EVERY WOMAN
EVERY CHILD

Consultations on updating the Global Strategy for Women's, Children's and Adolescents' Health:

Preliminary thoughts on lessons learned & future priorities

16th February 2015

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KEY ACRONYMS

Acronym	Full description
AIDS	*Acquired Immune Deficiency Syndrome*
ART	*Academic, Research and Teaching institutions*
CRVS	*Civil Registration and Vital Statistics*
CSO	*Civil Society Organisation*
GFF	*Global Financing Facility*
HCP	*Health Care Professional*
iERG	*Independent Expert Review Group*
INGO	*International Non-Governmental Organisation*
LMICs	*Lower middle income countries*
NGO	*Non-Governmental Organisation*
PMNCH	*Partnership for Maternal, Newborn & Child Health*
RMNCAH	*Reproductive, Maternal, Newborn, Child and Adolescent Health*
SDG	*Sustainable Development Goal*
SRHR	*Sexual Reproductive Health and Rights*
UN	*United Nations*
WASH	*Water, Sanitation and Hygiene*

EXECUTIVE SUMMARY

This report aims to synthesise the views of over 1,400 organisations and individuals (Appendix A) who contributed to the first phase of an on-going and broad consultation process around the development of the new global and national commitments to women's, children's and adolescents' health with their thoughts on the Millennium Development Goals (MDGs) and the Global Strategy for Women's and Children's Health. The first phase of the consultation was conducted between October and December 2014 and although it focused on the Global Financing Facility (GFF)[1], three open-ended questions that probed respondents' views about the broader policy environment for women's and children's health were also included. This report summarises the views expressed in these questions and builds on feedback received through the various consultation events.

The second consultation phase will be undertaken in the first half of 2015 and will focus on supporting the process to update the United Nations (UN) Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health, to be launched in September 2015 alongside the new Sustainable Development Goals (SDGs).

Lessons learned

The lessons learned emerge from respondents' views about the successes and limitations of the first Global Strategy and the MDGs:

1. **"Simple clear goals can drive action and lead to positive results"**

Focus matters, and clear focus can be instrumental in achieving results. The goals and targets were an important part of building this focus. Having only a few targets but giving them lots of attention worked.

2. **Being clear and focused also strengthened alignment and collaboration which facilitated some important (and measurable) secondary results,** including better donor alignment, more engagement with civil society, and shared ownership of efforts to achieve common goals. Collaboration strengthened the *possibility* of country leadership,

[1] The GFF was announced at the "Every Woman Every Child" event during the 69th UN General Assembly in New York, in support of the Global Strategy for Women's and Children's Health to build long-term domestic and international funding commitments for women's, children's and adolescents' health. The report, entitled *Consultations on updating the Global Strategy for Women's, Children's and Adolescents' Health: Perspectives on the Global Financing Facility*, was published on 15th December 2014, and is available at www.WomenChildrenPost2015.org.

built more focus on process, raised issues about data, instigated discussions in some settings about health systems strengthening, and strengthened decision-making.

3. **Equity should be built into the targets and goals, so that meeting the needs of the most vulnerable and marginalized individuals and populations is essential to success.** Measures of equity are needed to ensure that global/ national mortality data reflects fairness and an equitable reduction in burden (not just easier to reach/ less vulnerable people).

4. **Women's, children's and adolescents' health should be rooted in clear commitments to human rights**, including "*full endorsement of human rights for all as a basis for Sexual Reproductive Health and Rights (SRHR) services*", and including elimination of violence against women and children, early and forced marriage, female genital cutting and other violations of women's, children's and adolescents' human rights.

5. **The full continuum of care is necessary to deliver sustained results.** In particular, the initial exclusion of family planning from MDG 5 targets was a setback for maternal health. The global community "*must learn from this mistake and must safeguard the right of women to be able to access a range of high-quality family planning methods of their choice*".

6. **Quality matters.** Investments need to reach the right people with the right services but they also need to be delivered with a minimum standard of quality to avoid "*rapid scale-up of some interventions without consideration of the service quality improvement*" and to ensure that investments do deliver their intended benefits.

7. **Health systems strengthening is the foundation of lasting, sustained health-service driven outcomes for women and children.** Maternal mortality especially is "*intrinsically linked to health systems strengthening*". This includes comprehensive policies on access and equity, demand for services, the removal of complex and country-specific barriers to access, and both short and long-term investments to strengthen capacity at all levels of the health system.

8. **Having a strategy has limited impact if there is no accompanying financing plan, especially in the poorest countries.** Health financing, including domestic resource mobilization, user fees elimination, financial planning, longer term financing commitments, improved procurement, health worker retention, and better links to public financial management in districts/ devolved areas are all vital to success.

9. **The collection, management and use of data has been a major component of what has worked (measuring the same thing, streamlining indicators) and what has not worked (poor quality, poor incentives, too many competing multisectoral organisation initiatives).** Some respondents would add that there "*has not been enough focus on stakeholders reporting the progress of the implementation of commitments*", but many considered the independent Expert Review Group (iERG) "*an important accountability mechanism for monitoring progress and highlighting gaps*", particularly for marginalized women's health issues.

10. **"Developing countries should be consulted in the process of goal setting".** Country ownership is vital for global initiatives to succeed.

11. **All partner constituencies should be engaged in formulating and implementing major strategies at both global and country level.** Thus, the private sector, as an essential part of health services delivery and a partner in health outcomes, has the capacity to help or hinder outcomes and should be considered an important stakeholder.

12. **Understanding and addressing the underlying social and economic determinants of health - especially for maternal and child health - is vital to achieving sustainable outcomes that are cost-effective and transformative.** Multi-sector working is thus vital, with respondents particularly focusing on education, Water, Sanitation and Hygiene (WASH), nutrition, and addressing the social determinants of health, including poverty. While the health sector cannot directly address these areas, there is scope for better engagement and collaboration between sectors.

13. **Community-based working is critical to success, and should "not be an afterthought".** Community-based working and community health should be addressed substantively, not merely in passing. Although these can be expensive to deliver across a whole country, complex to establish and risk overloading community health workers, well thought out community-based programmes, with training, supplies, management and quality assurance, can significantly improve outcomes.

Priorities for the future updated Global Strategy

Respondents identified the following areas as being priorities for the updated Global Strategy:

- **Equity, quality, access and coverage** should lie at the heart of the updated Global Strategy, with no individual, community or country left behind.

- A **comprehensive approach to the continuum of care,** especially for maternal and SRHR services, in the context of sustained and serious investments in **health systems strengthening** and the integration of services, with particular community-level focus.
- Address the **economic and social determinants of health** (namely nutrition, education, poverty, WASH and social protection).
- **Country ownership** of the Global Strategy, including the development, priority-setting, planning and implementation processes, promoted alongside the SDGs.
- **Inclusive, bottom-up planning** (sub-national, national, regional and global), with wide stakeholder engagement feeding in to timed and costed roadmaps.
- **Flexible targets independently selected by countries** to achieve global goals.
- **National and sub-national data collection and management systems,** feeding in to a unified sustainable system that tracks progress within and between countries.
- A high quality, realistic **human resources for health plan.**
- **Bridge the gap "between global strategy and community activities** … with a systematic approach to this".
- Include a **costing analysis, investment case, and guidelines** about what spending is required in order to achieve outcomes.
- **Private sector involvement** that includes clear contribution of commitments with do-no-harm agreements.
- **Retain the strengths of the first plan,** including clarity, evidence-based interventions, focus, accountability, and forging a common set of goals.

1. Introduction

Background

This report aims to synthesise the views of over 1,400 organisations and individuals (Appendix A) who contributed to the first phase of an on-going and broad consultation process around the development of the new global and national commitments to women's and children's health with their thoughts on the Millennium Development Goals (MDGs) and the Global Strategy for Women's and Children's Health.

The Partnership for Maternal, Newborn & Child Health (PMNCH) was asked to co-ordinate wide-ranging consultations to support the development of important policies, strategies and instruments for women's, children's and adolescents' health anticipated in 2015. The first phase of the consultation was conducted between October and December 2014 and focused on the Global Financing Facility (GFF).[2] Embedded in the GFF consultation instruments were three open-ended questions that probed respondents' views about the broader policy environment for women's and children's health. Respondents were asked to reflect on: the contribution that the MDGs and the Global Strategy have made to strengthening health outcomes for women and children; to identify what lessons can be learned; and to suggest future priorities for the development of the updated Global Strategy and in the context of the emerging Sustainable Development Goals (SDGs). This report summarises the views expressed in response to these three questions and builds on feedback received through the various consultation events.

The second consultation phase will be undertaken in the first half of 2015 and will focus on supporting the process to update the United Nations (UN) Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health, to be launched in September 2015 alongside the new SDGs.

Outline of the Report

This report begins by considering the experience with both the MDGs and the first Global Strategy – presenting feedback on what worked well and less well. The main

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lessons learned are identified and the priorities for the updated Global Strategy, including thoughts about consultation and engagement, are presented. Where helpful, quotations from respondents have been used, with the constituency group of the respondent given in brackets.

What will happen with this report?

This report has been developed to provide a timely and constructive input to the up-coming review of lessons learned about the MDGs and the development and implementation of the first Global Strategy for Women's and Children's Health, expected to be published in late March and to the process of updating the next Global Strategy. The report will be posted on the consultation web-hub (www.WomenChildrenPost2015.org). Through its on-going participation in the Global Strategy updating process, PMNCH will continue to refer to the key messages coming out of this report.

This is the second report in a consultation process which began in November 2014 and will extend through the first half of 2015. In early 2015, PMNCH will focus on working through its partners to develop and advocate for an updated Global Strategy using this initial consultation response as a guide to issues which are likely to be of greatest concern to the broader health community.

2. What worked well with the first Global Strategy and the MDGs

This first section considers past experience and collates the views of hundreds of respondents around the MDGs (specifically 4, 5 and 6) and the Global Strategy for Women's and Children's Health, highlighting what was successful about these policy instruments. Respondents did not always separate their views about the MDGs from their views about the Global Strategy: as such, they are presented together.

Focus

Among respondents, the most common observation was the benefit of a clear, agreed focus. The identification of limited goals and a few, well-articulated targets was considered to be – by a long way - the most important advantage or strength of the MDGs and a fundamental policy achievement.

The focus created through the establishment of the MDGs generally "*made eliminating extreme poverty a common cause and … inspired investment in campaigns for public health*" (NGO – Non-governmental organisation). It also put a spotlight on women's

and children's needs and this has led to a better balancing of health investments based on objective need rather than subjective interests.

Political will

"*A joint action increases the impact, efficiency, accountability, and inclusion … in the decision making process*" (Country NGO).

The global goals, championed by the UN and agreed by member states, helped to build and sustain political commitment from world leaders to eradicate the causes and consequences of poverty. Despite the "*stark differences between and within countries*" (HCP – Health Care Professional), this political commitment has resulted in a shift in attitude towards poverty and its underlying causes. Poverty eradication is now an important objective everywhere and political leaders are held more accountable for poverty eradication (and by extension, health outcomes) than ever before. Global and national efforts aimed at meeting the goals have "*gained unprecedented visibility, resources and focus*" (ART - Academic, Research and Teaching institutions). In addition, the Global Strategy "*provided the broad architecture and the champion/ special envoy needed (in Every Woman Every Child) to ensure sustained financing for this important health agenda*" (Private Sector).

Collaboration

The common focus, clear targets and political will (expressed through better national leadership in many cases) led to better collaboration among stakeholders. This collaboration was, in some settings, already underway through Sector Wide Approaches, pooled funding mechanisms and other national planning, financing, and aid coordination instruments. However, first the MDGs and then, in some countries, the Global Strategy reinforced collaborative working, at least with regards to uniting health sector partners around a common set of outcomes and targets. While there remained plenty of scope for donors and others to fund their own priorities, many respondents said that the MDGs, and subsequently the Global Strategy, did have an important impact on building collaboration within countries around delivering specific results.

Evidence-based interventions

While quality assurance was often raised as a challenging problem (see below), respondents mentioned the important role of the Global Strategy in promoting the use of evidence-based interventions to support the delivery of key services for women and children.

Transparency and accountability

With global goals and targets came more scope to track and measure results and to be able to compare the progress within and between countries over time. As one multilateral said, *"the Global Strategy provided an accountability architecture and political will"* (Multisectoral). This was considered a significant advantage and an important condition for building political will and making partners (including governments, health authorities, donors, civil society, multisectoral and technical partners) accountable for their role and contribution to supporting outcomes.

Engagement of a broader range of partners, including from the private sector

Quality control and supporting better quality outcomes in human resources for health, drug management, care and delivery of outcomes is linked to quality of services across the whole of the health system. As countries worked towards achieving the MDG targets, the roles and responsibilities of a much wider range of partners became clearer and efforts to build better cooperation accelerated. This included the many ways in which the private sector contributed to health outcomes (as suppliers, providers, contractors). As the MDG timeframe draws to a close, we have – collectively – a much more nuanced appreciation and understanding of the complexity of health service delivery than we did fifteen years ago.

3. What worked less well with the first Global Strategy and the MDGs

Despite these considerable benefits, which most stakeholders suggested were fundamental to changing the policy landscape, especially for women's health, the experience of the last 15 years has led to the identification of some shortcomings and limitations, many of which were almost certainly unintended consequences.

It is important to acknowledge that not all of these weaknesses require action: some are inevitable and will be the result of identifying priorities or of sequencing. Some are more likely to be unintended consequences that may have hindered or limited progress in achieving MDGs or Global Strategy targets, especially for disadvantaged communities. The distinction between these two may be a matter of perspective and will merit further discussion. This section therefore sifts through both the strengths and challenges of the past in order to identify lessons learned, which are presented in the following section.

Equity and inclusion

Equity and inclusion were not built into the targets and goals. This meant the goals could be achieved without affecting, or only in a limited way, the bottom quintile. Therefore, the disparities within countries were not under the spotlight, so although there was more transparency about country progress towards achieving the targets overall, the distribution of the benefits/ outcomes within countries were not monitored. It was specifically noted that, "*sustainability of development and equity need to have a prominent place in the next development agenda*" (HCP).

Continuum of care

Many respondents considered that the focus, although a strength, had a downside, in that it enabled (and in some cases forced or incentivised) too narrow a concentration of effort. This in turn led to some damaging limitations:

- Prevention and public health suffered as a result of disease-focused goals;
- The continuum of care essential to building quality was often missing, under-funded or overlooked;
- There were inevitable gaps. The most serious of these were thought to be family planning (rectified with MDG 5b, although this was a catch-up manoeuvre), perinatal and newborn care, and adolescent health;
- Furthermore, adolescent health "*received very little attention*" (Country Governments) in both strategic documents and programs; and
- The lack of full endorsement of sexual and reproductive health and rights (SRHR), while understandable given the timing of the goals, the process undertaken and their purpose, nonetheless, in combination with the lack of a target around the full continuum of care was seen by some as a set-back.

Health systems strengthening

Linked to, but distinct from, the idea of the continuum of care, a common observation among respondents was the way that the foundation for achieving the MDGs and especially women's and children's health outcomes relied on broad, sustained investments in health systems strengthening. While few respondents thought health-systems strengthening should have been a separate goal or a target, they pointed out that several goals, particularly maternal mortality reduction, could not be achieved without systematic investment in sound health systems and "*if we could have*

recognized adequately that Women's and Children's Health is a multisectoral issue just like nutrition, it could have worked much better" (Country Governments).

Of the main health system building blocks, human resources for health was most often cited as a constraint, or as an essential enabler that was often neglected. In particular, community health workers along with midwives and nurses, were mentioned as crucial to the achievement of maternal and child mortality reduction. "*Those countries that have prioritized strengthening the health workforce have seen immense payoffs"* (Country Governments).

Along with health systems in general and human resources in particular, respondents raised concerns about other aspects of service delivery capacity and structures:

- Quality assurance was often weak even where coverage increased;
- The need to embrace and welcome innovation and to build "*a more welcoming focus on innovation... [with] stronger encouragement of innovative approaches from a broader base*" (INGO – International non-governmental organisation);
- Commodities were seen as a constraining factor for much of the past 15 years, and even with the UN Commission on Life-Saving Commodities, the availability, affordability, distribution and management of vital commodities was noted by respondents several times as an aspect of health-systems strengthening that had received insufficient attention; and
- User fees, access to services and reaching the last mile were all raised in the context of health-systems strengthening.

Social and Economic Determinants of Health

Another common observation concerned the potential for the MDGs and the Global Strategy to result in an overly narrow focus on health service inputs, including the planning, financing, delivery and monitoring of health services to address health impacts that were equally if not more determined by broader social and economic conditions. Specific social and economic determinants listed were:

- Water, Sanitation and Hygiene (WASH) was made a separate goal and "*an infrastructure goal at that (despite targets on hygiene) separating it from health*" (INGO);
- "*Nutrition is a social justice issue*" (Civil society network);
- Education and literacy especially for women, and social protection; and
- *"More investment in gender, equity and human rights"* (Country Governments).

Strategy, planning and financing

Some respondents thought that policy goals and outcome targets were insufficient and that especially for under-resourced, high burden countries, guidance about prioritisation, sequencing and strategy was needed (and not necessarily forthcoming) to really help countries get started on making progress. In particular, some respondents pointed to the following limitations as constraining progress:

- Lack of a clear financing structure (for the MDGs);
- MDGs did not consider barriers to implementation;
- Focus on impacts meant high burden countries sometimes struggled to identify priorities, develop robust plans and optimise available funds;
- "*The Global Strategy didn't attach funding to specific needs/ outcomes*" (Donors and Foundations) and fell short of a roadmap of actions and an allocation key for funding. While acknowledging this is not the role of a global strategy, the evident gap in many countries was noted by many respondents; and
- The Global Strategy "*did not engage countries sufficiently, with result that there is low awareness or understanding of the value-add*" (Multisectoral).

Process and governance

Both for the MDGs and especially the Global Strategy, respondents considered that there were some limitations in the way countries engaged and led on "nationalising" what were global policies. The process of building this country identification with or ownership of the Global Strategy was insufficiently supported to the extent that some respondents said they did not think the Global Strategy or even Every Woman Every Child (EWEC) was well enough understood in their countries, or "*even within national governments who may have made commitments*" (INGO). Some additional observations were:

- Need for more attention to leadership/ governance;
- Country consultations seemed an afterthought;
- "*We need to develop local effective strategies keeping in mind global commitments*" (Country NGO);
- Country based civil society involvement in planning, verification, delivery and accountability was patchy;
- Involvement of local actors could have been improved and would "*help in minimising wastage and accountability*" (ART);

- Some countries/ communities are *still* unaware of the Global Strategy and EWEC; and
- Some believed that the MDGs acted to entrench silos (e.g. disease-specific activities) in countries rather than break these down.

4. Lessons learned

Considering this experience presented above, respondents identified a number of important lessons to draw out of this collective experience. Many arise from the strengths and limitations raised above and some introduce new ideas. The main lessons are listed below, although it should be noted that some contradict each other.

1. **"Simple clear goals can drive action and lead to positive results" (Country Governments)**

Focus matters and clear focus can be instrumental in achieving results. The goals and targets were an important part of building this focus. Having only a few targets but giving them lots of attention worked.

2. **Being clear and focused also strengthened alignment and collaboration which facilitated some important (and measurable) secondary results,** including better donor alignment, more engagement with civil society, shared ownership of efforts to achieve common goals. Collaboration strengthened the *possibility* of country leadership, built more focus on process, raised issues about data, instigated discussions in some settings about health systems strengthening, and strengthened decision-making.

3. **Equity should be built into the targets and goals, to ensure that meeting the needs of the most vulnerable and marginalized individuals and populations becomes essential for successful achievement of results.** Measures of equity are needed to ensure that global/ national mortality data reflects fairness and an equitable reduction in burden (not just easier to reach/ less vulnerable people).

4. **Women's, children's and adolescents' health should be rooted in clear commitments to human rights**, including "*full endorsement of human rights for all as a basis for SRHR services*", and including elimination of violence against women and children, early and forced marriage, female genital cutting and other violations of women's, children's and adolescents' human rights.

5. **The full continuum of care is necessary to deliver sustained results.** In particular, the initial exclusion of family planning from MDG 5 targets was a setback for maternal

health. The global community "*must learn from this mistake and must safeguard the right of women to be able to access a range of high-quality family planning methods of their choice*" (Private Sector).

6. **Quality matters.** Investments need to reach the right people with the right services but they also need to be delivered with a minimum standard of quality to avoid "*rapid scale-up of some interventions without consideration of the service quality improvement*" (Mulitsectoral Organisations) and to ensure that investments do deliver their intended benefits.

7. **Health systems strengthening is the foundation of lasting, sustained health service driven outcomes for women and children.** Maternal mortality especially is "*intrinsically linked to health systems strengthening*". This includes comprehensive policies on access and equity, demand for services, and the removal of complex and country specific barriers to access, and both short and long-term investments to strengthen capacity at all levels of the health system.

8. **Having a strategy has limited impact if there is no accompanying financing plan, especially in the poorest countries.** Health financing, including domestic resource mobilization, user fees elimination, financial planning, longer term financing commitments, improved procurement, health worker retention, and better links to public financial management in districts/ devolved areas are all vital to success.

9. **The collection, management and use of data has been a major component of what has worked (measuring the same thing, streamlining indicators) and what has not worked (poor quality, poor incentives, too many competing multisectoral organisation initiatives).** Some respondents would add that there "*has not been enough focus on stakeholders reporting the progress of the implementation of commitments*" (INGO) but many considered the independent Expert Review Group (iERG) "*an important accountability mechanism for monitoring progress and highlighting gaps*" (Private Sector), particularly for marginalized women's health issues.

10. **"*Developing countries should be consulted in the process of goal setting*"** (Country NGO)

Country ownership is vital for global initiatives to succeed. "The Global Strategy for Women's and Children's Health was [insufficiently] disseminated to get [broad] country ownership" (Country Governments) while "local country level planning is a must, otherwise there is less accountability. (Country NGO). Would having common

milestones or interim goals have helped direct and drive action in countries? Or should countries have developed their own set of interim goals against which they could be measured? These [could have been] process goals or health-systems strengthening goals linked to human resources for health or life-saving commodities for example. (INGO).

11. **All partner constituencies should be engaged in formulating and implementing major strategies at both global and country level.** Thus, the private sector as an essential part of health services delivery and a partner in health outcomes, has the capacity to help or hinder outcomes and should be considered an important stakeholder.

12. **Understanding and addressing the underlying social and economic determinants of health - especially for maternal and child health - is vital to achieving sustainable outcomes that are cost-effective and transformative.** Multi-sector working is thus vital, with respondents particularly focusing on education, WASH, nutrition, and addressing the social determinants of health, including poverty. While the health sector cannot directly address these areas, there is scope for better engagement and collaboration between sectors.

13. **Community-based working is critical to success, and should "not be an afterthought"** (Private Sector). Community-based working and community health should be addressed substantively, not merely in passing. Although these can be expensive to deliver across a whole country, complex to establish and risk overloading community health workers, well thought out community-based programmes, with training, supplies, management and quality assurance, can significantly improve outcomes.

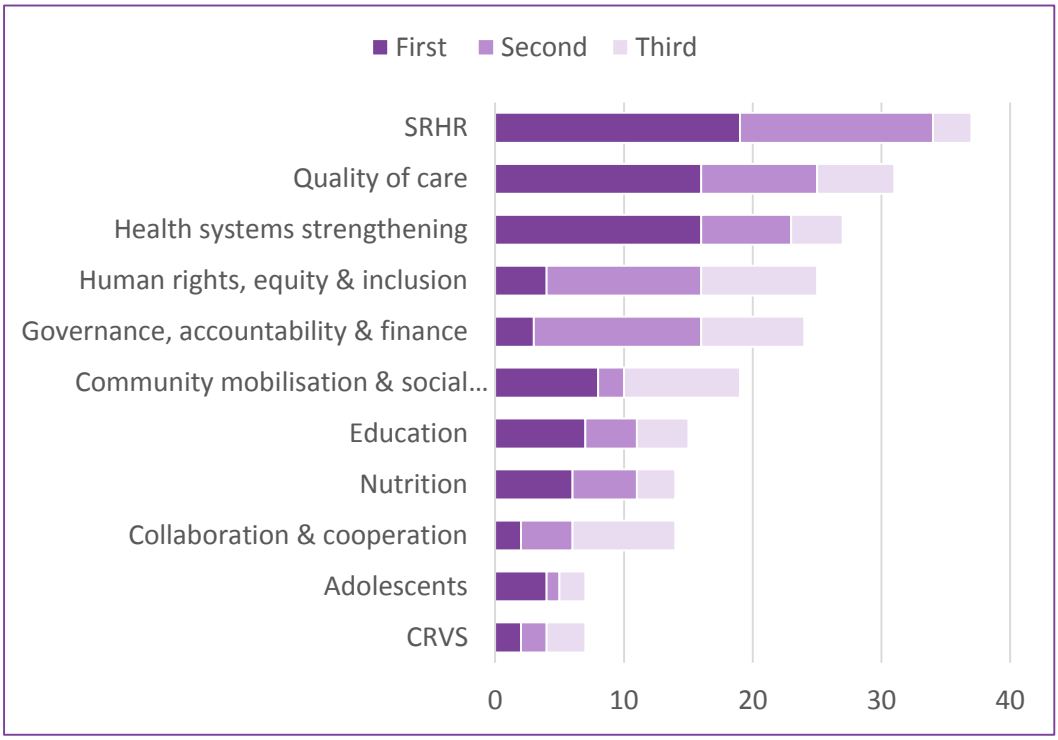
5. Priorities for the updated Global Strategy

"The new framework is a crucial opportunity to forge a new, modern global partnership for sustainable development that recognises the interconnectedness of all countries, their people and our planet, respects the different stages of development of countries, provides adequate financing and establishes an open and inclusive accountability framework to accelerate progress towards an end to extreme poverty" (INGO).

Many respondents welcomed the opportunity to provide their thoughts on what areas or themes should be prioritised in the updated Global Strategy, with questions on this topic eliciting some of the highest response rates. Responses to the specific

question asking respondents to list their top three priorities for inclusion in the updated Global Strategy were grouped into 11 thematic areas, as shown in Figure 1.[3]

Figure 1: Priority themes for the updated Global Strategy



Unsurprisingly, given the review of lessons learned, concerns about SRHR, quality, equity, health-systems strengthening, financing, accountability and human rights were most commonly cited.

Lastly, in terms of priorities for the next strategy, many respondents chose to link their views about lessons learned (past experience) to 'critical elements' for a fit-for-purpose updated Global Strategy. These are not all thematic areas (therefore not captured by the question on top three priorities) and were not all immediately lessons learned. Indeed, thoughts about critical components for the next Global Strategy were mentioned throughout the entire consultation process. This range of ideas for priority areas is presented below (Box 1).

The operationalization of these critical elements may not be uniformly straightforward as some may conflict with others. For example, being clear and focused necessitates selecting priorities; and if countries choose their own goals or targets, comparison between them or tracking progress over time becomes harder. However, they are

[3] Responses were not necessarily given in order of preference. Figure 1 should therefore be interpreted with caution.

presented here in a group, without further analysis, as the collective thinking of a large number of individuals and organisations:

Box 1: Priorities for the updated Global Strategy

- **Equity, quality, access and coverage** should lie at the heart of the updated Global Strategy, with no individual, community or country left behind
- A **comprehensive approach to the continuum of care,** especially for maternal and SRHR services, in the context of sustained and serious investments in **health systems strengthening** and the integration of services, with particular community level focus
- Address the **economic and social determinants of health** (namely nutrition, education, poverty, WASH and social protection)
- **Country ownership** of the Global Strategy, including the development, priority-setting, planning and implementation processes, promoted alongside the SDGs
- **Inclusive, bottom-up planning** (sub-national, national, regional and global), with wide stakeholder engagement feeding in to timed and costed roadmaps
- **Flexible targets independently selected by countries** to achieve global goals
- **National and sub-national data collection and management systems,** feeding in to a unified sustainable system that tracks progress within and between countries
- A high quality, realistic **human resources for health plan**
- **Bridge the gap "*between global strategy and community activities*...** *with a systematic approach to this" (ART)*
- Include a **costing analysis, investment case, and guidelines** about what spending is required in order to achieve outcomes.
- **Private sector involvement** that includes clear contribution of commitments with do no harm agreements
- **Retain the strengths of the first plan,** including clarity, evidence-based interventions, focus, accountability, and forging a common set of goals

6. BUILDING CONSENSUS: WHO TO ENGAGE AND HOW TO CONSULT

Respondents also contributed thoughts about how consensus on these priorities should be built over the coming months, as well as who to engage with and through what modalities. It was widely felt that in updating the Global Strategy, a broader and more inclusive range of stakeholders should be engaged than previously. Although the updated Global Strategy will need buy-in from the full range of stakeholders, respondents noted that the following groups were essential:

- **Countries** to bring about fundamental change, to ensure the Global Strategy is translated into policy, programmes and financial commitment, countries needed to be in the lead, fully participative and committed.
- **Country-based civil society organisations** specifically to support (i) the development of guidelines for countries to take ownership of the Global Strategy; (ii) the adaptation of the strategy to in-country settings; (iii) accountability processes such as reporting on progress; and (iv) holding governments and INGOs to account.
- **Marginalised groups** to give the intended beneficiaries of the updated Global Strategy a strong voice and build demand.
- **Private sector** organisations across a range of functions including providers, contractors, suppliers, innovators, and others.

Responses on how consultations for the updated Global Strategy should be carried out are summarised below (Box 2).

Box 2: Recommendations on consultation methods for developing an updated Global Strategy

- **Mixed methods** to reach as inclusive a range of stakeholders as possible;
- **Online surveys** in conjunction with face-to-face discussions, debates, and consultations;
- **Social media** to spread the conversation wider;
- **Integrated multi-sector approach**, e.g. cross-constituency meetings;
- Circulating a **draft strategy** prior to consultations to encourage more focussed feedback; and
- Providing **clear and current information**; i.e. through succinct briefings.

Appendix A: List of Respondents and Consultation Events

A.1 Organisations[4]

- A World At School
- Action Against Hunger| ACF
- Action Canada for Population and Development
- Action For Development In Underserved Areas (ADUA)
- ADIFE-ONG
- Advance Family Planning, Johns Hopkins University
- African Management Services Company (AMSCO)
- African Women Leaders Network for Reproductive Health and Family Planning (AWLN)
- Aga Khan University
- AIDOS Italian Association for Women in Development
- AIDS Information Centre
- Alliance Pour la Recherche et le Renforcement des Capacités (ARECA)
- American Academy of Paediatrics
- American Board of Medical Specialties (ABMS)
- American College of Nurse-Midwives
- Amnesty International Mexico
- Amref Health Africa
- Apoyo a Programas de Población (APROPO)
- Asia Pacific Alliance for Sexual and Reproductive Health and Rights
- Asociación Hondureña de planificacion de Familia (ASHONPLAFA)
- Asociación Pro-bienestar de la Familia de Guatemala (APROFAM)
- Asociación Protección a la Salud (PROSALUD)
- Association Béninoise Pour la Promotion de la Famille (ABPF)
- Association de Soutien à l'Autopromotion Sanitaire et Urbaine (ASAPSU)
- Association des Gestionnaires pour le Développement
- Association for Reproductive and Family Health.
- Association Marocaine de Planification Familiale
- Association Mauritanienne pour la Promotion de la Famille
- Association of Non-Governmental Organisations (TANGO)
- Association Togolaise pour le Bien-Etre Familial (ATBEF)
- Association Tunisienne de la Santé de la Reproduction
- Bahrain Reproductive Health Association
- Bangladesh Institute of Development Studies
- Bayer Healthcare

[4] Members of these organisations submitted their views to the GFF consultations via (i) the GFF online survey; (ii) the CHESTRAD civil-society e-survey; (iii) partner-held consultations; or (iv) direct submission through the GFF consultation team.

- Bhartiya Mahila Evam Gramin Utthan Sansthan
- Bill and Melinda Gates Institute for Population and Reproductive Health
- Black Francophone Africa Pediatric Association
- BMZ (Federal Ministry for Economic Cooperation and Development, Germany)
- Boston University
- Cameroon Agenda for Sustainable Development (CASD)
- CAMI Health
- Care USA
- Center for the Right to Health
- Centre for Catalyzing Change (Formerly CEDPA India)
- Centre for Healthworks, Development and Research (CHEDRES) Initiative
- Centre for Reproductive Health and Education
- Centre National de Nutrition et de Technologie Alimentaire (CNNTA), Chad
- Centro de Promoción y Defensa Derechoa sexuales y Reproductivos PROMSEX
- Chatham House
- CHOICE for Youth and Sexuality
- Christian Connections for International Health
- CIAM- Public Health Research and Development Centre
- Civil Society for Family Planning in Nigeria (CiSFP)
- Civil Society for HIV/AIDS in Nigeria, Ekiti State
- Clinton Health Access Initiative
- Community And Family Aid Foundation
- Community Development Centre
- Concern Worldwide
- Cordaid
- Dandelion Kenya
- Department for International Development, UK (DFID)
- Deutsche Stiftung Weltbevoelkerung (DSW)
- Development & Integrity Intervention Goal Foundation (DIG Nigeria)
- Direct Relief
- Dnet
- East, Central and Southern Africa Health Community
- Egyptian Family Planning Association (EFPA)
- Elizabeth Glaser Paediatric AIDS Foundation
- Eminence Associates for social development
- EngenderHealth
- Eniware, LLC
- Equilibres & Populations
- European Commission, EuropeAid
- European Patients' Forum (EPF)
- Famedev
- Family Care International
- Family Care International - Burkina Faso
- Family Planning 2020
- Family Planning Association of India (FPA India)
- Family Planning Association of Nepal (FPAN)

- Fédération nationale des associations de santé communautaire du Mali (FENASCOM)
- Federation of Reproductive Health Associations of Malaysia (FRHAM)
- Female Health Company
- Feminists for Nonviolent Choices
- Femmes-Santé-Developpement en Afrique Sub-Saharienne (FESADE)
- FHI360
- Financing for Development (F4D)
- Forum for African Women Educationalists (FAWE)
- Forum for FP and Development
- Forum for Human Rights and Public Health-Nepal
- Foundation for leadership initiatives
- Foundation for the Education and Study of Women (FEIM)
- Fountain Africa Trust
- Francophone African Midwives Federation
- Free University of Brussels (VUB)
- Frontline Health Workers Coalition
- Fundacion Mexicana para la Planeacion Familiar AC MEXFAM
- Fundación Oriéntame
- Gender and Development Action
- Generation Development
- Genos Global
- Ghana News Agency
- Global Health Council
- Gram Bharati Samiti (GBS)
- Great-Lakes in Action for Peace and the Sustainable Development (GLAPD)
- Greenstar Social Marketing Limited Pakistan
- Groupe De Volontaires Pour La Promotion De La Matrnite Sans Risques En RDC (GVP-MASAR/RDC)
- Health Actions Promotion Association
- Health and Rights Education Programme (HREP)
- Health Development Consultancy Services (HEDECS)
- Health Education and Skills Development Initiative (HESDI)
- Health Partners International
- Health Poverty action
- Healthy Living and Women Empowerment Initiative
- High-Level Task Force for ICPD Secretariat
- Hollender Sustainable Brands
- HRA Pharma Foundation
- Humani Africa
- Hunger Project
- i+solutions
- ICS Integrare
- Impact Aid International
- Institute for Reproductive and Family Health
- Institute of Tropical Medicine, Antwerp
- Integrated Rural Youth Development Initiatives
- International Community of Women Living with HIV/AIDS Chilean Chapter
- International Consortium for Emergency Contraception
- International Disability Alliance

- International Federation of Medical Student Associations (IFMSA)
- International Paediatric Association
- International Planned Parenthood Federation
- International Society of Ultrasound in Obstetrics and Gynecology (ISUOG)
- International Youth Alliance for Family Planning
- International-Lawyers.Org
- IntraHealth
- Investigación en Salud y Demografía (INSAD)
- Ipas
- Istanbul Medical School, Public Health
- Ivory Coast Pedriatric Society
- Jaklen Muoi Tuyen Foundation (JMTF)
- Japanese Organisation for International Cooperation in Family Planning (JOICFP)
- JHPIEGO
- John Snow Inc
- Johns Hopkins Center for Communication Programs (JHUCCP)
- Johns Hopkins University
- KPA
- L'Association Burkinabè pour le Bien-Être Familial (ABBEF)
- Latin American and Caribbean Womens Health Network
- Le Conseil Burkinabè des organisations de lutte contre le Sida (BURCASO)
- LeeNorman, llc
- Liya Kebede Foundation
- Malian Midwives' Association
- Mama Alive Initiatives
- Management Sciences for Health (MSH)
- Marie Stopes International
- Marie Stopes Mexico
- Marie Stopes Nigeria
- Mark Tuschman Photography
- Maternity Foundation
- Medela AG
- Medical Aid Films
- Medicos del Mundo
- Mentoring and Empowerment Programme for Young Women (MEMPROW)
- Merck-MSD
- Mercy Corps
- Micronutrient Initiative
- Ministere de la sante Publique et de la Population, Haiti
- Ministère de la Santé, Guinea
- Ministry of Foreign Affairs, the Netherlands
- Ministry of Health and Family Welfare, Bangladesh
- Ministry of Health and social welfare, Senegal
- Ministry of Health Makurdi, Benue State, Nigeria
- Ministry of Health, Burkina Faso
- Ministry of Health, Costa Rica
- Ministry of Health, Kenya
- Ministry of Health, Niger
- Ministry of Health, Republic of South Sudan

- Ministry of Youth and Education, Mali
- Mongolian Family Welfare Association
- mPowering Frontline Health Workers
- Muslim Family Counselling Services
- Naretu Girls and Women Empowerment Programme
- National Center for Child Health and Development
- National Committee for Maternal, Child and Neonatal Health (NCMNH), Pakistan
- National Empowerment Network of People living with HIV/AIDS in Kenya (NEPHAK)
- National Institute for Medical Research, Tanzania
- National Nutrition Council of Sri Lanka
- National Planning Commission, Nepal
- National Primary Health Care Development Agency, Abuja, Nigeria
- National Program of Reproductive Health, DRC
- NCD (Non-Communicable Diseases) Alliance
- NGO Gender Coordination Network
- NGO Women's-Health-Development
- Niger Network of health organizations and associations
- Nigerian Women Agro Allied Farmers Association
- Novo Nordisk
- ONG AcDev
- ONG STOPSIDA
- Oratechsolve Inc
- Organisation Ouest Africaine de la Santé
- Organization of African Youth
- Packard Foundation
- Palestinian Family Planning & Protection Association (PFPPA)
- Pan-Armenian Family Health Association/Family Health Care Network
- Parliamentary Health Committee, Senegal
- Partners in Health
- Partners in Population and Development Africa Regional Office (PPD ARO)
- PATH
- Pathfinder International
- Peace and Life Enhancement Initiative International
- Peace Foundation
- People's Health Movement (PHM)
- Philips
- Plan International
- Planned Parenthood Association Of Ghana
- Population Action International
- Population Communication
- Population Council
- Population Foundation of India
- Population Matters
- Population Services International
- Population Services Pilipinas Incorporated
- Poverty Action Network Ethiopia
- Pregna International Ltd.

- Premier Medical Systems
- Present Purpose Network
- Prime Lactation Center Cameroon
- Princeton university
- PROMACO
- Rabin Martin
- Rahnuma Family Planning Association of Pakistan
- Redeem Community Health Consulting
- REEDAAS
- Reproductive Health Supplies Coalition (RHSC)
- Reproductive Health Uganda
- RESULTS Canada, Grandmothers Advocacy Network
- RESULTS UK
- RFSU Tanzania (Swedish Association for Sexuality Education)
- ROASSN
- Rotarian Action Group for Population & Development (RFPD)
- Rutgers WPF
- Rwanda Biomedical Center
- Samasha Medical Foundation
- SEEK Development
- Seva Sahayog network
- Shades For Health
- Shah Muqeem Trust
- Shirkat Gah- Women's Resource Centre
- Siemens AG Healthcare
- Sightsavers
- Social Development and Management Society
- Social Economic and Governance Promotion Centre (SEGP)
- Solidarité des Femmes pour le Développement Intégral
- Spandana Educational Society
- St John of God Health Care
- Structure de plaidoyer pour la promotion de la SSR
- SUN Civil Society Network
- Sustainablue Consulting
- Swami Ram Krishna Paramhansa Maa Sharda Sewa Samiti (SRPMSSS)
- Swinfen Charitable Trust. UK
- Swiss Tropical and Public Health Institute
- Technoaid Associates
- Thohohoyandou Victim Empowerment Programme
- Uganda Family Planning Consortium
- UN Foundation
- UN Women
- UNFPA
- Union of Ethiopian Women Charitable Associations
- United Action for Democracy (UAD)
- United Nations REACH
- Universal Access to Female Condoms (UAFC)
- Universal Versatile Society
- Universidad Autónoma De Nuevo León
- University Hospital of Cocody
- University of British Columbia
- University of California
- University of Dundee
- University Of Lagos
- University of Papua New Guinea

- University of Washington
- University Stellenbosch
- USAID
- Vision for Mission Initiative-Ethiopia
- VODA Uganda
- Voice of Independent Women
- WASH Advocates
- White Ribbon Alliance
- WHO
- WHO Lao PDR
- Witkoppen Health and Welfare Centre
- Women & Community Livelihood Foundation
- Women and Children First, UK
- Women and Youth Development Association
- Women Deliver
- Women in Law and Development in Africa (WILDAF) Mali
- Women on Waves (WOW)
- Women's Health and Education Center (WHEC)
- World Food Program USA
- World Vision India
- Young Women's Christian Association of Tanzania
- Youth Ambassadors for Family Planning, Benin
- Youth Preparation For A Better Future

A.2 Networks and Organisational responses

- CHESTRAD international
- GAVI, the Vaccine Alliance
- International Planned Parenthood Federation[5]
- Reproductive Health Supplies Coalition (RHSC) Advocacy and Accountability Working Group[6]
- RMNCAH Commodities Advocacy Working Group[7]
- Save the Children[8]
- JHPIEGO Technical Team Leads of the Maternal and Child Survival Program[9]

[5] Representing 152 member associations

[6] Representing 269 individuals from 57 countries and 166 organisations

[7] Representing approximately 100 partners from more than ten countries

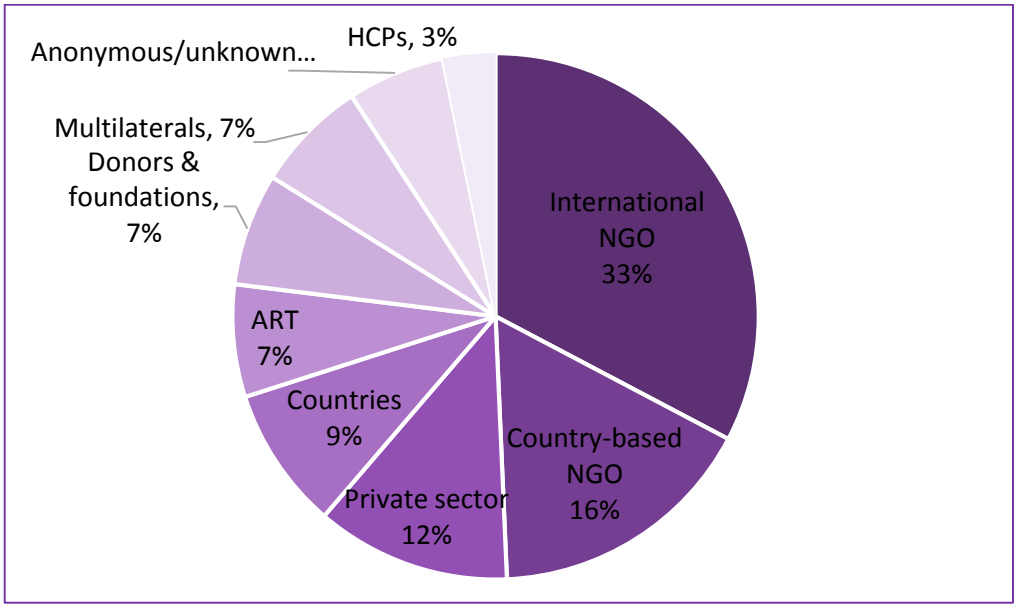
[8] Representing 120 staff across Save the Children's global network

[9] This response does not reflect the views of either USAID or the technical team leads' home organisations

A.3 Additional Events in support of the overall consultation process

Event	Participants
African stakeholder interviews[10]	6
Beijing +20 Review Asian Parliamentarian forum	30
Beijing+20 Review (Asia) CSO forum	15
Beijing+20 Review Africa CSO side event	42
Commission on Information and Accountability (CoIA) for Women's and Children's Health, GFF Working Group session	70
ICPD Berlin	25
Ministerial Conference on CRVS in Asia and the Pacific, Bangkok	350
PMNCH Board Retreat	24
RHSC meetings in Mexico City	325
Partners in Population and Development (PPD), 11th Inter-Ministerial Conference on Population and Development, Delhi	26
World Bank Webinar	100
Youth Google Hangout on the GFF	4

A.4 Demographics of Survey Respondents



[10] These were interviews with the following: Mr. Ousmane Ouedraogo Burkina Council of NGOs, CBOs and Associations against HIV/AIDS, Burkina Faso; Dr. Folquet Amorissani Madeleine, Ivory Coast Pedriatric Society, Ivory Coast; Mr. Sidiki Koné, Ministry of Youth and Education, Mali; Mr. Hamidou Diarra, Malian National Federation of community health associations; Mr. El Hadj Ide Djermakoye, Niger Network of health organizations and association, Niger; Mame Mbayame Dione, MP & Health Commission, National Assembly, Senegal; Mrs. Fatoumata Maiga Dicko, Francophone African Midwives Federation

APPENDIX B: CONSULTATION SURVEY

The questions of the online survey in support of updating the Global Strategy for Every Woman Every Child are reproduced below for reference:

Developing an updated Global Strategy

1. What lessons can we learn from the Millennium Development Goals and the Global Strategy for Women's and Children's Health (2010-2015)? What worked well, and what could have worked better?
2. What are the top three priorities you would like to see in a Global Strategy for Women's, Children's and Adolescents' Health for the post-2015 era?
3. What are the best ways to consult with stakeholders on developing an updated Global Strategy?

Global Financing Facility (GFF) Goals, Principles and Objectives

4. The GFF has five major objectives, as listed below. Please rate these objectives in terms of which you find most important (5= very, 1=not at all):

Objective 1: Finance national RMNCAH scale-up plans and measure results

Objective 2: Support countries in the transition toward sustainable domestic financing of RMNCAH

Objective 3: Finance the strengthening of civil registration and vital statistics systems

Objective 4: Finance the development and deployment of global public goods essential to scale-up

Objective 5: Contribute to a better-coordinated and streamlined RMNCAH financing architecture

5. Are there potential objectives currently missing from the concept note that should be addressed? If so, please specify
6. More specifically:

i. In relation to Objective 4 (Finance the development and deployment of global public goods essential to scale-up): Please rank the proposed global public goods and services in terms of which should be prioritised by the GFF (5 = high, 1 = low):

a) Research and development

b) Disease surveillance

c) International norms and standard setting

d) Market shaping to ensure sustainable access to key commodities

e) Technological developments that simplify delivery

f) Innovations in the delivery services (e.g. task shifting)

g) Impact assessments

h) Supply chain management coordination

i) Other (please specify)

ii. In relation to Objective 5 (Contribute to a better-coordinated and streamlined RMNCAH financing architecture): What role do you think that the GFF should play in this?

iii. The concept note mentions that the GFF will support multi-sectoral approaches to RMNCAH. Please rank the proposed sectors in terms of which should be prioritised by the GFF and any that should not be addressed at all (5 = high to 1 = low; 0 = not address at all):

a) Climate change	b) Education	c) Energy	d) Gender
e) Human rights	f) ICT	g) Infrastructure	h) Livelihoods
i) Nutrition	j) Rule of law	k) Social protection	l) WASH

Other (Please specify)

iv. The GFF will not have unlimited resources, so there is a trade-off between funding health services/ health systems and funding other sectors (nutrition, water, sanitation etc). What percentage of GFF resources should be channelled towards multi-sectoral approaches (from 0-100%):

a) 0-25%　　b) 25-50%　　c) 50-75%

d) 75-700%　　e) Other (please specify)

Financial Sustainability and Accountability

7. The GFF focuses on the financing gaps in a set of 63 target countries that together account for 92% of maternal deaths and 87% of child deaths. Additionally, some funding will be available to Lower middle income countries (LMICs) even when they graduate to Upper middle income (UMIC) classification. According to this information, how would you rate the following statements (5 = fully agree, 1 = fully disagree)

    a) The GFF should be targeted to fewer countries with the greatest burden

    b) The proposed GFF targeted countries is the right balance and the selection criteria for countries is adequate

    c) The GFF should be targeted to all 75 high-burden countries under the Countdown to 2015 initiative

    d) The 77 International Development Association (IDA) World Bank eligible countries (59 IDA only and 18 blend countries plus India which is receiving transitional support)

    e) Other (please specify)

8. Considering that many of the countries with the highest burden of maternal and child deaths are fragile or conflict-affected states, how do you think the GFF should be supportive in these contexts?

9. Please order the following challenges to achieving optimal global financing for women's, children's and adolescent's health from the most important (1) to least important (5):

    a) Absolute amount of global funding is insufficient

    b) Absolute amount and sources of domestic financing for health is insufficient

    c) Global funding goes to the wrong countries (not those most in need) or is earmarked for the wrong needs

d) Poor coordination and a lack of harmonisation between global funding bodies leads to both duplication and gaps

e) Poor coordination between international partners and countries inhibits funding flows and wastes resources, creating gaps and duplication

Global Financing Facility Mechanics and Functionality

10. In considering how the GFF will operate once it is launched, what elements can the business plan help to explain and clarify? What operational components of the GFF need to be clearer?

11. What are potential strengths/advantages for implementation?

12. What do you think about the GFF's proposals for accountability? Is there an example of good accountability that the GFF should emulate? What are the most important elements of an accountability mechanism?