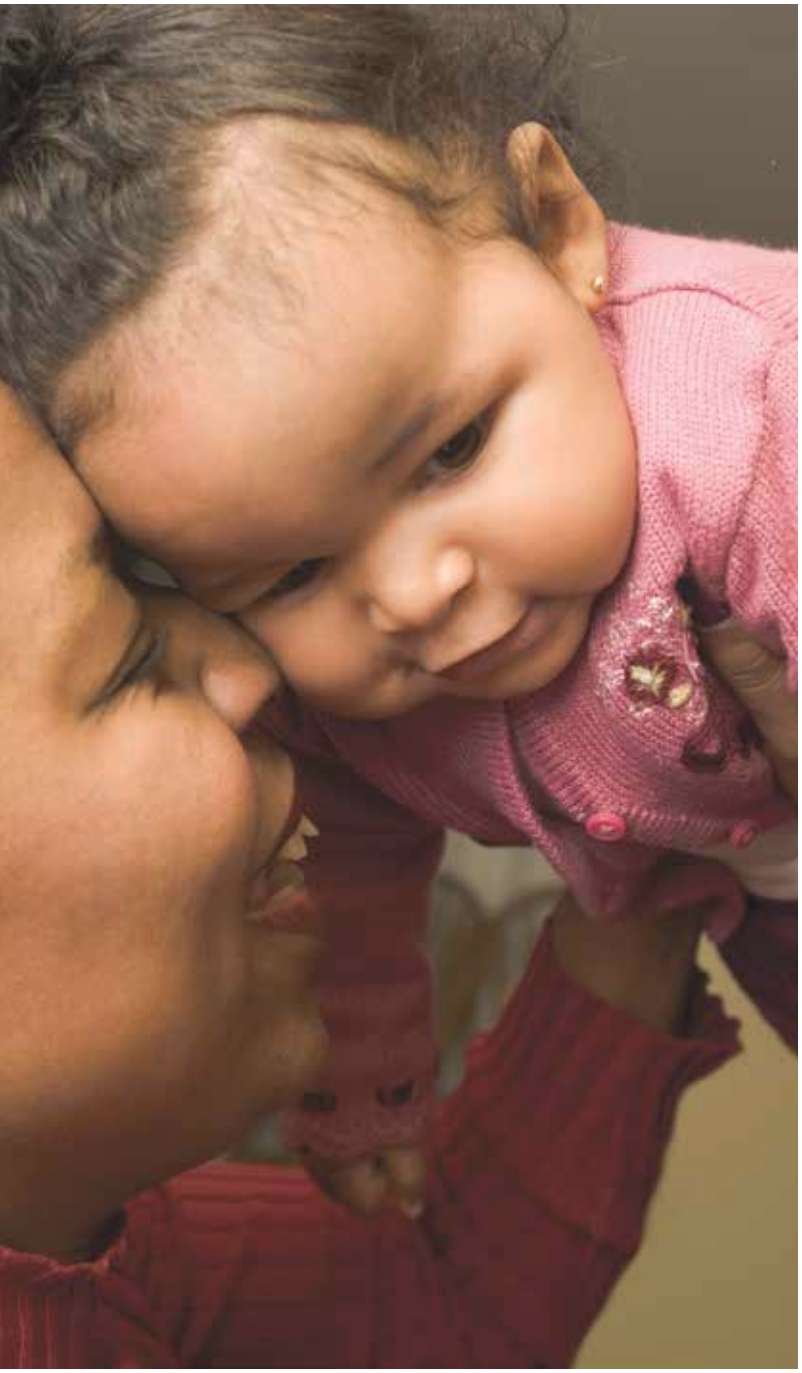
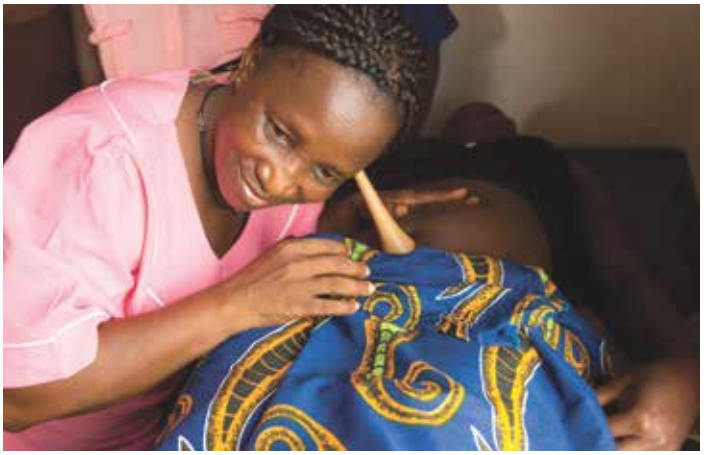
2013





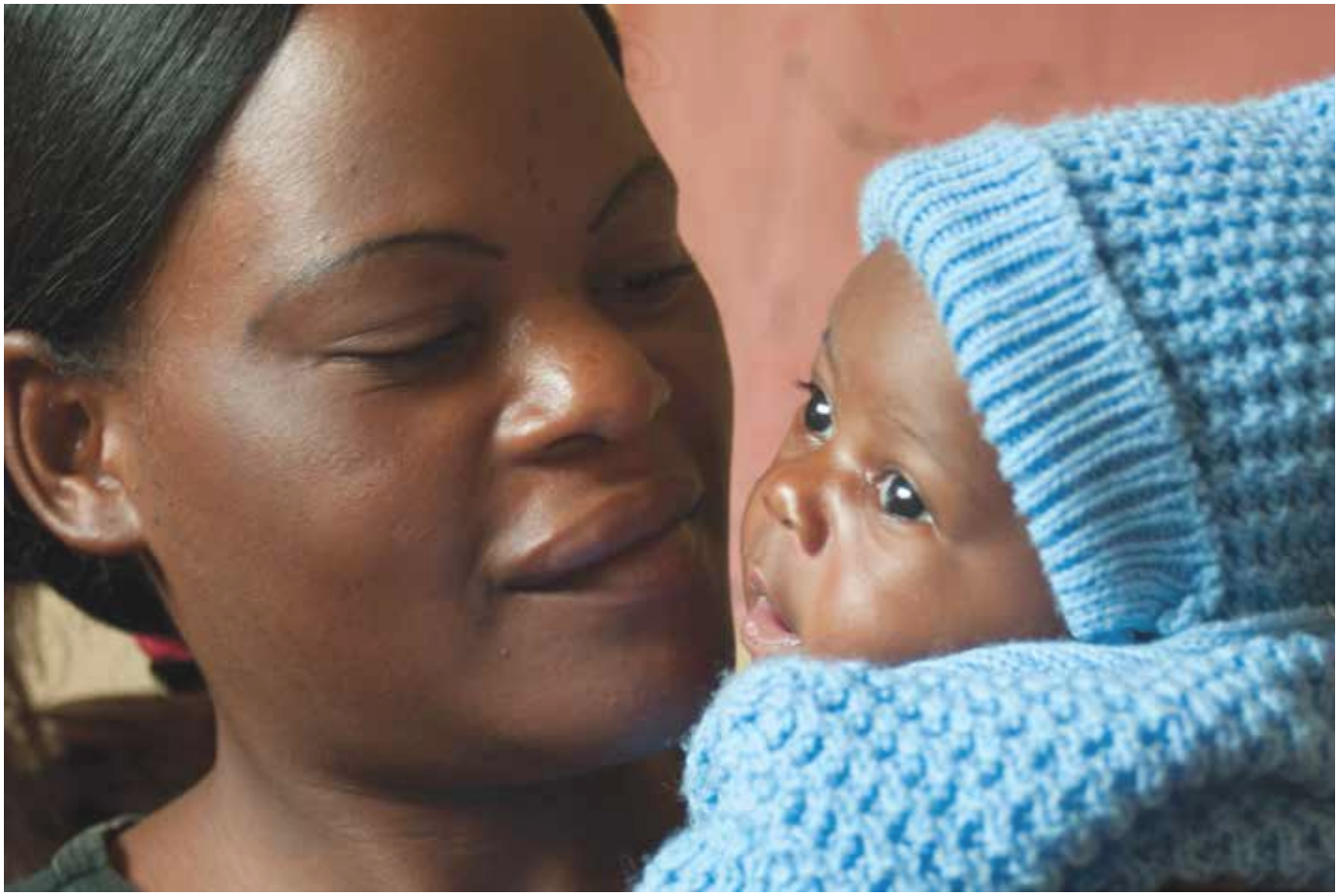
The PMNCH 2013 Report

Analysing Progress on Commitments to the Global Strategy for Women's and Children's Health

World Health Organization

The Partnership for Maternal, Newborn & Child Health

Executive Summary



The Global Strategy for Women's and Children's Health (Global Strategy), launched by the United Nations (UN) Secretary-General Ban Ki-moon in September 2010, aims to save 16 million lives in 49 countries by 2015 through enhanced financing, strengthened policy and improved service delivery. These 49 countries were the poorest countries according to the World Bank's list of economies as of April 2008. The Every Woman Every Child movement was established at the same time to mobilize and intensify the international and national action needed to advance the Global Strategy. The direct costs and the health systems costs for programmes and services targeting women and children in the 49 countries were estimated to be US$ 88 billion for 2011-2015 (excluding costs for scaling up to meet other health MDGs*).

This report is the third annual report produced by the Partnership for Maternal, Newborn & Child Health (PMNCH) analysing the commitments made by countries and development partners to the Global Strategy and Every Woman Every Child. The PMNCH 2012 report contributed to the independent Expert Review Group (iERG)'s first annual report to the UN Secretary-General. The iERG requested PMNCH to produce a 2013 report on the progress of the implementation of commitments to the Global Strategy.

* The US$ 88 billion is in addition to the estimated US$ 81 billion of other costs for scaling up to meet the health MDGs. These include the remaining half of health-systems costs, plus costs for diagnosis, information, referral and palliative care for any presenting conditions; remaining treatment costs for major infectious diseases, such as tuberculosis, HIV/AIDS and malaria; and costs associated with nutrition and health promotion.

The main objective of this year's report is to assess the extent to which the 293 stakeholders who have made commitments to the Global Strategy since its launch in 2010 (up to June 2013) have implemented their commitments, and the extent to which implementation is contributing to reaching the goals of the Global Strategy. It is not a comprehensive stocktaking of all that is being done at national, regional and global levels to improve women's and children's health.

The content of the report is based on a range of information sources and data collection methods as relevant to the nature of the individual commitments and their implementation. The methods used were: a content analysis of all commitment statements from the Every Woman Every Child website; an online survey sent to commitment-makers, of which 120 fully completed the survey; detailed interviews based on semi-structured questionnaires with a selection of stakeholders; and an extensive desk review of relevant literature and databases.

Financial and non-financial commitments: key findings

1. Commitments to advance the Global Strategy continue to increase: the total number of commitment-makers rose from 111 in September 2010 to 293 in June 2013. Particular initiatives and events were important drivers of new commitments in 2012.

2. Stakeholders generally focus their commitments on countries with high numbers of maternal and child deaths. Some countries with very high child and maternal mortality rates but lower numbers of deaths receive substantially less attention. This has not significantly changed since the first PMNCH report in 2011.

3. The global, regional and national communities are working towards implementing the interventions and health systems improvements required to meet the women's and children's health related goals of the Global Strategy, estimated to cost US$ 88 billion. Some of these efforts can be expressed in explicitly financial terms (e.g. grants to support implementation of national health plans), while other work cannot be readily monetized (e.g. training of health workers, or transfer of technology).

4. Of the US$ 40.4–44.7 billion in total commitments made to the Global Strategy (that can be expressed in explicitly financial terms), at least US$ 17.7–22.0 billion can be considered as confirmed new and additional funding. Of this amount, an estimated US$ 12.4–16.5 billion is targeted at the 49 Global Strategy countries.

5. There is growing evidence that committed funding is being disbursed. An estimated US$ 25.0 billion was disbursed between the launch of the Global Strategy in September 2010 and June 2013, more than double the US$ 11.6 billion disbursements reported as of September 2012.

6. Official Development Assistance (ODA) to the 49 Global Strategy countries and the 75 Countdown countries peaked in 2010, decreasing slightly in 2011 as a result of the financial crisis that affected donor flows to reproductive, maternal, newborn and child health (RMNCH). However, it should be noted that already in 2009, RMNCH disbursements grew much less than in all previous years since 2006.

7. The launch of the Global Strategy did not alter the geographical targeting of RMNCH ODA. The top 10 recipient countries were the same in 2011 as in 2008. They included India and nine countries in sub-Saharan Africa. Eight of the 10 countries that received the least RMNCH ODA in 2008 were also among the bottom 10 recipients in 2011.

8. For the past two years, family planning has received the largest number of commitments, and commitments have increased since the 2012 PMNCH report, mainly driven by the London Summit on Family Planning (FP2020) in July 2012.

9. Interventions critical to improving women's and children's health that are receiving less attention include postnatal care for mothers and newborns, antibiotics for pneumonia, and adequate sanitation facilities.

10. While implementing countries are focusing on policies for RMNCH financing, other stakeholders have a strong focus on service delivery policies. Information and accountability policies are the least prioritized areas.

Progress towards implementing commitments to the Global Strategy

Progress towards implementing commitments has accelerated substantially. Tables 1 and 2 below provide a snapshot of progress, based on the information included in this report. However, caution is needed when interpreting these data, for several reasons. First, the Global Strategy inputs are not only financial: for example, health systems strengthening, an essential element of the Global Strategy, has been ongoing and is not fully monetized. Second, some information reported is for all low- and middle-income countries, not only the Global Strategy's 49 focus countries. The US$ 88 billion financial gap, calculated at the launch of the Global Strategy in 2010, emerged from a costing exercise based on 49 countries, using figures from 2008. It would be inappropriate to relate that figure only to disbursed funds to date.

Progress aside, only about half the survey respondents answering this question (57 of 113) anticipate fully implementing their commitments by 2015. Of the other half, some expected that their commitments would not be implemented by 2015 (29 respondents) and others lacked sufficient evidence to predict when implementation would be completed (27 respondents).

A majority of survey respondents (71%) reported having a transparent mechanism to monitor progress on implementing their Global Strategy commitments. More than two thirds (69%) make their progress reports on implementation publicly available. However, only nine survey respondents (20%) said they conduct or plan to conduct voluntary independent audits of their commitments.

Table 1: Financial commitments and disbursements, US$ billion

Countries	Financial commitments made since 2010	New/additional funds committed (as of June 2013)	Funds disbursed (as of June 2013)	Disbursed new/ additional funds (projected to 2015)
All low- and middle-income countries	40.4 – 44.7 (excluding double counting)	17.7 – 22.0	25.0 (11.6 as of September 2012)	Z
Global Strategy focus countries (49)	X	12.4 – 16.5	Y	14.5

Insufficient information to estimate X, Y, Z.

Table 2: Services and systems commitments that have not been monetized

	Projected to 2015	Estimated by 2013	Relevant Global Strategy goal progress by 2015	Global Strategy goal
New users' access to family planning	17 100 000	N/A	40%	43 000 000
More health workers	1 746 000*	873 000	50% to 70%	2 500 000 – 3 500 000
More quality health facilities	8900*	4450	10%	85 000

* Estimated on the basis of doubling estimates for 2013, which is approximately halfway along the Global Strategy's timeline (September 2010 to December 2015).

Key findings from the four thematic analyses

This year's report includes four thematic analyses. The key findings are as follows.

Family planning

- An estimated 40% (117 out of 293) of commitments to the Global Strategy include family planning. The London Summit on Family Planning (11 July 2012) was a major driver of recent increases, generating 68 commitments.
- Low- and middle-income countries have made 46% of the family planning-specific commitments, followed by NGOs (27%). The private sector has made only 1% of the commitments in this area, but these are of high monetary value.
- Commitments focus on: improving access to and delivery of family planning services and commodities; addressing demand-side barriers; integrating family planning with other health-care services; and mobilizing political and community support.
- Several commitments use terms such as "rights" and "gender", reflecting the recognition that programmes need to be rights based.
- Many stakeholders have made significant progress in implementing their commitments and some data are beginning to emerge concerning the Global Strategy's goals of preventing 33 million unintended pregnancies and reaching 43 million new users in 49 countries in 2015. Progress is being bolstered by FP2020's target to provide an additional 120 million women and girls with access to voluntary family planning services, contraception and information in 69 countries.
- To accelerate progress, political commitment at the highest level is needed to promote voluntary family planning. Countries need to continue to strengthen the training of front-line health workers in the provision of family planning services. Countries and development partners should build on and augment their financial commitments. A wide range of demand-side interventions are needed to address deep-rooted social, cultural and behavioural factors that inhibit women and girls from accessing family planning information and services.

Adolescent health

- Slightly over a quarter of total commitments to the Global Strategy (77 out of 293, or 26%) relate to adolescent health. NGOs account for 32% of the 77 adolescent health commitments, while low- and middle-income countries account for 37%; all other constituency groups, including multilateral organizations, foundations and the private sector, account for less than 10% each.
- Commitments relate to: adolescent sexual and reproductive health policies and services; reducing early, child and forced marriage; improving access to educational services; reducing violence against girls; and increasing youth empowerment.
- Commitments are broadly in line with the main gaps and priorities, but pledges to disaggregate data by age are lacking. Reducing coerced sex and unsafe abortion among adolescents receives little attention. Also there are no commitments to increase access to skilled antenatal, childbirth and postnatal care specifically for adolescent girls.
- Approximately 40% of survey respondents indicated that the implementation of their commitments to adolescent health would be completed by 2015.
- The analysis in this chapter suggests that stronger leadership and coordinated approaches; empowering and engaging with young people; and improving data, information and evidence would all help to accelerate progress in adolescent health.

Newborn health

- Approximately 25% of all commitments to the Global Strategy focus on newborn health.
- Despite increased interest in newborn health following the launches of Committing to Child Survival: A Promise Renewed and Born Too Soon in 2012 (the latter being accompanied by 30 new and expanded commitments), evidence suggests

that this has not yet been translated into proportionate increases in financial resources.

- Commitments to newborn health focus on: preterm births, preventing stillbirths, human resources for health, coverage of newborn services, postnatal care, and the registration and classification of newborn deaths. Two priority areas that are not well covered are preventing and treating neonatal infections, and tracking newborn health expenditure.
- Although the implementation of many commitments is under way, stakeholders' views on whether commitments will be fulfilled by 2015 are mixed.
- Achieving the Global Strategy goals to prevent more than 3 million newborn deaths between 2011 and 2015 and to treat an additional 2.2 million neonatal infections in 2015 will require greater efforts in 2014 and 2015 to improve both the coverage and quality of newborn care interventions. The development of the Global Newborn Action Plan, embedded in the continuum of care, should see new commitments and action in the remainder of 2013 and through 2014. The role of the midwife in delivering newborn care, not just at the time of birth, but in the days following, needs to be strengthened.
- More and better use of domestic and external resources and increased awareness of the most effective interventions for improving newborn health are also needed to accelerate progress.

Advocacy

- The majority of survey respondents (80%, or 96 out of 120) indicated that their commitment contributes to advocacy for the goals of the Global Strategy. However, only 135 of all 293 stakeholders (46%) have made commitments that specifically include advocacy activities. This discrepancy suggests that many commitment-makers believe that the act of commitment, whatever its content, itself contributes to advancing the Global Strategy's goals.
- Advocacy commitments are well aligned with the Global Strategy's priorities. Advocacy for policy development and political support features more often than advocacy for accountability (71% and 56%, respectively, of survey respondents with advocacy commitments).
- All categories of advocacy are generally well represented: more than 80% of respondents indicated commitments to more than one area of advocacy, suggesting that advocacy commitment-makers tend to see advocacy goals as cross-cutting.
- Although stakeholders' responses point to progress being made, only 45% (30 out of 66) expect that their advocacy commitments will finish being implemented by 2015.
- Almost 30% of survey respondents with advocacy commitments (19) had no or limited evidence to demonstrate that their commitments are contributing to the specific goals of the Global Strategy, suggesting a need for greater investment in and attention to monitoring and evaluation of advocacy.
- The main constraints to implementation are insufficient financial and human resources.

Lessons learnt from producing three annual reports on commitments

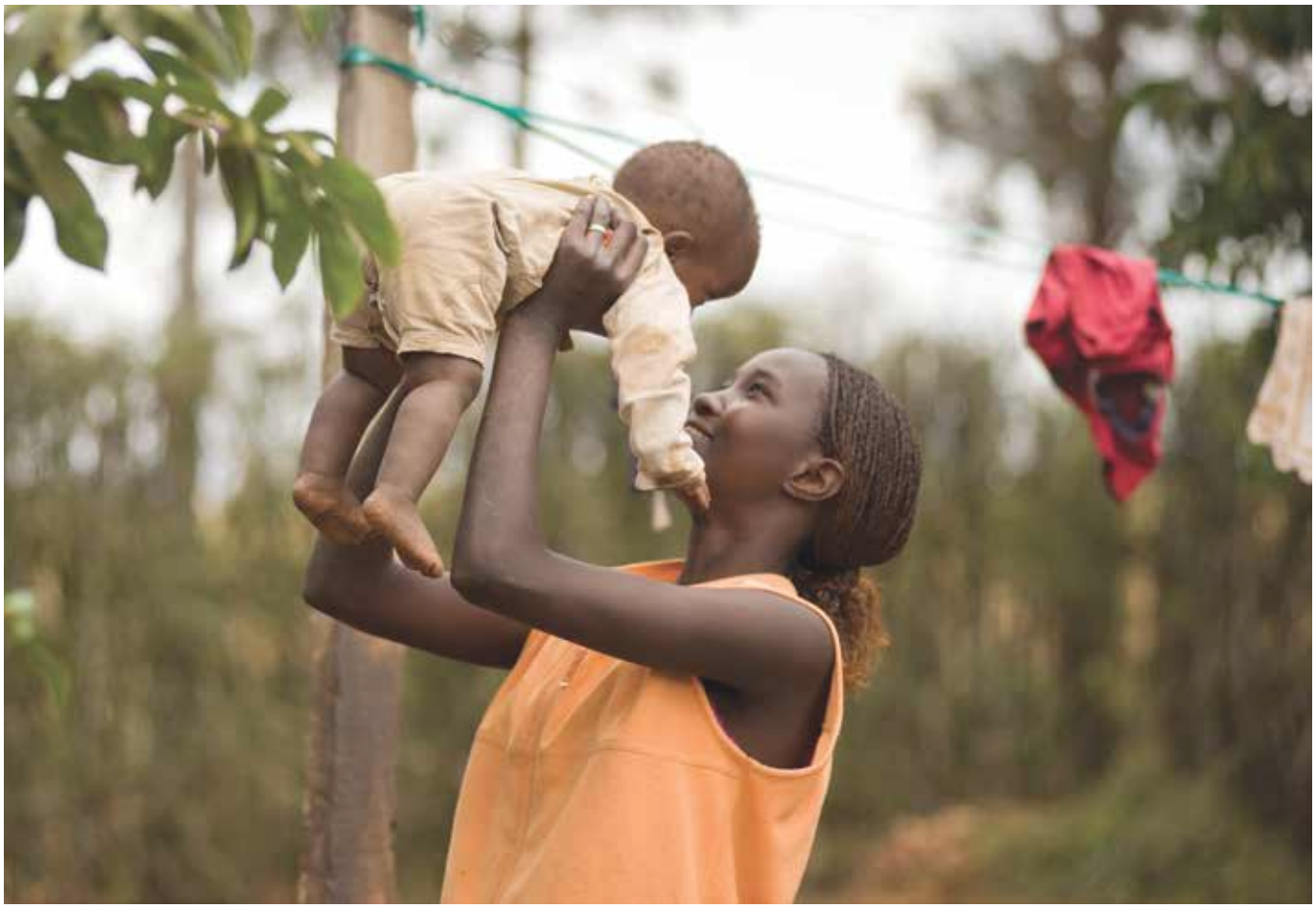
In 2010, the Global Strategy catalysed global interest in, and commitments to, women's and children's health. PMNCH published its first report in 2011 documenting the nature of these commitments. In 2011, following the recommendations of the CoIA, the iERG was established to promote accountability for progress towards women's and children's health. PMNCH was asked by the iERG to continue reporting on progress towards implementing stakeholder commitments to the Global Strategy, as part of a wider global process to increase and support mutual multi-stakeholder accountability for commitments to women's and children's health. The 2012 report documented new commitments made after the launch of the Global Strategy in 2010, began to review progress towards their implementation, and looked in more detail at commitments in three countries. This 2013 report focuses on reviewing progress in implementing commitments, within the context of a growing number of commitments and initiatives and in

four thematic areas: family planning, adolescent health, newborn health and advocacy. It also assesses whether and how the implementation of these commitments has contributed to achieving the Global Strategy's goals.

In terms of the report's objectives, reliance on self-reported survey responses has several limitations. For example, it is difficult to learn lessons from what has not worked, because respondents prefer to share positive progress. The 120 responses to the survey included few examples of implementation that had not gone according to plan, or of unexpected results. Those without "good news" to share or progress to report might be less inclined to respond to the survey. Those who do respond are likely to be more accountable and transparent. On the other hand, some accountable and transparent commitment-makers might choose not to devote time to completing a long questionnaire if most of the information requested is already in the public domain. In summary, these shortcomings might limit the meaningful conclusions that can be drawn from the survey responses sections of the report. A more focused approach to commitments might be required for future work on accountability to the Global Strategy. Despite these limitations, some conclusions can reasonably be drawn about progress on implementation.

Recommendations

This report makes recommendations in three areas. First, building on the successes of the Global Strategy to date, recommendations are made to accelerate progress towards bridging the financial and non-financial gaps that remain, based on the survey responses, interviews and analysis of commitment text on the Every Woman Every Child website. Second, more specific recommendations are made related to the different thematic chapters of the report. Finally, a set of recommendations focuses on the methods and approaches used to report on the commitments to the Global Strategy and to track progress on disbursements and implementation.



I. Accelerating progress towards bridging remaining gaps

Improve targeting and implementation of commitments

- Take advantage of the mobilizing power of the Global Strategy to maintain high-level political support, involve additional stakeholders through multi-stakeholder action and accelerate implementation of commitments.
- Address inequities in the geographical distribution of Global Strategy commitments by providing additional support to countries currently receiving little attention that have not made progress in improving access to reproductive health services or that have high maternal and child mortality rates.
- Focus commitments more strongly on priority interventions that are receiving less attention and on the integration of nutrition, food safety, education, safe water, sanitation and hygiene with health.

Continue to secure resources to bridge the financing gap and further accelerate disbursements

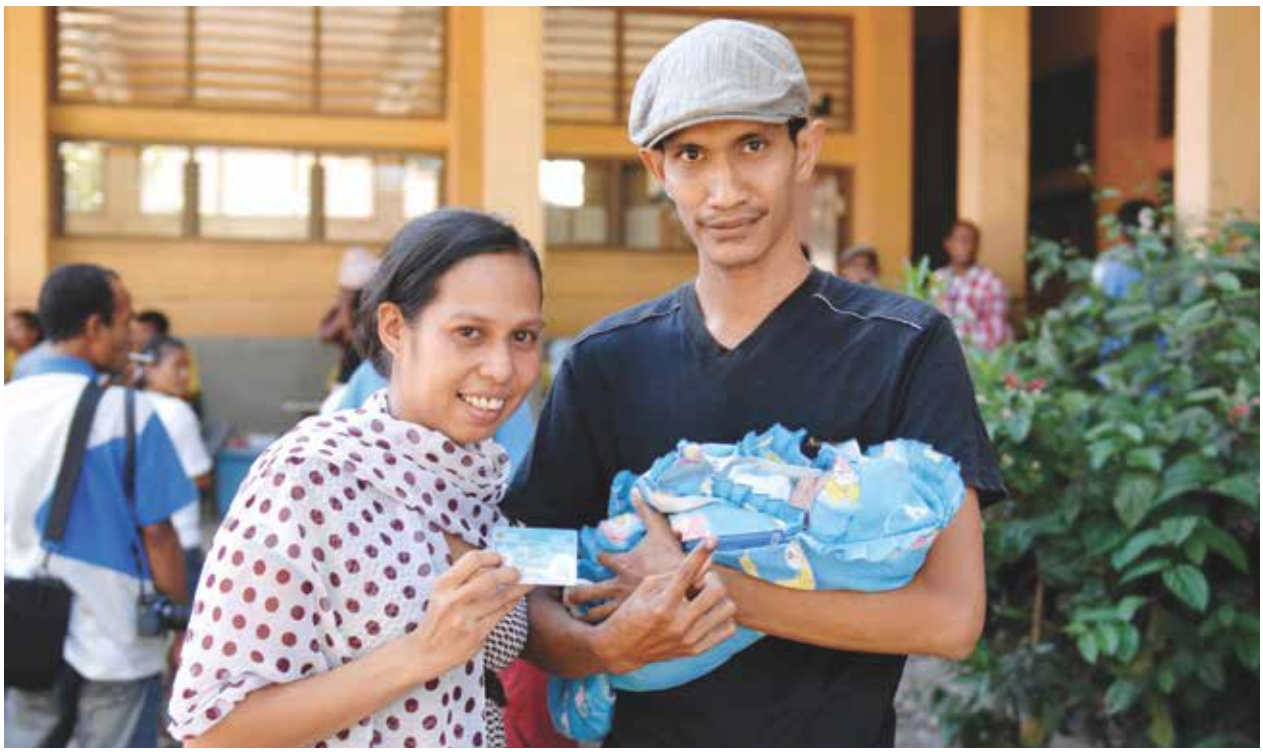
- Raise additional funding, including from domestic sources, and allocate existing and additional resources (both those that can and cannot be readily monetized) to close the remaining geographical and intervention gaps towards achieving the Global Strategy's goals.
- Improve value for money, not only by prioritizing cost-effective essential interventions, but also by taking action to reduce inefficiencies in resource allocation and use.
- Build on the acceleration of disbursements of financial commitment in 2012 by increasing clarity at source about how these funds can be accessed, and improve the ability of countries to receive and administer funds.

Mitigate constraints

- Continue to take action to address the critical human resources challenges and other health systems weaknesses, such as poor infrastructure and shortage of commodities.
- Consider gender and sociocultural issues when designing policies and programmes and allocating resources.

Improve accountability

- Integrate, as much as possible, all accountability efforts that aim to support the implementation of the Global Strategy, including any future work on tracking commitments, performance monitoring and accountability functions of individual initiatives (e.g. FP2020, A Promise Renewed, etc.) and all activities under the CoIA framework, including the Country Accountability Frameworks.
- Promote the accountability recommendations as specifically noted in the PMNCH 2012 report.



II. Recommendation related to the four thematic analyses

Family planning

- Acknowledge and support the efforts of FP2020 to drive accountability in alignment with the existing Every Woman Every Child mechanisms (see recommendation above on integration of accountability mechanisms), especially with regard to continued vigilance to realizing the rights of girls and women to voluntary family planning and to holding all commitment-makers accountable for implementing those commitments.
- Work with countries and development partners who have not yet made commitments to family planning to do so.
- Continue to promote and monitor family planning as a component of comprehensive sexual and reproductive health and rights, including access to safe abortion where it is legal, and as part of integrated services (including prevention and treatment of HIV) for girls and women, according to their needs.

Adolescent health

- Consolidate and further strengthen the observed progress in improving adolescent health by promoting stronger leadership, policy debate and harmonized approaches.
- Encourage countries to publish periodic national reports on adolescent health and offer technical and financial support to countries in need, including on improvements in civil registration and vital statistics.
- Involve young people in RMNCH initiatives.

Newborn health

- Promote greater resource allocation across global, regional and national levels to newborn care.
- Focus attention on improving both the coverage and quality of newborn care interventions, including preventing and treating neonatal infections.

Advocacy

- Increase the capacity of civil society organizations, particularly those working at the national and local level, to carry out advocacy work and ensure that progress on accountability and health outcomes is sustained and accelerated.
- Invest in further research into the impact of advocacy on RMNCH outcomes.

III. Future methods and approaches to track commitments

Engage with potential new commitment-makers and focus on implementation of commitments

- Engage more with the private-sector and explore opportunities to attract new commitment-makers both within the health sector (e.g. human resources) and in other sectors (e.g. nutrition and education).
- Focus future accountability-related work on monitoring implementation of commitments, including tracking progress on disbursements of financial commitments and documenting any relevant policy changes.
- As attempted in this report, monitor the way that implementation of commitments contributes towards the Global Strategy's goals, which were agreed in 2010.

Address difficulties in monetizing many Global Strategy commitments

- In monitoring progress towards meeting the estimated cost of US$ 88 billion that is required for delivering the Global Strategy goals related to women's and children's health (but not for all health MDGs), recognize that all commitments cannot be monetized, and find ways to express their value without undertaking extensive costing exercises.

As focus shifts to monitoring implementation, consider other approaches to reporting

- Define the audience and outcomes expected from any future reporting on commitments to the Global Strategy, and what is needed to drive implementation and accountability.
- Identify synergies across accountability reporting processes (CoIA, Countdown, FP2020, H4+, RMNCH Trust Fund, Decade of Vaccines, etc.) and strive towards greater integration and coordination of reporting, building on iERG's role to synthesize and analyse all reports provided.
- Recognize that any reporting option and format will require significant effort and resources, both from those providing information (often the same information stemming from different requests) and those collecting it. Declining response rates on self-reported surveys are a considerable accountability challenge and an important steer that new approaches are required to encourage commitment-makers to participate in efforts to monitor progress.
- Consult with partners on innovative, more effective and more cost efficient ways to track progress on the implementation of commitments to the Global Strategy. Some examples might include approaches based on: more targeted national or regional score cards on progress towards implementing specific commitments; a series of concise country-focused reports, constituency led and owned accountability efforts; and synthesizing data from initiative-specific accountability reports and annual reports from commitment-makers.

Summary

This report has shown that Every Woman Every Child, the global movement to take forward the Global Strategy, has successfully brought people together around common goals, mobilizing commitments and intensifying global action to improve the health of women and children around the world. The implementation of commitments and pace of disbursements has accelerated in the past year, and more action is reported this year than last.

The challenge for the next two years is to put into operation the commitments already made. This will require considerable additional investment in RMNCH financing, policy and services, as well as in technical support and human resource capacities, particularly at national and subnational levels. All stakeholders – countries and development partners – have a role to play in addressing the gaps in and challenges for implementation, and all have a responsibility to be accountable for their promises.

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The Partnership for Maternal, Newborn & Child Health would like to express its gratitude to all those who have taken part in the survey and interviews and provided information more generally during the report's development process.

Advisory Group

The Advisory Group of PMNCH Partners played an important role in the development of the report. Its objectives were: first, to comment and advise on the proposed methods for data collection and analysis to ensure they were technically sound and rigorous; second, to review any initial and emerging findings and drafts of the report, with a particular focus on pre-agreed areas of expertise; and third, to advise on how the relevance and impact of the report's analysis and findings can be maximized to improve the delivery and impact of commitments to the Global Strategy.

The members of the Advisory Group were: Geoff Black (Chair), Foreign Affairs, Trade and Development Canada; Rebecca Affolder, Executive Office of the UN Secretary-General; Ann Starrs and Martha Murdock, Family Care International; Peter Berman, Harvard School of Public Health; Julia Bunting, International Planned Parenthood Federation; Joy Lawn, London School of Hygiene & Tropical Medicine; Lene Lothe, Norwegian Agency for Development Cooperation; Julian Schweitzer, Results for Development; Louise Holly, Save the Children; Richard Horton, *The Lancet*; Nel Druce, UK Department for International Development; Jane Ferguson and Tessa Tan-Torres, World Health Organization; Stefan Germann, World Vision International.

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