Executive Summary

The Partnership for Maternal, Newborn & Child Health

2015 Accountability Report

Strengthening Accountability:

Achievements and Perspectives for Women's, Children's and Adolescents' Health

The Partnership for Maternal, Newborn & Child Health

Executive Summary

This is the fifth Partnership for Maternal, Newborn & Child Health (PMNCH; the Partnership) annual accountability report. It presents the final update on financial commitments to the Global Strategy for Women's and Children's Health (2010-2015)[1] and looks ahead to the implementation of its successor, the updated Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).[2] Lessons learned from tracking and analysing commitments to the 2010 Global Strategy are discussed in the light of how they can help strengthen accountability for the updated Global Strategy in key areas such as:

- Integrating human rights into all aspects of women's, children's and adolescents' health;
- Engaging with civil society organizations (CSOs), parliamentarians and other stakeholders to align accountability and advocacy;
- Building capacity to conduct budget analysis and citizens' hearings.

The report includes a short overview of the accountability work of the Countdown to 2015 for Maternal, Newborn & Child Survival (Countdown).

Core findings from tracking financial commitments to the 2010 Global Strategy

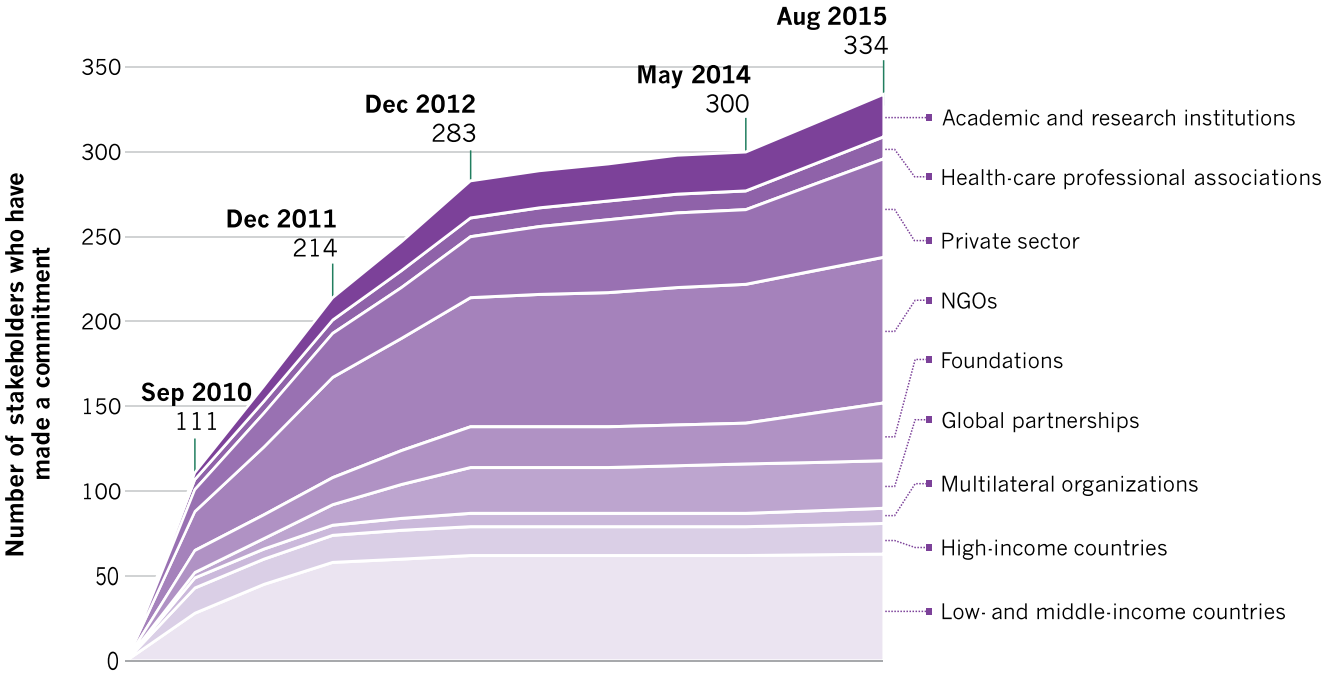
The analysis of financial commitments shows a number of encouraging trends in the implementation of Global Strategy commitments and financing for reproductive, maternal, newborn and child health (RMNCH).[3] It also highlights areas that require additional focus.

1. Unprecedented support for the health of women and children.

By August 2015, 334 stakeholders had made 428 commitments to the Global Strategy (some made multiple pledges).[4]

Figure i

Global Strategy commitment-makers tripled to 334 in 2015



Source: Every Woman Every Child website.

2. Significant new financial commitments.

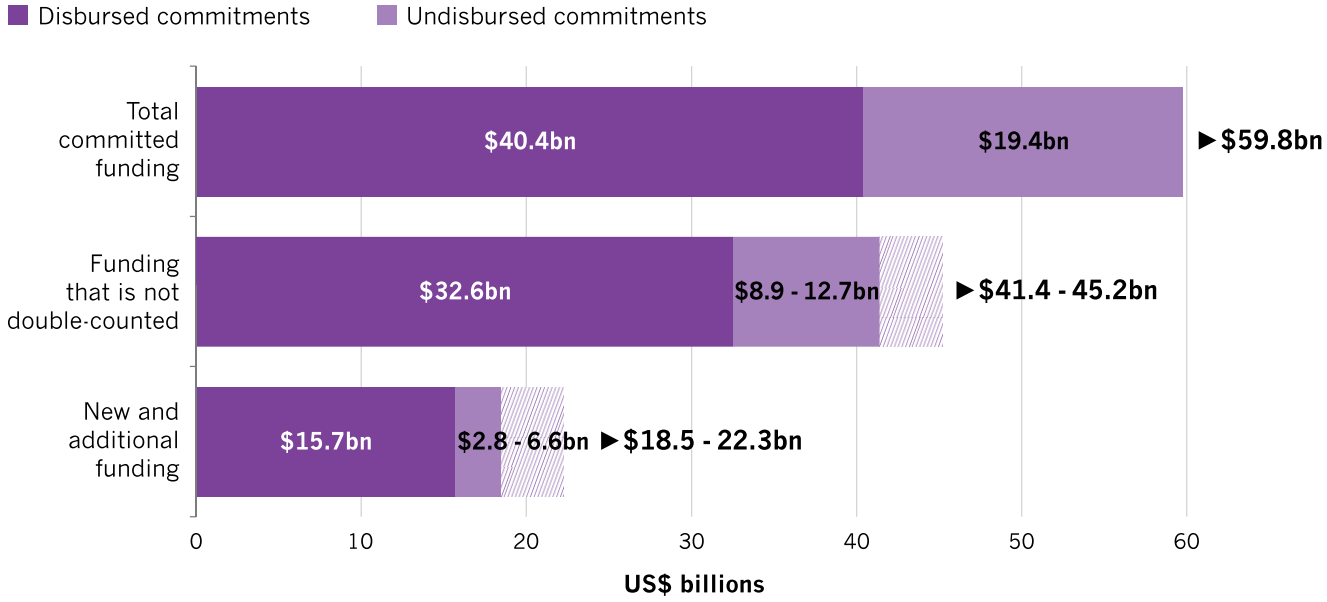
118 commitment-makers made financial commitments totalling almost US$60 billion (US$45 billion once double-counted funds have been removed[5]). US$22 billion of these financial commitments were new and additional funding. The totals would be substantially higher if non-financial commitments were monetized.

3. Commitment-makers have disbursed at least three-quarters of their committed funding.

More than US$40 billion (US$33 billion once double-counted funds have been removed) of the US$60 billion committed has now been disbursed – up from US$34 billion in 2014 – indicating a disbursement rate of 74% since 2010 (Figure ii). The true rate is probably higher given delays in reporting.

Figure ii

Committed funding is being disbursed



Note: Actual disbursements are likely to exceed those shown: commitment-makers either provided data through Dec. 2013, Dec. 2014 or mid-2015. Striped segment visualize range of commitments. "Double-counting" relates to funding committed twice by different stakeholders. New and additional funding relates to investments that stakeholders committed in addition to their RMNCH spending levels prior to the Global Strategy.

Source: SEEK Development analysis

4. Overall donor funding has increased, but geographical inequities remain.

Commitments to the Global Strategy have contributed significantly to the trend of increased official development assistance for RMNCH.[6] Donors disbursed US$9.5 billion for RMNCH in the 49 Global Strategy countries in 2013; an increase of 31% since 2010.[7] However, several high-burden countries received comparatively little donor funding, so inequities in the targeting of donor disbursements remain.

5. Domestic RMNCH spending has grown significantly since 2010, but funding levels remain insufficient.

Overall RMNCH expenditures by the 49 Global Strategy countries grew to a total of US$2.8 billion in 2013; a 20% increase from 2010. However, expenditures on RMNCH have fallen in some countries, including in a number of fragile and conflict-affected states such as Haiti and the Central African Republic. Households are still the main source of RMNCH spending, and absorb much of the rise in health-care costs through out-of-pocket payments. The updated Global Strategy calls for greatly increased funding for RMNCH from domestic and international sources – and from both the public and private sectors – in order to hit targets for scaling up key health interventions by 2030.[8]

Key lessons learned from the Partnership accountability work

Based on the experience of the Partnership since the launch of the Global Strategy in 2010, this report has identified 12 key areas in which to improve overall accountability for the health of women, children and adolescents:

1. Support stakeholders in developing sound commitments, with strong linkages to internationally agreed goals and principles.

Technical support should be offered to stakeholders to help them produce clear, unambiguous commitments that are aligned with the Global Strategy, the SDGs and human rights obligations. In the past five years, the lack of specificity of commitments made it challenging to track their implementation. In addition, commitments were insufficiently focused on key goals (for example, only 16% specifically mentioned the MDGs), so assessing their impact was difficult. Commitments fell short of legally binding human rights obligations, despite women's and children's health being recognized as a fundamental human right.

2. Ensure that all tracking efforts are integrated.

Multiple accountability initiatives emerged for the Global Strategy, which led to a fragmented landscape. The updated Global Strategy proposes a single, integrated global accountability framework – including a comprehensive annual synthesis report on the State of Women's, Children's and Adolescents' Health prepared by an Independent Accountability Panel (IAP) – to improve overall coherence, cost-effectiveness and impact. This unified mechanism should be developed and deployed rapidly to avoid further duplication of tracking efforts.

3. Strengthen capacity to collect, analyse and synthesize data on resources, results and rights.

Additional investments are urgently required to strengthen existing capacity at global, regional and country levels for tracking progress for resources, results and rights, including the ability to cross-check self-reported data independently.

4. Highlight persistent cases of non-reporting.

Some commitment-makers repeatedly fail to meet the requirement to report annually on progress in implementing Global Strategy commitments. Under the new unified accountability framework, the IAP should highlight and comment on persistent cases of non-reporting. Stakeholders should receive support to help them overcome existing reporting barriers and improve accountability for their commitments.

5. Build on existing efforts to improve the tracking of funding.

Stakeholders should work together to harmonize and better utilize existing methodologies and approaches for tracking funding. An example is the policy-marker introduced by the OECD Development Assistance Committee in 2013 to track funding for RMNCH. Only a few donors have used the marker to date, and more extensive use is required if it is to produce meaningful data. The Global Strategy now includes an enhanced focus on adolescent health – as well as a stronger focus on non-financial commitments – a new and updated criteria for how to track commitments to adolescent's health as well as non-financial commitments will be needed. Formation of a time-limited technical working group should be considered to address this issue. As more countries acquire the means to finance their domestic health needs, institutionalized and standardized tracking of health expenditure will become increasingly important.

6. Make better use of existing mechanisms to track non-financial commitments, and agree on a method to monetize them.

The imprecise nature of many non-financial commitments to the 2010 Global Strategy has made it challenging to track their implementation and to identify meaningful criteria for measuring impact. However, there is an opportunity to strengthen the tracking of non-financial commitments by building on existing mechanisms. For example, all states report to various human-rights bodies on their progress in realizing the right to health (including the health of women and children).[9] These mechanisms could potentially be updated to measure progress on the application of human rights to women's, children's and adolescents' health. To assist in assessing the value and impact of non-financial commitments, the time-limited working group (see point 5) should be tasked with developing an agreed method of monetizing non-financial commitments.

7. Collect disaggregated data to strengthen accountability for at-risk and vulnerable populations.

At-risk and vulnerable populations are often invisible in data collection and monitoring. To correct this, the collection and disaggregation of more financial and health-outcomes data are required, including by gender, age group, income and geography.

8. Hold individual commitment-makers accountable.

In the past, data aggregation has masked the lack of progress made by some individual commitment-makers. In future, disaggregated data should be used to hold them to account more rigorously by measuring their performance against their own commitments, and against identified human rights indicators and the SDG-related objectives of the Global Strategy.

9. Develop an accountability index to improve alignment between objectives and commitments.

An index, published annually, could rank individual commitments in terms of their contribution to the Global Strategy objectives. Existing indices, such as the Access to Medicine Index and the Access to Nutrition Index, could be used as models. The index should be closely linked to the unified accountability framework, and its rankings should be included in the State of Women's, Children's and Adolescents' Health report.

10. Facilitate a "mind shift" away from a traditional biomedical understanding of health, and expand accountability work to include monitoring of underlying determinants.

Continued efforts are needed to advocate for a holistic approach to public health. This should systematically integrate human rights and acknowledge the broader determinants of health and health inequalities – such as nutrition, access to education, discriminatory policies. Monitoring should be expanded to include the status of these underlying factors and the realization of related human rights.[10] The updated Global Strategy reflects this broader definition of health (also captured in the SDGs). It recognizes the importance of cross-sectoral collaboration and synergy with other policy domains to address the determinants of health outside the health sector, and to counter narrow definitions of sexual, reproductive and maternal health.

11. Foster leadership of national civil society organizations (CSOs) and support local champions.

Civil society and local communities can play a critical role in holding states accountable for their commitments to the health of women, children and adolescents and for their human-rights obligations, including the right to health. National and local CSOs should be supported to work together to make their voices heard to make their voices heard at the national, regional and global levels. Increased efforts are required to support local champions, who are key to progress within countries. Additional *longer-term* funding (from domestic and international sources) is required to ensure that citizens can perform their function of holding duty-bearers accountable to rights holders.

12. Increase efforts to promote the role of parliamentarians and citizens' hearings.

Parliamentarians require support to fulfil their role as influential champions for the health of women, children and adolescents. Citizens' hearings are also a key tool to elevate the (local) voice of women and children to the national, regional and global levels. As such, they are important for improving accountability across levels and putting people at the heart of the SDGs. Creating better linkages between the global, regional and national levels is critical to increased accountability for women's, children's and adolescents' health.

Endnotes

1. United Nations Secretary-General (UNSG). The Global Strategy for Women's and Children's Health (Global Strategy). New York, United Nations, 2010.
2. EWEC: SURVIVE, THRIVE, TRANSFORM · The Global Strategy for Women's, Children's and Adolescents' Health. New York, 2015.
3. This financial analysis focuses on funding for reproductive, maternal, newborn and child health (RMNCH), as there is no methodology for tracking investments to reproductive, maternal, newborn, child and adolescent health (RMNCAH) to date. It should be noted, however, that funding flows for RMNCH also contribute to the improvement of adolescent health.
4. Commitments to the Global Strategy are listed on the EWEC website, http://everywomaneverychild.org (accessed 26 August 2015). These numbers are based on an analysis of commitments on the EWEC website.
5. Double-counting relates to funding committed twice by different stakeholders. For example, there could be a bilateral donor commitment to a global health partnership that is reported as a Global Strategy commitment by both the donor and the partnership.
6. The overall analysis of trends in donor funding for RMNCH was conducted using the Creditor Reporting System (of the OECD DAC) and the Muskoka method. Organisation for Economic Co-operation and Development (OECD). Development Co-operation Directorate. Creditor Reporting System (CRS) Database. Paris: 2013, https://stats.oecd.org/Index.aspx?DataSetCode=CRS1 (accessed 16 March 2015); the Muskoka method is usually based on data of the OECD's CRS. It applies percentages to funding reported to the OECD under certain purpose codes or to selected multilateral organizations. The percentages applied vary depending on the intended target group of the respective donor activity. Activities targeting entirely or mostly women of reproductive age and/or children under five are assigned 100%; activities targeting the general population are counted at 40%. Disease-specific interventions are attributed at 18.5% for tuberculosis, 46.1% for HIV/AIDS and 88.5% for malaria. Basic drinking water supply and sanitation is counted at 15.0%, http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html (accessed 26 August 2015).
7. The 49 Global Strategy focus countries were the 49 lowest-income countries according to the World Bank list of economies as of April 2008. These countries were in the focus of work of the Taskforce on Innovative International Financing for Health Systems and then became the focus countries of the Global Strategy. These countries are: Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Cote d'Ivoire, Eritrea, Ethiopia, The Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, Kenya, Democratic Republic of Korea, Kyrgyz Republic, Lao PDR, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, Tajikistan, Tanzania, Togo, Uganda, Uzbekistan, Vietnam, Yemen, Zambia and Zimbabwe.
8. Every Women, Every Child (EWEC): SURVIVE, THRIVE, TRANSFORM· The Global Strategy for Women's, Children's and Adolescents' Health. New York, 2015.
9. This includes the Universal Periodic Review (UPR), the Committee on the Elimination of Discrimination Against Women (CEDAW Committee), and the Committee on the Rights of the Child (CRC). United Nations. Human Rights, Universal Periodic Review, http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx (accessed 26 August 2015); United Nations. Committee on the Elimination of All Forms of Discrimination against Women, http://www.un.org/womenwatch/daw/cedaw/committee.htm (accessed 26 August 2015); United Nations. Committee on the Rights of the Child, http://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIndex.aspx (accessed 26 August 2015).
10. In the context of the health system, this shift also means that citizens (as individual beneficiaries of a healthcare system) are recognized as rights holders, and improving health is not reduced to merely its economic or developmental benefits, but acknowledged as a fundamental obligation. Key Informant Interview.

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Advisory Group

The Advisory Group of PMNCH Partners played an important role in the development of the report. Its objectives were: (1) to comment and advise on the proposed methodology; (2) to review initial and emerging findings and drafts of the report; (3) to ensure that the voices of the Partnership's key stakeholders are captured; and (4) to advise on how to maximize the impact and reach of the report's findings and lessons learned.

The members of the Advisory Group were: Christopher Armstrong, Government of Canada; Zulfiqar Bhutta, Aga Khan University; Aleksandra Blagojevic, Inter-Parliamentary Union; Josephine Borghi, London School of Hygiene & Tropical Medicine; Lola Dare, Chestrad; Leith Greenslade, MDG Health Envoy; Betsy McCallon, White Ribbon Alliance; Jennifer Requejo, Countdown to 2015; Jyoti Sanghera, Office of the High Commissioner for Human Rights; Rotimi Sankore, Africa Health, Human & Social Development; Lale Say, World Health Organization

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