments of NGOs are subject to double-counting.

While LICs are also a potential source of funding (i.e. they generate new resources for health, e.g. through taxes), parts of their commitment are likely to be financed through external resources, which means that their commitment could also overlap with commitments of international sources. This was clearly indicated in the interviews and the online questionnaire.

Approach to estimating confirmed new and additional funding for RMNCH

As highlighted above, Global Strategy commitments included ongoing financial RMNCH investments as well as new investments specifically targeting the funding gap identified in the Global Strategy. Determining the extent to which the financial commitments address this funding gap was a complex exercise and methods and assumptions vary between different stakeholders. For example, the G8 members of the Muskoka Initiative equated new and additional funding with RMNCH-related investments above baseline spending of 2008, a baseline year that was chosen due to a lack of more up-to-date data. As described above, to estimate the additional funding committed by 24 low-income countries, a different approach and baseline were used (based upon the mean of government health spending in years 2006-2009).

FIGURE 24: Government health spending on RMNCH in 24 low-income countries with and without financial commitments to the Global Strategy, 2011-2015



TABLE 4: Approaches to controlling for double-counting

	APPROACH TO ELIMINATING DOUBLE-COUNTING
Multilateral agencies and global health partnerships	- Commitments of bilateral and private donors channeled through multilateral organizations and global health partnerships were counted - Donor commitments were then subtracted from the amounts pledged by the different multilateral organizations and global health partnerships
NGOs	- NGOs were requested to provide information on the extent to which their commitment relied on funding from international donors - To fill data gaps, relevant documents were reviewed to estimate the share of funding that was channeled by donors through NGO (e.g. annual reports, IHME data) - On average, it was estimated that approximately 60% of NGO commitments are subject to double-counting⁶²
LICs	- Share of external resources for health of total government health expenditures in 24 LICs which made financial commitments was calculated (for each LIC, the mean for 2006-09 was used, source: National Health Accounts data) - Subsequently, the interquartile range (IQR) for the 24 LICs was calculated. The IQR is the range of the middle 50% of the data, excluding extreme values ("outliers"). The IQR is considered as a more robust statistical measure than the range. - The calculated IQR 24% and 46% of LIC commitments was subtracted from projected LIC spending

A conservative approach was used to estimate the amount of additional funding. Funding was only counted as additional when at least some evidence was available that supported this assumption in a convincing manner. Stakeholders provided data on the additionality of funding in interviews and the online questionnaire.

Approach to estimating the reduction in the financing gap

For estimating how much of the confirmed additional funding would be for the 49 Global Strategy countries, the most recent financing data of Countdown to 2015 (Countdown) was used as a starting point. Countdown tracks the disbursements to maternal, newborn, and child health (MNCH) in 74 priority countries,⁶³ which include the 49 Global Strategy countries. For 2010, Countdown estimated that 77.1% of all official development assistance (ODA) for MNCH was allocated to these 74 countries (US\$ 5.0 billion out of US\$ 6.5 billion), and 60.5% (US\$ 3.9 billion) to the 49 Global Strategy countries.⁶⁴

Assuming that the allocation of donor commitments to the Global Strategy follows the same pattern, i.e. that 60.5% of the US\$12.5 billion in new confirmed funding from international stakeholders would be allocated to the 49 Global Strategy countries, a total of US\$ 7.6 billion would flow to these countries. This may be considered as a minimum as donors may have allocated an even higher share of their funding to the 49 priority countries due to the high visibility given by the Global Strategy since 2010.

As discussed above, the financial commitments by LICs can also be deemed additional once double-counting is taken into account. After controlling for double-counting, US\$ 5.7-8.1 billion in additional funding for 2011-2015 comes from LICs. However, it needs to be reflected that only 20 out of the 24 LICs with financial commitments are among the 49 Global Strategy countries, and that

only the funding of these 20 countries contributes to a reduction in the US\$ 88 billion funding gap. The additional funding provided by these 20 countries is estimated at US\$ 5.3-7.8 billion.

Total additional funding available to the 49 Global Strategy countries thus amounts to US\$12.9-15.3 billion (mean = US\$ 14.1 billion), which represents 14.7-17.4% of the US\$ 88 billion funding gap for 2011-2015.

Approach to estimating disbursements

Disbursement data was collected through several methods. The online questionnaire conducted for this report included a question on disbursements. In addition, key informant interviews were conducted. After the interviews, stakeholders provided data to inform the analysis of disbursements.

A key challenge for this analysis was the scarcity of disbursement data. This is often related to financial year cycles, not any lack of willingness to provide data, and the time-lag between the disbursement and reporting. For this reason, the disbursement figures presented in this report are likely to present an underestimation of the amount of resources actually disbursed.

It is important to note that the presented disbursement figure includes both existing and additional resources. It was not possible to differentiate between disbursement of existing resources and disbursement of additional resources.

In addition, some of the disbursements are subject to double-counting, but the exact amount is very difficult to estimate (for example, double-counting has likely occurred for disbursements of bilateral donors and those of global health partnerships). ■■■■

LIST OF ONLINE QUESTIONNAIRE RESPONDENTS

Low-income countries

- Afghanistan
- Benin
- Burkina Faso
- Burundi
- Cambodia
- Central African Republic
- Chad
- Comoros
- Congo, Democratic Republic of the
- Ethiopia
- Gambia
- Guinea
- Guinea-Bissau
- Haiti
- Kenya
- Kyrgyzstan
- Liberia
- Madagascar
- Malawi
- Mali
- Myanmar
- Nepal
- Niger
- Sierra Leone
- Tanzania, United Republic of
- Togo
- Uganda
- Zimbabwe

Middle-income countries

- China
- Congo
- Djibouti
- Guyana
- India
- Indonesia
- Lao People's Democratic Republic
- Lesotho
- Mauritania
- Mongolia
- Nigeria
- Papua New Guinea
- Sao Tome and Principe
- Senegal
- Sri Lanka
- Sudan
- Uzbekistan
- Viet Nam
- Yemen

High-income countries

- Australia
- Canada
- France
- Germany
- Japan
- Netherlands
- Norway
- Republic of Korea
- Sweden
- United Kingdom

Foundations

- A. K. Khan Healthcare Trust
- Bill and Melinda Gates Foundation
- The Children's Investment Fund Foundation
- The David and Lucile Packard Foundation
- Elizabeth Glaser Pediatric AIDS Foundation
- Ford Foundation
- Geddes Group
- Grand Challenges Canada
- John D. and Catherine T. MacArthur Foundation
- Medtronic Foundation
- Planet Wheeler Foundation
- UN Foundation
- International Network of Women's Funds

Multilateral organizations

- European Commission
- HRP (the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction)
- UNAIDS
- UNFPA
- UNICEF
- WHO
- World Bank

Global partnerships

- European Parliamentary Forum on Population and Development
- GAVI Alliance
- Global Fund to Fight AIDS, Tuberculosis and Malaria
- Global Health Workforce Alliance
- Inter-Parliamentary Union
- The Partnership for Maternal, Newborn & Child Health
- Stop TB Partnership
- The Elders
- United Nations Global Compact

NGOs

- 34 Million Friends of the United Nations Population Fund
- Africa Coalition on Maternal, Newborn and Child Health
- African Medical and Research Foundation (AMREF)
- Akaa Project, Inc
- American Academy of Pediatrics
- Amnesty International
- Bangladesh Rehabilitation Assistance Committee (BRAC)
- BBC Media Action
- Caring & Living as Neighbours
- D-Tree International
- DKT International
- EngenderHealth
- Every Mother Counts
- Family Care International (FCI)
- Fashion for Development (F4D)
- Global Alliance to Prevent Prematurity and Stillbirth
- Global Leaders Council for Reproductive Health (GLCRH)
- Health Alliance International
- International Association of Infant Massage, Australia
- International Baby Food Action Network
- International Budget Partnership
- International Council for Control of Iodine Deficiency Disorders
- International Diabetes Federation
- International Federation of Pharmaceutical Manufacturers and Associations
- International Planned Parenthood Federation (IPPF)
- IntraHealth International
- John Snow, Inc. (JSI)
- Junior Chamber International
- Management Sciences for Health
- March of Dimes
- Marie Stopes International
- mothers2mothers
- ONE
- PATH
- Pathfinder International
- Planned Parenthood Federation of America
- Population Council
- Population Services International
- Reproductive Health Supplies Coalition
- Rotarian Action Group for Population and Sustainable Development
- Save the Children
- Sesame Workshop
- The Bangladesh Women Chamber of Commerce and Industry
- Together for Girls
- US Coalition for Child Survival
- WaterAid
- The White Ribbon Alliance for Safe Motherhood
- Women and Children First (UK)
- Women Deliver
- Women's Health and Education Center
- World Vision International
- World YWCA
- Youth Coalition for Sexual and Reproductive Rights

Private sector

- (RED)
- Bristol-Myers Squibb Foundation
- GE & GE Healthcare
- Hewlett Packard
- Johnson & Johnson
- LifeSpring Hospitals of India
- Nestlé S.A.
- Nigerian Private Sector
- Novartis Foundation for Sustainable Development
- Novo Nordisk A/S
- Pfizer
- Safaricom
- TMA Development, Training & Consulting (Egypt)
- Viyellatex Group

Health care professional associations

- Council of International Neonatal Nurses
- Edna Adan University Hospital
- International Confederation of Midwives
- International Council of Nurses
- International Federation of Gynecology and Obstetrics (FIGO)
- The Society of Obstetricians and Gynaecologists of Canada

Academic, research and training institutions

- Centre for Health and Population Studies, Pakistan
- icddr,b
- Institute for Global Health of Barcelona
- Institute for Tropical Medicine, Antwerp
- International Federation of Medical Students' Associations
- RANZCOG
- Royal College of Obstetricians and Gynaecologists
- Royal Medical Society, University of Edinburgh
- University of Aberdeen ■■■■

BURDEN OF DISEASE, PROGRESS ON MDG 4 AND 5A IN COUNTDOWN TO 2015 COUNTRIES AND NUMBER OF COMMITMENTS[#]

COUNTRY	UNDER-5 MORTALITY RATE (DEATHS PER 1,000 LIVE BIRTHS), 2010 ²³	UNDER-5 MORTALITY AVERAGE ANNUAL % CHANGE 1990-2010	ON OR OFF TRACK FOR MDG4 ⁶⁵	NUMBER OF U5 DEATHS (THOUSANDS), 2010	MATERNAL MORTALITY RATIO (DEATHS PER 100,000 LIVE BIRTHS), 2010 ²⁴	MATERNAL MORTALITY ANNUAL % CHANGE 1990-2010	ON OR OFF TRACK FOR MDG5A ⁶⁶	NUMBER OF MATERNAL DEATHS, 2010	# OF COMMITMENTS
AFGHANISTAN*	149	-1.7	off track	191	460	-5.1	off track	6,400	13
ANGOLA	161	-2.1	off track	121	450	-4.8	off track	3,600	5
AZERBAIJAN	46	-3.5	off track	9	43	-1.3	off track	79	1
BANGLADESH*	48	-5.5	on track	140	240	-5.8	on track	7,200	25
BENIN*	115	-2.2	off track	39	350	-3.9	off track	1,200	9
BOLIVIA (PLURINATIONAL STATE OF)	54	-4	on track	14	190	-4.2	off track	510	5
BOTSWANA	48	-1	off track	2	160	0.7	off track	75	5
BRAZIL	19	-5.7	on track	55	56	-3.7	off track	1,700	9
BURKINA FASO*	176	-0.8	off track	120	300	-4.1	off track	2,100	15
BURUNDI*	142	-1.3	off track	38	800	-1.6	off track	2,200	10
CAMBODIA*	51	-4.3	on track	16	250	-5.8	on track	790	16
CAMEROON	136	0	off track	93	690	0.1	off track	4,900	9
CENTRAL AFRICAN REPUBLIC*	159	-0.2	off track	23	890	-0.2	off track	1,400	6
CHAD*	173	-0.9	off track	80	1,100	0.9	off track	5,300	7
CHINA	18	-4.9	on track	315	37	-5.7	on track	6,000	10
COMOROS*	86	-1.9	off track	2	280	-2.2	off track	79	3
CONGO	93	-1.1	off-track	13	560	1.5	off track	800	2
CONGO, DEMOCRATIC REPUBLIC OF THE*	170	-0.3	off-track	465	540	-2.7	off track	15,000	19
CÔTE D'IVOIRE*	123	-1	off track	80	400	-2.8	off track	2,700	11
DJIBOUTI	91	-1.5	off track	2	200	-1.8	off track	51	5
EGYPT	22	-7.3	on track	41	66	-6.1	on track	1,200	8
EQUATORIAL GUINEA	121	-2.3	off track	3	240	-7.7	on track	61	0
ERITREA*	61	-4.2	on track	11	240	-6.3	on track	460	2
ETHIOPIA*	106	-2.8	off track	271	350	-4.9	off track	9,000	27
GABON	74	-1.1	off track	3	230	-0.8	off track	94	2
GAMBIA*	98	-2.6	off track	6	360	-3.3	off track	230	3
GHANA*	74	-2.5	off track	57	350	-2.5	off track	2,700	19
GUATEMALA	32	-4.5	on track	14	120	-1.4	off track	550	8
GUINEA*	130	-2.8	off track	48	610	-3.3	off track	2,400	6
GUINEA-BISSAU*	150	-1.7	off track	8	790	-1.6	off track	460	3
HAITI*	165	0.4	off track	45	350	-2.8	off track	940	16
INDIA	63	-3	off track	1696	200	-5.3	off track	56,000	31
INDONESIA	35	-4.4	on track	151	220	-4.9	off track	9,600	10
IRAQ	39	-0.8	on track	43	63	-1.7	off track	710	0
KENYA*	85	-0.8	off track	122	360	-0.5	off track	5,500	25
KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF*	33	-1.6	on track	12	81	-0.9	off track	280	2

COUNTRY	UNDER-5 MORTALITY RATE (DEATHS PER 1,000 LIVE BIRTHS), 2010 ²³	UNDER-5 MORTALITY AVERAGE ANNUAL % CHANGE 1990-2010	ON OR OFF TRACK FOR MDG4 ⁶⁵	NUMBER OF U5 DEATHS (THOUSANDS), 2010	MATERNAL MORTALITY RATIO (DEATHS PER 100,000 LIVE BIRTHS), 2010 ²⁴	MATERNAL MORTALITY ANNUAL % CHANGE 1990-2010	ON OR OFF TRACK FOR MDG5A ⁶⁶	NUMBER OF MATERNAL DEATHS, 2010	# OF COMMITMENTS
KYRGYZSTAN*	38	-3.2	on track	5	71	-0.1	off track	91	7
LAO PEOPLE'S DEMOCRATIC REPUBLIC*	54	-4.9	on track	8	470	-5.9	on track	670	10
LESOTHO	85	-0.2	off track	5	620	0.9	off track	370	11
LIBERIA*	103	-4	on track	15	770	-2.2	off track	1,200	12
MADAGASCAR*	62	-4.7	on track	44	240	-4.8	off track	1,800	11
MALAWI*	92	-4.4	on track	56	460	-4.3	off track	3,000	21
MALI*	178	-1.8	off track	120	540	-3.5	off track	3,800	16
MAURITANIA*	111	-0.6	off track	13	510	-2	off track	590	4
MEXICO	17	-5.3	on track	37	50	-3	off track	1,100	10
MOROCCO	36	-4.4	on track	23	100	-5.1	off track	650	3
MOZAMBIQUE*	135	-2.4	off track	114	490	-3	off track	4,300	22
MYANMAR*	66	-2.6	off track	56	200	-4.7	off track	1,600	10
NEPAL*	50	-5.2	on track	35	170	-7.3	on track	1,200	15
NIGER*	143	-3.9	off track	100	590	-3.5	off track	4,500	7
NIGERIA*	143	-2	off track	861	630	-2.7	off track	40,000	24
PAKISTAN*	87	-1.8	off track	423	260	-3.1	off track	12,000	20
PAPUA NEW GUINEA*	61	-1.9	off track	12	230	-2.6	off track	480	8
PERU	19	-7.1	on track	11	67	-5.2	off track	400	7
PHILIPPINES	29	-3.6	on track	66	99	-2.7	off track	2,300	11
RWANDA*	91	-2.9	off track	38	340	-4.8	off track	1,500	19
SAO TOME AND PRINCIPE*	80	-0.8	off track	0	70	-3.7	off track	4	2
SENEGAL*	75	-3.1	off track	34	370	-2.9	off track	1,700	12
SIERRA LEONE*	174	-2.3	off track	39	890	-1.9	off track	2,000	13
SOLOMON ISLANDS*	27	-2.6	on track	0	93	-2.4	off track	16	2
SOMALIA*	180	0	off track	70	1,000	0.6	off track	4,200	7
SOUTH AFRICA	57	-0.3	off track	58	300	0.9	off track	3,200	15
SOUTH SUDAN	not available	not available	not assessed	not available	not available	not available	not assessed	not available	14
SUDAN	103	-1	off track	143	730	-1.6	off track	10,000	11
SWAZILAND	78	-1	off track	3	320	0.3	off track	110	9
TAJIKISTAN*	63	-3.1	off track	12	65	-1.8	off track	130	6
TANZANIA, UNITED REPUBLIC OF*	76	-3.6	off track	133	460	-3.1	off track	8,500	25
TOGO*	103	-1.8	off track	19	300	-3.6	off track	580	5
TURKMENISTAN	56	-2.8	off track	6	67	-1	off track	73	2
UGANDA*	99	-2.8	off track	141	310	-3.2	off track	4,700	21
UZBEKISTAN*	52	-2	off track	31	28	-3.7	off track	160	3
VIET NAM*	23	-4	on track	34	59	-6.8	on track	860	14
YEMEN*	77	-2.5	off track	69	200	-5.3	off track	1,900	6
ZAMBIA*	111	-2.5	off track	60	440	-0.3	off track	2,600	18
ZIMBABWE*	80	0.1	off track	29	570	1.2	off track	2,200	14

* Countries with an asterisk are among the 49 Global Strategy priority countries.

Annex 3 is based on UN Inter-agency estimates of maternal and child mortality in 2010. Since the PMNCH 2012 Report went to press, new UN estimates for child mortality (2011 data) have been published: <http://www.childmortality.org/>

NUMBER OF COMMITMENTS FOCUSING ON SPECIFIC COUNTRIES

* Countries with an asterisk are among the 49 Global Strategy priority strategies.

COUNTRY	# OF RECEIVED COMMITMENTS	COUNTRY	# OF RECEIVED COMMITMENTS
INDIA	31	BENIN*	9
ETHIOPIA*	27	BRAZIL	9
BANGLADESH*	25	CAMEROON	9
KENYA*	25	SWAZILAND	9
TANZANIA, UNITED REPUBLIC OF*	25	EGYPT	8
NIGERIA*	24	GUATEMALA	8
MOZAMBIQUE*	22	PAPUA NEW GUINEA*	8
MALAWI*	21	CHAD*	7
UGANDA*	21	KYRGYZSTAN*	7
PAKISTAN*	20	NIGER*	7
CONGO, DEMOCRATIC REPUBLIC OF THE*	19	PERU	7
GHANA*	19	SOMALIA*	7
RWANDA*	19	CENTRAL AFRICAN REPUBLIC*	6
ZAMBIA*	18	GUINEA*	6
CAMBODIA*	16	TAJIKISTAN*	6
HAITI*	16	YEMEN*	6
MALI*	16	ANGOLA	5
BURKINA FASO*	15	BOLIVIA (PLURINATIONAL STATE OF)	5
NEPAL*	15	BOTSWANA	5
SOUTH AFRICA	15	DJIBOUTI	5
SOUTH SUDAN	14	TOGO*	5
VIET NAM*	14	MAURITANIA*	4
ZIMBABWE*	14	COMOROS*	3
AFGHANISTAN*	13	GAMBIA*	3
SIERRA LEONE*	13	GUINEA-BISSAU*	3
LIBERIA*	12	MOROCCO	3
SENEGAL*	12	UZBEKISTAN*	3
CÔTE D'IVOIRE*	11	CONGO	2
LESOTHO	11	ERITREA*	2
MADAGASCAR*	11	GABON	2
PHILIPPINES	11	KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF*	2
SUDAN	11	SAO TOME AND PRINCIPE*	2
BURUNDI*	10	SOLOMON ISLANDS*	2
CHINA	10	TURKMENISTAN	2
INDONESIA	10	AZERBAIJAN	1
LAO PEOPLE'S DEMOCRATIC REPUBLIC*	10	EQUATORIAL GUINEA	0
MEXICO	10	IRAQ	0
MYANMAR*	10		

ENDNOTES

1. The report covers commitments made from the launch of the Global Strategy in September 2010 until April 2012. Due to the time frame, it was not possible to include commitments made in conjunction with the launch of *Born Too Soon: The Global Action Report on Preterm Birth* in May 2012, at the Child Survival Call to Action in June 2012 and at the Summit on Family Planning in July 2012.
2. PMNCH. *Analysing Commitments to Advance the Global Strategy for Women's and Children's Health*. Geneva, 2011: http://www.who.int/pmnch/topics/part_publications/2011_pmnch_report/en/
3. Commission on Information and Accountability for Women's and Children's Health. *Keeping Promises, Measuring Results*. Geneva, World Health Organization, 2011.
4. IWG, PMNCH, Norad. Private Enterprise for Public Health. Opportunities for Business to Improve Women's and Children's Health. A Short Guide for Companies. Geneva, The Partnership for Maternal, Newborn & Child Health, 2012. See also <http://www.everywomaneverychild.org/resources/innovation-working-group>
5. <http://www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities/about>
6. March of Dimes, PMNCH, Save the Children, WHO. *Born Too Soon: The Global Action Report on Preterm Birth*. Eds CP Howson, MV Kinney, JE Lawn. Geneva, World Health Organization, 2012.
7. <http://www.everywomaneverychild.org/borntoosoon>
8. <http://5thbday.usaid.gov/pages/ResponseSub/roadmap.pdf>
9. <http://www.londonfamilyplanningsummit.co.uk/>
10. Commission on Information and Accountability for Women's and Children's Health. *Keeping Promises, Measuring Results*. Geneva, World Health Organization, 2011.
11. PMNCH. *Analysing Commitments to Advance the Global Strategy for Women's and Children's Health*. Geneva, 2011.
12. Country income categories are based on the World Bank classification: <http://data.worldbank.org/about/country-classifications/country-and-lending-groups>
13. All commitments to the Global Strategy are listed on the Every Woman Every Child website: <http://www.everywomaneverychild.org/>
14. Due to the time-frame for the report's analysis, it was not possible to include commitments made in conjunction with the launch of *Born Too Soon: The Global Action Report on Preterm Birth* in May 2012, at the Child Survival Call to Action in June 2012, and at the Family Planning Summit in July 2012.
15. <http://5thbday.usaid.gov/pages/ResponseSub/roadmap.pdf>
16. http://www.londonfamilyplanningsummit.co.uk/1530%20CommitmentSummary_Final_.pdf
17. March of Dimes, PMNCH, Save the Children, WHO. *Born Too Soon: The Global Action Report on Preterm Birth*. Eds CP Howson, MV Kinney, JE Lawn. Geneva, World Health Organization, 2012.
18. <http://www.everywomaneverychild.org/borntoosoon>
19. The 49 countries highlighted in the Global Strategy are: Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Côte d'Ivoire, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, Kenya, Democratic People's Republic of Korea, Kyrgyzstan, Lao People's Democratic Republic, 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, the United Republic of Tanzania, Togo, Uganda, Uzbekistan, Viet Nam, Yemen, Zambia and Zimbabwe.
20. Numbers add up to more than 100% because the same commitment can focus on more than one issue, and be specifically financial or not.
21. The list of the 75 countries can be found at: <http://www.countdown2015mnch.org/>
22. Hsu J, Pitt C, Greco G, Berman P, Mills A. Countdown to 2015: changes in official development assistance to maternal, newborn and child health in 2009-10 and assessment of progress since 2003. *Lancet*, September 2012.
23. UNICEF, WHO, World Bank, UN DESA/Population Division. *Levels and Trends in Child Mortality – Report 2011*. New York, 2011.
24. WHO, UNICEF, UNFPA, World Bank. *Trends in maternal mortality: 1990 to 2010*. Geneva, 2012.
25. The extent to which countries are on track to achieve MDG 5b on universal access to reproductive health is not included in this analysis, which focuses on MDGs related to mortality reduction.
26. Countdown to 2015 includes 75 countries. South Sudan could not be included due to absence of epidemiological data.
27. A country is considered on track for MDG 4 if the under-5 mortality rate for 2010 is less than 40 deaths per 1000 live births or is 40 or more with an average annual rate of reduction of 4% or higher for 1990–2010. A country is considered on track for MDG 5a if the average annual rate of reduction of the maternal mortality ratio for 1990–2010 is 5.5% or more. For further details, see UNICEF et al. 2011 and WHO et al. 2012.
28. Afghanistan, Burkina Faso, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India, Kenya, Lesotho, Mali, Mozambique, Nigeria, Pakistan, Rwanda, Senegal, Sierra Leone, South Africa, Sudan, the United Republic of Tanzania, Uganda, Zambia and Zimbabwe.
29. Azerbaijan, Congo, Gabon, Sao Tome and Principe and Turkmenistan.
30. Bangladesh, Cambodia, China, Egypt, Lao People's Democratic Republic, Nepal and Viet Nam. The eighth country on track for both MDGs is Eritrea, which received two commitments.
31. PMNCH, WHO, Aga Khan University. *A global review of key interventions related to reproductive, maternal, newborn and child health (RMNCH)*. Geneva, 2011.
32. Coverage data from: Countdown to 2015. *Building a future for women and children – the 2012 report*. Geneva, WHO and UNICEF, 2012.
33. The category “Others” includes academic, research and training institutions, and health care professional associations.
34. As these resources also target other high-burden countries that were not among the 49 countries included in the estimated gap of US\$ 88 billion, for example India and Indonesia, we estimated the proportion of the US\$ 88 billion gap being filled (see Annex 1).

The analysis indicates that US\$12.9-15.3 billion of the confirmed new funding would be allocated to the 49 countries. This means that a funding gap of more than US\$ 70 billion for the 49 countries remains. However, it should be kept in mind that this analysis is based on the specific commitments to the Global Strategy only.

35. The discrepancy between this report's disbursement figure and that in the iERG report is due to the release of further disbursement data.
36. It was not possible to differentiate between disbursement of existing resources and disbursement of new and additional resources.
37. Due to rounding, the disaggregated numbers in this paragraph add to up US\$ 10.3 billion.
38. Institute for Health Metrics and Evaluation. *Financing Global Health 2011: Continued Growth as MDG Deadline Approaches*. Seattle, 2011.
39. WHO. Health topics – Health Policy: http://www.who.int/topics/health_policy/en/
40. It should be noted that many commitments providing support to policies were not expressed in explicit financial terms. While it was beyond the scope of this report to monetize those commitments, the financial value would be significant.
41. Numbers add to more than 100% because respondents could indicate that their commitment included support for more than one policy area.
42. Hatt L, et al. *Economic Evaluation of Demand-Side Financing (DSF) for Maternal Health in Bangladesh [Draft]*. Bethesda. Abt Associates Inc. 2010.
43. Ahmed S and Khan M. Is demand-side financing equity enhancing? Lessons from a maternal health voucher scheme in Bangladesh. *Social Science & Medicine*, vol 72, Issue 10, 2011, pp1704-1710.
44. Global Fund to Fight AIDS, Tuberculosis and Malaria. *MNCH practical guidance tool. Strengthening support for maternal, newborn and child health within Global Fund proposals*. Geneva, GFATM, August 2011.
45. Other areas related to human resources, such as distribution and performance, are addressed in policy commitments.
46. Eds Howson CP, Kinney MV and Lawn JE. *Born Too Soon: The Global Action Report on Preterm Birth*. Geneva. March of Dimes, PMNCH, Save the Children, World Health Organization. 2012.
47. The “three delays” in using EmONC services are: (1) deciding to seek appropriate medical help for an obstetric emergency; (2) reaching an appropriate obstetric facility; and (3) receiving adequate care when a facility is reached.
48. Funding for the Uganda country case study was provided by World Vision Uganda Child Health Now Campaign.
49. Countries were asked about implementation of recommendations 1-8 of the COIA. The last two relate to tracking external financial resources through the OECD and the setting up of the iERG (see Box 9).
50. <http://everyone.org/independent-assessment-of-save-the-childrens-commitments/>
51. This fundamental right is recognized in the majority of the core set of international human rights treaties, including: the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Elimination of All Forms of Racial Discrimination (CERD); the Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD); and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).
52. <http://www.ohchr.org/en/hrbodies/upr/pages/uprmain.aspx>
53. Center for Reproductive Rights and Federation of Women Lawyers–Kenya. *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*. New York, 2007. Available for download at: <http://fidakenya.org/other-materials-at-the-resource-center/>
54. HRC. Resolution 18/2. *Preventable maternal mortality and morbidity and human rights*. 18th session of the Human Rights Council – resolutions, decisions and President's statements. Geneva, 2011 (A/HRC/RES18/L.8).
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56. The Partnership for Maternal, Newborn & Child Health and the Inter-Parliamentary Union. *Taking the lead: parliamentarians engage with maternal, newborn and child health*. Geneva, WHO and PMNCH, 2010.
57. Full text available at <http://ipu.org/conf-e/126/Res-3.htm>
58. CVA operates in communities in more than 20 countries, including: Armenia, Albania, Georgia, Pakistan, India, Indonesia, Philippines, Cambodia, Kenya, Malawi, Mozambique, Senegal, Sierra Leone, South Africa, the United Republic of Tanzania, Uganda, Zambia, Plurinational State of Bolivia, Brazil and Peru.
59. Hofbauer H, Garza M. *The missing link: Applied budget work as a tool to hold governments accountable for maternal mortality reduction commitments*. Washington, DC, International Budget Partnership (IBP) and International Initiative on Maternal Mortality and Human Rights (IIMMHR), 2009.
60. Data collection for the PMNCH 2011 Report was conducted through a semi-structured phone interview guided by a questionnaire. This approach had certain advantages: it provided rich qualitative information and allowed for probing of issues as the interview proceeded. However, the approach also had certain disadvantages: it was very labor-intensive and quantitative analysis was constrained by the qualitative nature of the interview questionnaire.
61. Institute for Health Metrics and Evaluation (IHME). *Financing global health 2010. Development assistance and country spending in economic uncertainty*. Seattle, University of Washington, 2010.
62. This estimate is based on an analysis using a mixed methodology of reviewing questionnaire responses, interviews and other information provided by the NGO, such as annual reports.
63. Although there are 75 Countdown countries, Sudan had to be analyzed as one entity due to the recent creation of South Sudan.
64. Hsu J, Pitt C, Greco G, Berman P, Mills A. Countdown to 2015: changes in official development assistance to maternal, newborn and child health in 2009-10 and assessment of progress since 2003. *Lancet*, September 2012.
65. A country is considered on track to achieve MDG 4 if the under-five mortality rate is less than 40 deaths per 1,000 live births in 2010 or the average annual rate of reduction of the under-five mortality rate was at least 4% over 1990-2010.
66. A country is considered on track to achieve MDG5a if the maternal mortality ratio (MMR) was at least 100 in 1990 and the average annual rate of reduction of the MMR was at least 5.5% over 1990-2010.

ACRONYMS

ACOG	American College of Obstetricians and Gynecologists	IHME	Institute for Health Metrics and Evaluation
AIDS	Acquired immune deficiency syndrome	IHP+	International Health Partnership
ALMA	African Leaders Malaria Alliance	IMNCH	Integrated maternal, newborn and child health
ANC	Antenatal care	IMPAC	Integrated management of pregnancy and childbirth
AP	Arogya Parivar	IPU	Inter-Parliamentary Union
APR	Annual programme reviews	IT	Information technology
ASEAN	Association of Southeast Asian Nations	JSSK	Janani-Shishu Suraksha Karyakram initiative
ASHAs	Accredited social health activists	KNCHR	Kenya National Commission on Human Rights
AU	African Union	LIC	Low-income country
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa	LOGIC	Leadership in Obstetric and Gynecology for Impact and Change
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women	M&E	Monitoring and evaluation
CERD	Convention on the Elimination of All Forms of Racial Discrimination	MCTS	Mother and child tracking system
CIDA	Canadian International Development Agency	MDG	Millennium Development Goal
COIA	Commission on Information and Accountability for Women's and Children's Health	MDG 1c	Millennium Development Goal 1c: Reduce hunger by half
CRC	Convention on the Rights of the Child	MDG 3	Millennium Development Goal 3: Promote gender equality and empower women
CRPD	Convention on the Rights of Persons with Disabilities	MDG 4	Millennium Development Goal 4: Reduce child mortality
CSO	Civil society organization	MDG 5	Millennium Development Goal 5: Improve maternal health
CVA	Citizen Voice and Action	MDG 5a	Millennium Development Goal 5a: Reduce maternal mortality by three quarters
DFID	UK Department for International Development	MDG 6	Millennium Development Goal 6: Combat HIV/AIDS, malaria and other diseases
DPT3	Diphtheria, pertussis, tetanus vaccine – 3 doses	MDG 8	Millennium Development Goal 8: Develop a global partnership for development
DSW	German Foundation for World Population	MIC	Middle-income country
EALA	East Africa Legislative Assembly	MMR	Maternal mortality ratio
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation	MNCH	Maternal, newborn and child health
EmOC	Emergency obstetric care	MNH	Maternal and newborn health
EmONC	Emergency obstetric and newborn care	MOH	Ministry of Health
EMTCT	Elimination of mother-to-child transmission of HIV	MP	Member of parliament
EVIPNET	Evidence-informed policy network	NCD	Non-communicable disease
EWEC	Every Woman Every Child	NGO	Non-governmental organization
FIGO	International Federation of Gynecology and Obstetrics	NHRI	National human rights institution
GAPPS	Global Alliance to Prevent Prematurity and Stillbirth	OECD	Organisation for Economic Co-operation and Development
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	OECD-DAC	OECD's Development Assistance Committee
Global Strategy	United Nations Secretary-General's Global Strategy for Women's and Children's Health	OHCHR	Office of the High Commissioner for Human Rights
GLOBVAC	Programme for Global Health and Vaccination Research	ORS	Oral rehydration solution
H4+	Health 4+ (UNFPA, UNICEF, WHO, World Bank, UNAIDS, UN Women)	PAP	Pan-African Parliament
HCPA	Health-care professionals associations	PMNCH	Partnership for Maternal, Newborn & Child Health
HIC	High-income country	PMTCT	Prevention of mother-to-child transmission of HIV
HIV	Human immunodeficiency virus	PNC	Postnatal care
HPNSDP	Health, population and nutrition sector development plan	PNDS	National health development plan (Burkina Faso)
HRC	Human Rights Council	PSRH	Pacific Society for Reproductive Health
HRH	Human resources for health	RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
HRP	UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction	RMNCH	Reproductive, maternal, newborn and child health
HSR	Health sector review	SWAp	Sector-wide approach
HSSIP	Health sector strategic and investment plan	UN	United Nations
IBP	International Budget Partnership	UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
ICM	International Confederation of Midwives	UNAIDS	Joint United Nations Programme on HIV/AIDS
ICPD	International Conference on Population and Development	UNFPA	United Nations Population Fund
ICESCR	International covenant on economic, social and cultural rights	UNICEF	United Nations Children's Fund
ICT	Information and communication technologies	USAID	United States Agency for International Development
iERG	Independent Expert Review Group	UWOPA	Uganda Women's Parliamentary Association
IFMSA	International Federation of Medical Students' Associations	WBF	Wellbeing Foundation
		WHO	World Health Organization
		WRA	White Ribbon Alliance for Safe Motherhood

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