

Strengthening the Global Financing Architecture for Reproductive, Maternal, Newborn and Child Health: Options for Action

An independent analytical report commissioned by:
The Partnership for Maternal, Newborn and Child Health

Prepared by:



In association with:



12 October 2011

Disclaimer

This report was commissioned by the Partnership for Maternal, Newborn and Child Health (PMNCH), and prepared by SEEK Development, Strategic and Organizational Consultants, in association with the Global Health Group at the University of California, San Francisco. The report was discussed at the 11th PMNCH Board meeting in Paris on October 25–26, 2011, and feedback from this meeting was incorporated in the final version. The views expressed are those of the authors alone. Neither SEEK Development, nor PMNCH accepts any liability in relation to use by any third party of the analysis, findings or conclusions contained in this report.

Authors:

Christina Schrade
Marco Schäferhoff
Gavin Yamey
Emil Richter

Contact details:

 **SEEK**
development
C. SCHRADER | STRATEGIC AND ORGANIZATIONAL CONSULTANTS

Käthe-Niederkirchner-Str. 23
10407 Berlin, Germany
www.seekdevelopment.org

Acknowledgements

The authors would like to acknowledge the support received from the PMNCH secretariat, James Droop of DFID, Helga Fogstad and Ingvar Theo Olsen of Norad, and Ann Starrs of Family Care International. They would also like to thank the interviewees, the PMNCH Board, as well as WHO's Department of Health Systems Financing, which kindly provided data for the cost-impact analysis.

Table of Contents

Abbreviations	3
Executive Summary.....	4
CHAPTER 1: Analyzing the RMNCH Financing Architecture: Aims, Methods, and Approach	9
1.1 Aims of the analysis	9
1.2 Methods	9
1.3 Approach	10
1.4 Data limitations.....	10
CHAPTER 2: Tracking Progress Towards Improving RMNCH: Disease Burden, Intervention Coverage, and Underlying Determinants of Maternal and Child Mortality	11
2.1 Progress towards the health MDGs and causes of maternal, neonatal and child deaths	11
2.2 Gaps in coverage with evidence-based interventions	14
2.3 Country barriers to improving maternal and child health	16
CHAPTER 3: RMNCH Financing Flows and Resource Requirements	18
3.1 International financing for RMNCH	18
3.2 Domestic financing for RMNCH in Countdown countries	21
CHAPTER 4: The Global Health Financing Architecture for RMNCH	22
4.1 Introduction	22
4.2 Who funds RMNCH?	22
4.3 Misalignment between RMNCH financing flows and needs: is the financing architecture to blame?	25
4.4 The road to the global strategy—assessment of recent efforts to enhance the volume and effectiveness of RMNCH financing	28
CHAPTER 5: Options for Strengthening the Financing Architecture for MDGs 4 and 5	35
5.1 Approach to option development and assessment	35
5.2 Presentation of options	35
CHAPTER 6: Option Assessment	42
CHAPTER 7: Conclusions and Recommendations	49
APPENDIX 1: Key informants interviewed	52

APPENDIX 2: Semi-structured questionnaire	55
APPENDIX 3: Estimated impact of different RMNCH packages upon mortality	56
APPENDIX 4: Coverage of key RMNCH interventions tracked by Countdown to 2015	57
APPENDIX 5: Cost-effectiveness of RMNCH interventions	58
APPENDIX 6: Mapping of Options for Strengthening the RMNCH Financing Architecture Discussed in the Literature	61
APPENDIX 7: Method for Calculating the Costs and Health Impacts of the Options	63
REFERENCES	64

Boxes

Box 1: The Health Systems Funding Platform (HSFP)	29
Box 2: Core functions to be undertaken by H4+ agencies based on comparative advantages	31

Figures

FIGURE 1: Steps of analysis	9
FIGURE 2: Progress towards MDGs 4 and 5	12
FIGURE 3: Causes of maternal and child deaths, based on the most recent estimates from the Countdown to 2015 decade report	13
FIGURE 4: Integrated RMNCH packages supported by PMNCH	14
FIGURE 5: Country barriers to improving RMNCH	16
FIGURE 6: Commitments to HIV/AIDS, reproductive health (RH), and nutrition compared to total health ODA (1995–2009)	18
FIGURE 7: Multilateral financing for Rmnch in 2008	22
FIGURE 8: Bilateral financing for RMNCH in 2008	23
FIGURE 9: The road to the Global Strategy	28
FIGURE 10: Options “staircase”	36
FIGURE 11: Assessment framework for RMNCH architectural options	42

Tables

TABLE 1: The health MDGs and the health-related MDG on nutrition	11
TABLE 2: Countries with the highest number of maternal and child deaths	13
TABLE 3: Three key gaps in coverage across the continuum of care	15
TABLE 4: Investment priorities of the largest bilateral donors to RMNCH	24
TABLE 5: Largest multilateral financing channels for global health	27
TABLE 6: Operationalization of assessment categories	42
TABLE 7: Summary assessment of options to improve the global aid architecture for RMNCH	50

Abbreviations

AMC:	Advanced Market Commitment	IMCI:	Integrated Management of Childhood Illnesses
AMFm:	Affordable Medicines Facility-malaria	ITN:	Insecticide-Treated Net
ANC:	Antenatal Care	JANS:	Joint Assessment of National Strategies
ARV:	Antiretroviral Therapy	LIC:	Low-Income Country
AU:	African Union	M&E:	Monitoring and Evaluation
CCM:	Country Coordinating Mechanism	MBB:	Marginal Budgeting for Bottlenecks Tool
CGD:	Center for Global Development	MDG:	Millennium Development Goal
CMR:	Child Mortality Rate	MHTF:	Maternal Health Thematic Fund
COIA:	Commission on Information and Accountability for Women's and Children's Health	MIC:	Middle-Income Country
CRS:	Creditor Reporting System	MMR:	Maternal Mortality Ratio
C-SECTION:	Caesarean Section	NGO:	Non-Governmental Organization
DALY:	Disability-Adjusted Life Year	NORAD:	Norwegian Agency for Development Cooperation
DFID:	United Kingdom Department for International Development	OECD:	Organisation for Economic Cooperation and Development
DRC:	Democratic Republic of the Congo	OECD-DAC:	OECD's Development Assistance Committee
ERG:	Expert Review Group	ODA:	Official Development Assistance
EU:	European Union	PMNCH:	Partnership for Maternal, Newborn and Child Health
GAVI:	GAVI Alliance	PMTCT:	Prevention of Mother-to-Child Transmission of HIV
GDP:	Gross Domestic Product	PPH:	Postpartum Hemorrhage
GHI:	United States Global Health Initiative	RH:	Reproductive Health
GLOBAL FUND:	Global Fund to Fight AIDS, Tuberculosis and Malaria	RMNCH:	Reproductive, Maternal, Newborn, and Child Health
GLOBAL STRATEGY:	Global Strategy for Women's and Children's Health	SBA:	Skilled Birth Attendant
GPRHCS:	Global Program to Enhance Reproductive Health Commodity Security	SRH:	Sexual and Reproductive Health
HLTF:	High Level Taskforce on Innovative International Financing for Health Systems	SSA:	Sub-Saharan Africa
HNP:	Health, Nutrition, and Population	SUN:	Scaling Up Nutrition
HSFP:	Health Systems Funding Platform	TA:	Technical Assistance
HSS:	Health Systems Strengthening	TFR:	Total Fertility Rate
IBRD:	International Bank for Reconstruction and Development	UK:	United Kingdom
IDA:	International Development Association	UN:	United Nations
IFFIM:	International Finance Facility for Immunization	UNAIDS:	Joint United Nations Programme on HIV/AIDS
IHME:	Institute for Health Metrics and Evaluation	UNFPA:	United Nations Population Fund
IHP+:	International Health Partnership and Related Initiatives	UNICEF:	United Nations Children's Fund
		UNSG:	United Nations Secretary General
		US:	United States
		USAID:	United States Agency for International Development
		WHO:	World Health Organization

Executive Summary

Key Messages at a Glance

Although significant progress has been made in the last decade towards the health MDGs, MDGs 4 and 5 (and indeed elements of MDG 6) will not be reached according to the latest projections. One reason is that the current global financing architecture for reproductive, maternal, newborn, and child health (RMNCH) may not be structured in a way that optimally facilitates the mobilization and channeling of financing and the rapid scale-up of RMNCH interventions. This report examines options for improving this aid architecture in order to accelerate progress towards MDGs 4 and 5.

Several initiatives have recently been launched aimed at addressing gaps and inefficiencies in the current architecture for RMNCH. These initiatives include the 2010 launch of the Global Strategy for Women's and Children's Health (Global Strategy). The Global Strategy and other recent efforts such as the International Health Partnership and the Health Systems Funding Platform are critically important, but they still leave weaknesses in the architecture, which could potentially delay the rapid implementation of the Global Strategy. Options for addressing these weaknesses, and thus strengthening the financing architecture, are therefore being considered by policymakers.

Based on stakeholder interviews, a comprehensive literature review, and original analysis, this report suggests that there are three major options (two of which have “sub-options”) to address these remaining gaps. The options build on each other and were assessed along the dimensions of strategic fit, cost, impact, and feasibility.

OPTION 1 would involve strengthening the coordination and division of labor between major multilateral funding channels and bilateral programs. It would also entail enhancing the implementation architecture for the Global Strategy at the global and country level and fully leveraging the funding mandates of existing multilateral financiers, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). A greater role for the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF) in financing and/or procuring RMNCH drugs could also be considered. While this option would be feasible and relatively low cost, it is unlikely to bring the necessary urgency, new resources, and leadership required to get close to reaching MDGs 4 and 5.

OPTION 2 would start with strengthening coordination, fully leveraging existing funding mandates, and improving accountability, but would also add a targeted, rapid scale-up initiative focused on opportunities for quick impact. **Option 2A** would provide pooled donor funding, via a multi-donor trust fund (likely to be at the World Bank), for RMNCH-related elements of jointly assessed national health plans, initially for five low-income countries (LICs) that have these plans in place. This option could be quickly implemented with potential for substantial impact in these five countries, but it may be hard to rapidly roll out this approach in a larger number of countries. **Option 2B** would focus on scaling up coverage of selected high impact, low coverage interventions (management of childhood illnesses, skilled birth attendance, and family planning) in a subset of LICs with the highest rates of maternal and child deaths (many of which are related to HIV/AIDS and malaria). Given the synergies of these interventions with current Global Fund investments, this initiative could be led by the Global Fund (but other mechanisms are also possible). This initiative could achieve even higher impact than Option 2A at similar cost. Under certain conditions, rapid roll out should be feasible.

OPTION 3 would go a step further still, creating a dedicated global funding channel. **Option 3A** would focus on a channel for RMNH only (with child health covered through existing financing arrangements). **Option 3B** proposes the creation of a fully integrated global funding channel for all health MDGs. The impact of both options on public health and aid effectiveness could eventually be very high. However, significant additional investments would be required, and feasibility of and political support for rapid implementation appear low at this time.

Based on this assessment, this report recommends that Option 2 should be pursued, which includes a combination of Option 1 with one (or a blend of both) of the two rapid scale-up initiatives. If implemented rigorously, this combination would allow the global community to capture opportunities for increased efficiency, streamlining, and accountability of the current system, while testing—on a smaller scale—two innovative, strategic, and potentially high-impact scale-up approaches.

Insufficient progress towards MDGs 4 and 5

While there has been a significant reduction in child deaths over the past decade, the world is still only half way towards reaching the target of cutting the child mortality rate (CMR) by two-thirds by 2015 (MDG 4). The neonatal mortality rate is falling more slowly than the CMR, and reducing the maternal mortality ratio (MMR) by three quarters by 2015 (MDG 5) appears out of reach for many countries, at this time. With regard to MDG 6, many countries are on track to halt by 2015 and beginning to reverse the spread of HIV/AIDS and of tuberculosis, but progress on malaria has been slower.

The vast majority of maternal, neonatal, and child deaths worldwide are avoidable: the causes are well described and are amenable to preventive and therapeutic interventions. Yet, there are a number of key gaps in coverage with these evidence-based interventions across the continuum of care. Coverage is low during childbirth and the neonatal period, when maternal/neonatal mortality is highest (e.g., there is low coverage with skilled birth attendants). Coverage of essential reproductive and sexual health interventions is similarly low, 22% of African women still have an unmet need for contraception. There is also low coverage of prevention and treatment of childhood pneumonia and diarrhea, which cause half of all child deaths outside the neonatal period, and of family planning. Scaling up coverage of these interventions will require overcoming country-level bottlenecks, particularly weak health systems and massive shortages of health workers. The challenges will be particularly acute in conflict-affected fragile states.

Financing for RMNCH

Scale-up also requires a vast increase in dedicated RMNCH financing. Yet, until very recently, improving the health of women and children was not a priority in international and domestic resource allocation relative to other areas (especially MDG 6). The Global Strategy for Women's and Children's Health (Global Strategy) estimates the resource gap at \$88 billion for the 2011–15 period for the 49 lowest-income countries, of which \$62 billion will be needed for health systems strengthening (HSS). In 2010, and again in 2011, stakeholders made significant financial, policy, and service delivery commitments to the Global Strategy that are starting to close this funding gap. However, even if a significant portion of these commitments was new and additional, a large

financing gap for RMNCH would persist. Bridging this funding gap will require a combination of increased international funding and increased domestic investment. Middle-income countries (MICs), in particular, should be able to mobilize sufficient domestic resources to finance their own RMNCH needs, whereas LICs will continue to rely on external funding. Donor support also needs to be less fragmented and better targeted at those countries with the highest burden of maternal and child deaths, most of which are in Sub-Saharan Africa and South Asia.

Weaknesses in the Current RMNCH financing architecture

The mismatch between RMNCH financing flows and needs can be explained by at least five features of the existing RMNCH financing architecture up to very recently:

1. **There has been no focused, coordinated approach to mobilizing and channeling resources for RMNCH.** This is in stark contrast to the highly focused approaches to funding MDG 6 (through the Global Fund and UNITAID) and immunization and vaccines (through the GAVI Alliance [GAVI]), which have raised and invested large amounts for intervention scale-up.
2. **Only a few bilateral donors have prioritized RMNCH and associated HSS sufficiently.**
3. **Family planning and reproductive health programs have suffered, particularly in recent years.** Although vital to the health of women, they were a low priority for many donors, and are particularly vulnerable to political trends. Family planning and reproductive health have only recently been put back firmly on the development agenda.
4. The lower priority placed on RMNCH was reflected in the **lack of a global mechanism to track RMNCH funding flows and results**; in recognition of this, the Commission on Information and Accountability for Women's and Children's Health (COIA) was set up, and its recommendations have the potential to address this gap. However, concerted efforts will now be needed to implement the Commission's recommendations, and to ensure that the independent Expert Review Group is able to fulfill its mandate.
5. There is **no consensus on how best to strengthen and measure the success of health systems to scale up RMNCH interventions.**

Emerging focus and recent initiatives

Fortunately, these issues have begun to garner global attention. A broad coalition of political leaders, civil society, the United Nations, health care professionals, academics and researchers, and private foundations and enterprises has made a concerted effort to place the health of women and children at the top of the development agenda. This process resulted in a host of new initiatives aiming to address the gaps and inefficiencies in financing RMNCH and associated HSS, culminating in the Global Strategy. The strategy's greatest achievement to date is the mobilization of high level political attention and significant financial, policy, and service delivery commitments for MDGs 4 and 5.

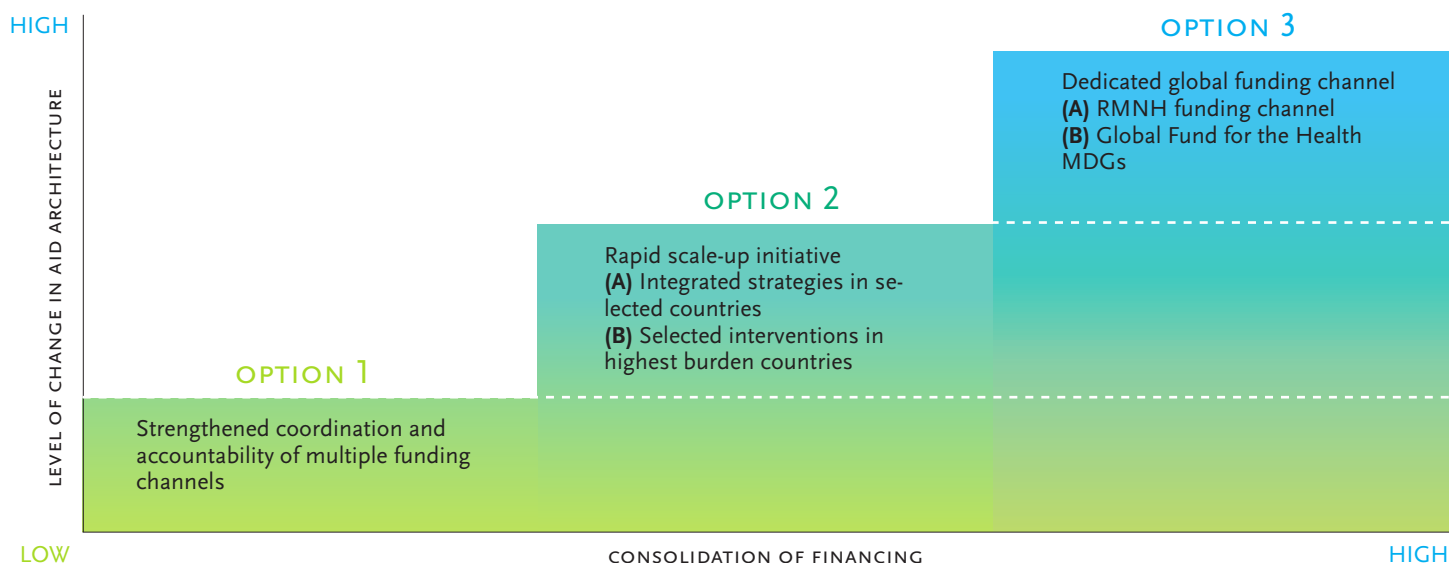
Other important initiatives include the International Health Partnership (IHP+). This initiative encourages LICs to develop long-term national health strategies as a way of harmonizing and aligning donor funding and strengthening health systems. The strategies are then jointly assessed by cooperating partners/donors, technical experts, and country stakeholders. While the IHP+ has successfully created a forum for country level dialogue between governments and donors on national health strategies, the initiative suffers from not being linked to a dedicated pool of funding for these jointly assessed national strategies. The new Health Systems Funding Platform, involving the Global Fund, GAVI, and the World Bank, is still in its early phase of implementation, and significant funding has not yet been realized. In addition, the IHP+ does not specifically focus on achieving rapid scale-up of RMNCH packages along the continuum of care. The other major harmonization initiative, the H4+, which brings together World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS),

UNFPA, UNICEF, and the World Bank to accelerate progress towards MDG 5, is promising, but also early in its implementation, so that its full impact is yet to be demonstrated.

While the recent mobilization around RMNCH is thus significant, it still leaves significant gaps and structural issues in the current financing architecture for RMNCH. For example, there are, to date, no clear implementation and accountability mechanisms (though it is hoped that the COIA follow-up will address this gap) to ensure that financial commitments are rapidly translated into action at the country level, nor is there a clear mechanism by which countries can quickly access additional RMNCH financing. These issues could potentially delay the rapid implementation of the Global Strategy.

Options for further improving the RMNCH financing architecture

In view of these issues, additional opportunities for further strengthening the RMNCH architecture should be considered by policymakers. Interviews with 55 decision-makers and stakeholders, some initial discussion by the PMNCH board, together with a review of the literature and original analysis, suggests that there are three major options (two of which have "sub-options") as shown in the figure below ("the options staircase"). The options can be described along two dimensions: (1) the level of consolidation of global financing for RMNCH implied by the option (a low level refers to highly diffuse financing, a high level refers to a highly centralized global financing approach); and (2) the level of change to the current aid architecture that would be required to successfully implement the option:



The framework used to assess the ‘business case’ for these institutional options considered four characteristics:

- A. the strategic fit between the business models, financing approaches, and comparative strengths of the option’s suggested lead institutions;
- B. cost;
- C. impact on maternal and child mortality; and
- D. the feasibility of actual implementation.

Application of this framework suggests that:

- Option 1 would be feasible and relatively low in cost. Fully exploiting the financing mandates of existing multilaterals, particularly of the Global Fund and the World Bank, and strengthening coordination and accountability between existing multilateral and bilateral financiers, could bring substantial benefits for the health of women and their children. A greater role of UNFPA and UNICEF in financing and/or procuring RMNCH drugs and commodities could also be beneficial for addressing existing supply gaps. However, while Option 1 represents a way forward, it is unlikely to bring the urgency, new resources, and strong leadership required to be a “game changer” in RMNCH.
- Option 2A, which would provide pooled funding for RMNCH-related elements of jointly assessed national health plans for five LICs that have these plans ready to go, could offer substantive impact at moderate to medium cost. However, given that the initiative focuses on funding gaps in jointly-assessed national strategies it may be challenging to roll out the initiative rapidly to a larger set of countries. The World Bank could be well placed to host the multi-donor trust fund suggested in Option 2A, and rapid implementation in the initial set of countries should be feasible.
- Option 2B, which would focus on scaling up selected high impact, low coverage interventions that are synergistic with existing funding platforms in the highest burden LICs, could potentially achieve even higher impact than Option 2A, and at a similar cost. This is because Option 2B strategically focuses on a subset of the highest burden countries and on

high impact, low coverage interventions. The initiative builds on and exploits significant synergies with existing Global Fund programs: the proposed interventions could easily be added to existing Global Fund programs (e.g., interventions targeting major childhood illnesses could be integrated with malaria programs) rather than being delivered vertically. The option would focus on a number of countries that have received limited donor attention to date. Given these existing synergies, it should be feasible to implement the initiative rapidly, subject to sufficient attention to the initiative being available in the context of the ongoing overall reform process at the Global Fund.

- A dedicated RMNH Funding Channel as suggested by Option 3A could have high impact on maternal and neonatal health. If hosted at the Global Fund, it could also show some important synergies with the Fund’s current portfolio and financing approach. However, start-up and program costs would be significant and, as discussed in Chapter 6, it is unlikely that there would be support for this initiative at this point in time.
- Option 3B, the expansion of the Global Fund’s mandate to take on all Health MDGs, could be potentially be very high impact, but would also be costly. In addition, rapid implementation is unlikely to be feasible due to ambivalence among key donors, in the current economic and financial climate, and lack of capacity at the Global Fund to take on such a significant expansion of its mandate, given various significant, and ongoing, reform efforts.

Conclusions and recommendations

Based on this assessment, this report concludes by recommending that **Option 2 should be pursued**. Option 2 is essentially a blend of Option 1 with one (or a combination of both) of the two rapid scale-up initiatives—Options 2A (pooled funding for jointly assessed national health plans, in 5 LICs) and 2B (pooled funding for high impact, synergistic interventions, in 12 highest burden LICs). If implemented rigorously, this would allow the global community to capture opportunities for increased efficiency, streamlining, and accountability of the current system, while testing—on a smaller scale—the potentially innovative and high-impact approaches offered by the rapid scale-up initiatives.

Option 2 promises a pragmatic, yet ambitious approach to strategically address the weaknesses in the current aid architecture for RMNCH and to contribute to the rapid implementation of the Global Strategy. Based on an initial analysis, Option 2B is likely to have a higher impact on RMNCH than Option 2A, as it focuses on scaling up packages of low coverage/high impact interventions in the subset of countries with the highest child and maternal mortality rates globally (many of which otherwise do not get sufficient donor attention). It

could also be attractive to test 2A in one set of countries (those with a strong, jointly assessed national health plan) and simultaneously test 2B in a different set of countries (the highest burden LICs without such plans).

Finally, the report recommends rapidly developing and testing the parameters of Option 2 (e.g., eligible countries, scope of financing, evaluation approach), gathering the necessary input and suggestions from key stakeholders, and exploring financial support with interested donors.

Chapter 1: Analyzing the RMNCH Financing Architecture: Aims, Methods, and Approach

1.1

Aims of the analysis

The Partnership for Maternal, Newborn and Child Health (PMNCH) commissioned an analysis of the RMNCH financing architecture aimed at helping to address these uncertainties. The specific remit was:

- To assess the degree of alignment between the burden of maternal and child mortality, the gaps in coverage with RMNCH interventions, the amount of funding for MDGs 4 and 5, and the way in which the aid architecture is organized to support these MDGs.
- To consider the extent to which recent commitments to women's and children's health are expected to increase coverage of key MDG 4 and 5 interventions in high burden countries and whether there is scope to improve the impact of these commitments.
- Based on these findings, to set out possible options and recommendations to address gaps and inefficiencies in the global aid architecture in order to accelerate progress on MDGs 4 and 5, while simultaneously providing good value for money and aligning with national efforts and plans.

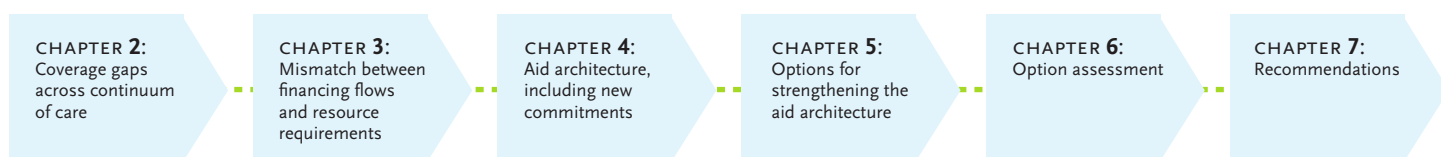
1.2

Methods

The analysis conducted for this report used a “mixed methods” approach, with two key components:

- A review of the published relevant literature on: progress towards the MDGs; evidence-based interventions (and “packages” of interventions) across the RMNCH continuum of care; coverage gaps and possible reasons for these gaps; financing flows to RMNCH; financing approaches and performance of key organizations in global health, including bilateral and multilateral donors; impact assessments of innovative approaches for scaling up of access to services; new commitments for improving the RMNCH architecture; and the debates on potential options for institutional realignment. The review included both the peer-reviewed literature as well as documents and reports published by global health foundations, think tanks, donor agencies, and non-governmental organizations (NGOs).
- 55 key informant interviews with decision-makers and stakeholders from donor organizations, recipient countries, civil society, United Nations (UN) organizations, and financing institutions (see Appendix 1 for an overview of the interview process). The interviews used a semi-structured questionnaire (Appendix 2).
- Quantitative analysis of OECD-DAC data, and WHO cost-impact data for assessing options to strengthen the global aid architecture for RMNCH.

FIGURE 1: Steps of analysis



1.3

Approach

This analysis used a step-wise approach, as shown in **FIGURE 1**.

The analysis begins, in **Chapter 2**, by examining global progress towards the health MDGs; the causes of the high burden of maternal, neonatal, and child deaths, most of which are avoidable using evidence-based biomedical interventions; gaps in coverage with these interventions across the continuum of care; and the underlying social and structural reasons for these gaps.

Chapter 3 assesses the degree of alignment, or misalignment, between global RMNCH financing flows and the resources needed to address the coverage gaps identified in Chapter 2. It includes an examination of whether or not financing is targeted to the highest-burden countries and whether donors are adhering to the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.

Chapter 4 examines the global health financing architecture to assess whether gaps and inefficiencies in this architecture are at the root of the misalignment between financing flows and needs identified in Chapter 3. The chapter focuses on the key RMNCH donors and their investment priorities, and also assesses the impact to date of recent initiatives, starting in 2007 and culminating in the Global Strategy, to improve the aid architecture for RMNCH.

Chapter 5 outlines institutional options for improving the aid architecture.

Chapter 6 assesses the “business case” for each of these options based on an analytical framework, taking into account the findings of Chapters 2–5.

Finally, **Chapter 7** lays out recommendations for strengthening the global aid architecture for RMNCH.

1.4

Data limitations

A recurring problem faced in this analysis was the large gaps in the underlying data. To give just two examples: (a) the tracking of RMNCH financing flows is patchy (e.g., as highlighted by the Commission on Information and Accountability for Women’s and Children’s Health, the tracking mechanism of the Development Assistance Committee of the Organisation for Economic Cooperation and Development (OECD-DAC) does not yet include a specific coding category for RMNCH), and (b) while there is widespread consensus that accelerating progress on MDGs 4 and 5 requires scale-up of “packages” of interventions, there is insufficient evidence on the efficacy and effectiveness of these different packages in reducing maternal and child mortality and there is also little available data on scale-up costs. These data gaps are indicative of the low status afforded to RMNCH to date within the global community.

Chapter 2: Tracking Progress Towards Improving RMNCH: Disease Burden, Intervention Coverage, and Underlying Determinants of Maternal and Child Mortality

2.1

Progress towards the health MDGs and causes of maternal, neonatal and child deaths

Significant progress has been made over the past decade towards the health MDGs, particularly the goal of halting and beginning to reverse the spread of HIV/AIDS, TB and malaria (MDG 6). While there has also been a significant reduction in child deaths, the world is still only half way towards reaching the target of cutting the child mortality rate (CMR) by two-thirds by 2015 (MDG 4). Progress towards improving maternal and newborn health has been slowest. With less than five years to go until 2015, the world is not even half way to reducing the maternal mortality ratio (MMR) by three quarters (MDG 5), and the neonatal mortality rate is falling more slowly than the CMR.

In the year 2000, all 189 UN member states signed the Millennium Declaration, which established eight MDGs and a series of time-bound targets by which progress can be measured. Three of these goals (MDGs 4–6) are specific to health, and MDG 1c is health-related (TABLE 1).

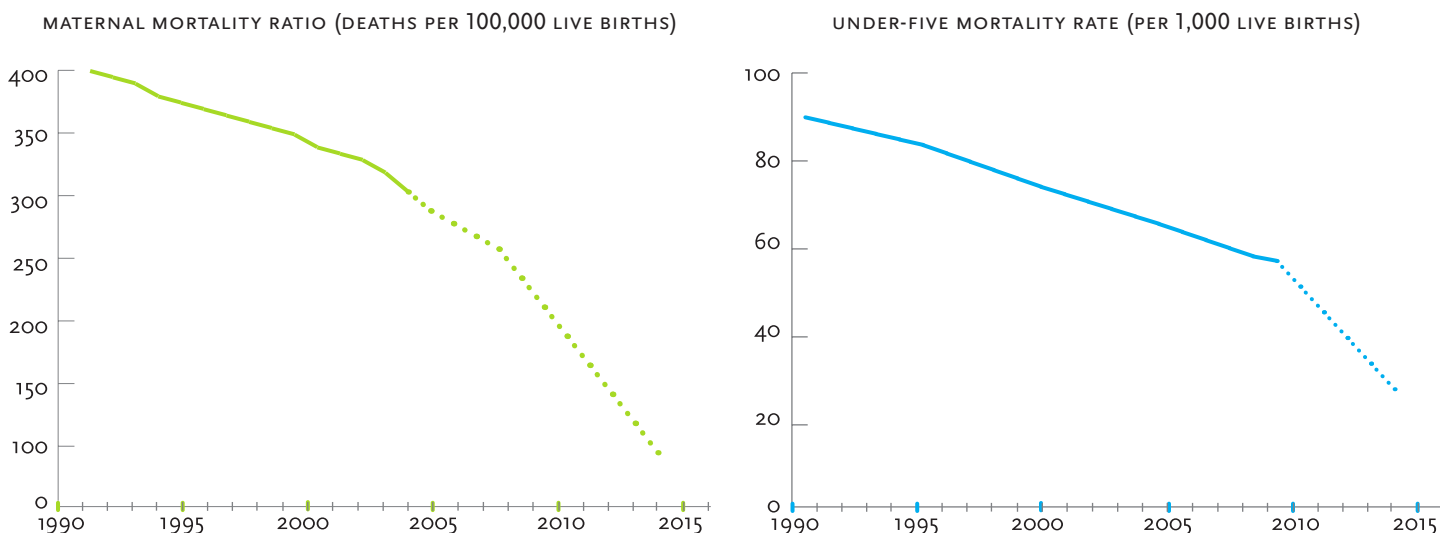
Many developing regions are on track to meet two of the **MDG 6** targets, 6A and 6C: three out of nine developing regions have reached or are within reach of halting by 2015 and beginning to reverse the spread of HIV/AIDS (6A), and seven out of nine regions have reached or are within reach of halting by 2015 and beginning to reverse the incidence of tuberculosis (6C).^{2,3} There has been only a small decrease in the annual number of malaria cases, from 233 million in 2000 to 225 million in 2009. Nevertheless, since 2000, eleven African countries have seen reductions of over 50% in the number of confirmed malaria cases or malaria admissions/deaths.²

Although maternal and child deaths have also fallen since 1990, progress towards **MDGs 4 and 5**, and particularly MDG 5, has been slower. The annual number of child deaths fell from 12.0 million in 1990 to 7.6 million in 2010, a reduction by more than one third in the CMR.^{4,5} Despite this significant progress,

TABLE 1:
The health MDGs and the health-related MDG on nutrition

Goal	Target
MDG 4: REDUCE CHILD MORTALITY	4A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
MDG 5: IMPROVE MATERNAL HEALTH	5A: Reduce by three quarters between 1990 and 2015, the MMR 5B: Achieve, by 2015, universal access to reproductive health (RH) ¹
MDG 6: COMBAT HIV/AIDS, MALARIA, AND OTHER DISEASES	6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
MDG 1: ERADICATE EXTREME POVERTY AND HUNGER	1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

FIGURE 2: Progress towards MDGs 4 and 5*



* Dotted lines show the accelerated rate of decline that would be needed to reach MDGs 4 and 5.

Source: WHO, UNICEF, UNFPA, World Bank: Trends in maternal mortality, 1990–2008; UNICEF: Levels and trends in child mortality 2011.

reaching MDG 4 would mean cutting the CMR by nearly another third by 2015 (FIGURE 2).² At the current pace, the CMR is falling too slowly to achieve this target.⁴

The challenges in reaching the health-related MDGs are even more pronounced for mothers and their newborns. Over a period of almost 20 years (1990–2008), the global MMR fell by only about one third, from 400 per 100,000 live births to 260 per 100,000 live births. This is less than half way to the MDG 5A target of 100 per 100,000 live births (FIGURE 2).⁶ At the current pace, the 2015 target of reducing maternal mortality by three quarters is out of reach.⁷

A major threat to reducing maternal, neonatal and child mortality is malnutrition and undernutrition, yet MDG 1c is also not within reach. In 1990, 20% of people went hungry; the MDG 1c target is to reduce this to 10% by 2015. Although the proportion fell to 16% in 2000–2002, it has now plateaued at this level. The proportion of children under 5 in developing regions who are underweight has fallen only very slowly (from 30% in 1990 to 23% in 2009). Neither SSA nor Southern Asia as a whole are on track to reach MDG 1c.² Southern Asia has the highest prevalence of childhood underweight in the world (43% in 2009), followed by SSA (22% in 2009).²

Sub-Saharan Africa (SSA) and Southern Asia have the world's highest rates of child and maternal mortality and of childhood under-nutrition, which contributes to one third of all child deaths.²

Almost all maternal, neonatal and child mortality (95%) is concentrated in 68 low- and middle-income countries.⁸ Countdown to 2015 tracks progress towards MDGs 4 and 5 in these 68 priority countries.⁹ Its latest report shows that only 19 out of the 68 countries are on track to reach MDG 4. Due to data limitations, the report does not include the number of countries that are on track to reach MDG 5 but it does show that 59 out of 68 Countdown countries experienced reductions in MMR between 1990 and 2008, and 33 of these countries achieved reductions in the MMR of at least 40% between 1990 and 2008. All nine Countdown countries with increases in MMR are in SSA and most of these are countries with a high HIV prevalence. However, a 2010 analysis by the Institute for Health Metrics and Evaluation (IHME) found that despite this overall progress only 23 out of all of the world's developing countries are on track to reach MDG 5.

The burden of child mortality remains highest in SSA and Southern Asia: a child in SSA has a 1 in 8 chance of dying

TABLE 2: Countries with the highest number of maternal and child deaths*

	Number of Maternal Deaths 2008	Number of Child Deaths 2009
INDIA	63,000	1,696,000
NIGERIA	50,000	861,000
DRC	19,000	465,000
AFGHANISTAN	18,000	191,000
PAKISTAN	14,000	423,000
ETHIOPIA	14,000	271,000
TOTAL	178,000	3,907,000

6 countries account for 50% of maternal deaths and for 51% of child deaths worldwide.

*Table excludes China.

Source: WHO, UNICEF, UNFPA, World Bank: Trends in maternal mortality, 1990–2008; UNICEF: Levels and trends in child mortality 2011

before her fifth birthday, almost twice the risk facing children in the developing world as a whole. The risk is 1 in 14 for a child in Southern Asia. Almost 9 in 10 (87%) of all maternal deaths are in SSA and Southern Asia, although the MMR

has fallen over twice as quickly in Southern Asia than in SSA. About 50% of child and maternal deaths are concentrated in just six countries, of which three (India, Nigeria, and Pakistan) are lower middle-income countries (TABLE 2).^{4,6} A number of the high burden countries have experienced recent civil conflict or political instability and have very high rates of poverty and undernutrition.

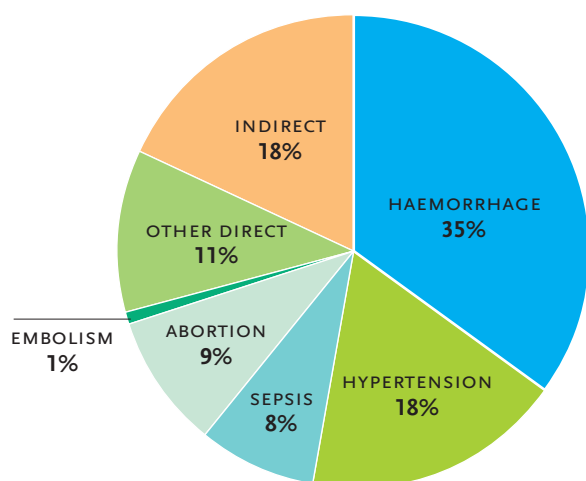
The vast majority of maternal, neonatal, and child deaths worldwide are avoidable—the causes are well described and are amenable to preventive and therapeutic interventions.

About four in five maternal deaths are from direct causes (see Figure 3, which shows causes of death from 1997–2007), particularly hemorrhage, high blood pressure, infections, and post-abortion complications, and one in five are from indirect causes (e.g., HIV, malaria, cardiac diseases).⁸ By far the most important cause of maternal deaths is hemorrhage, responsible for 35% of deaths—these deaths are largely preventable through appropriate care at childbirth. High total fertility rate (TFR) is a major risk factor for mortality, since it increases women’s exposure to the high risks of pregnancy and pregnancy-related death. TFR is highest in SSA, which also has the highest MMR.¹⁰

Pneumonia, diarrhea, and malaria account for 41% of all child deaths¹¹ (FIGURE 3, which shows child deaths in 2008)

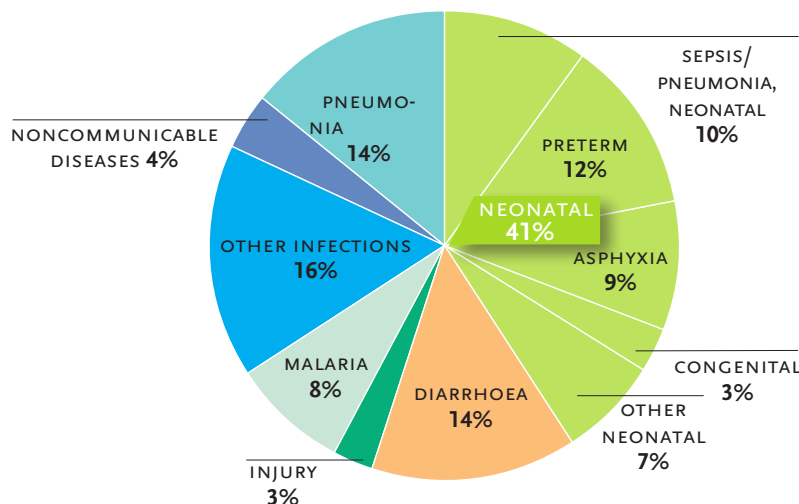
FIGURE 3: Causes of maternal and child deaths, based on the most recent estimates from the Countdown to 2015 decade report

GLOBAL CAUSES OF MATERNAL DEATHS, 1997–2007



Source: Countdown to 2015 Decade Report, 2010.

GLOBAL CAUSES OF DEATH AMONG CHILDREN AGES 0–59 MONTHS, 2008



Undernutrition contributes to one-third of child deaths.

and are responsible for 6 in 10 deaths outside the neonatal period.⁸ Over 40% of child deaths are in the neonatal period, and most of these deaths are from preterm birth, asphyxia, and sepsis/pneumonia. Most maternal and neonatal deaths occur during childbirth or the early postnatal period.

2.2

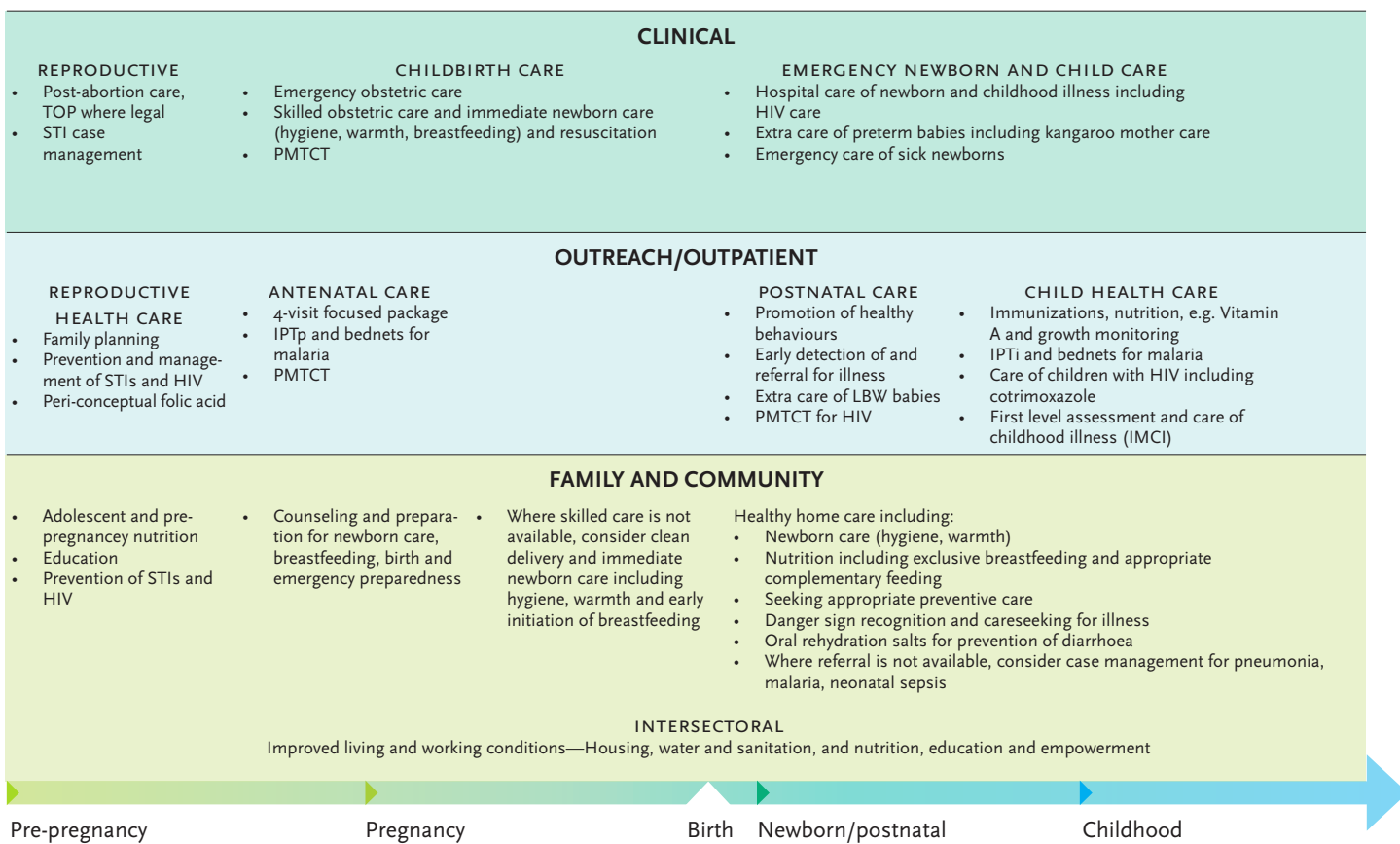
Gaps in coverage with evidence-based interventions

Within the continuum of care, there are three key gaps in coverage with integrated “packages” of evidence-based interventions. Coverage is low during child birth and the neonatal period, when maternal/neonatal mortality is highest. There is also low coverage of prevention and treatment of childhood pneumonia and diarrhea, which cause half of all child deaths outside

the neonatal period. A third major coverage gap is family planning. In contrast, coverage of key MDG 6 interventions that have an impact on women’s and children’s health has increased very rapidly in recent years.

While rapidly scaling up individual interventions remains an important strategy to reduce mortality (e.g., insecticide-treated bed nets [ITNs] reduce the risk of childhood deaths by 20%¹²), a more sustainable solution is to deliver integrated packages of multiple interventions. Packaging interventions benefitting women and children and providing these packages through a variety of different service delivery models, tailored to suit the existing health system, could feasibly maximize the use of available human resources and may be more cost-effective than delivering single interventions.¹³ PMNCH has championed the set of integrated RMNCH service delivery packages shown in **FIGURE 4**. The packages can be “built up incrementally according to local context and resources available.”¹⁴

FIGURE 4: Integrated RMNCH packages supported by PMNCH



Source: Kinney et al. (2010)

Packages of care, which contain a set of essential, integrated, and mutually reinforcing interventions, “address the needs of the mother, newborn, and child throughout the life cycle wherever care is provided: at home, the primary care level, and at district and regional hospitals.”¹³ While the impact of integrated packages on mortality has not been formally evaluated in randomized controlled trials, a review of the available literature suggests that:

- The highest impact is likely to come from scaling up the childbirth and child care packages (Appendix 3 summarizes the likely impact, in terms of averting deaths).¹⁵
- The lowest impact is likely to come from scaling up the antenatal care package (partly because baseline coverage is already high; see Appendix 4). The Lancet Maternal Survival Series steering group concluded that antenatal care

packages have only a “limited potential to affect maternal mortality ratios,”¹⁶ and Darmstadt and colleagues concluded that scaling up such a package would have a low impact on neonatal deaths.¹⁷ Nevertheless, antenatal care is seen as a core component of RMNCH because it provides an opportunity to provide other health services (e.g., HIV, TB, and malaria services) and to establish a positive relationship between women and their health providers.¹⁶

- The RH and postnatal care packages are likely to be of intermediate impact.¹⁵

Three gaps in coverage of key RMNCH interventions across the continuum of care (TABLE 3) help to explain the burden of avoidable deaths across this continuum (Appendix 4); current levels of financing are clearly inadequate for closing these gaps.

TABLE 3: Three key gaps in coverage across the continuum of care

Coverage Gap

CARE DURING BIRTH AND THE EARLY NEONATAL PERIOD

- Highest risk mortality period for mother/baby
- Low coverage with interventions, e.g. in 68 countdown countries, only 54% of women are attended by an SBA⁸

PREVENTION AND TREATMENT OF CHILDHOOD PNEUMONIA AND DIARRHEA

- In countdown countries, only 27% of children with pneumonia and 42% with diarrhea receive appropriate treatment
- Treatments can be safely delivered by CHWs¹⁸
- Coverage with diarrhea prevention (e.g., hand-washing, rotavirus vaccination) is very low¹⁹

FAMILY PLANNING

- Contraceptive prevalence rate is only 31% in countdown countries (rate in SSA is 22%)⁸
- About 1 in 4 women have an unmet need for family planning

Financing Gap

- Global campaign for the Health MDGs estimates additional program/HSS costs of scaling up quality facility birth care in 51 countries at \$2.4 billion in 2009, rising to \$7.0 billion in 2015 (total of \$33 billion would be required for 2009–2015)²⁰
- Over 50% would be for HSS (e.g. functioning health facilities, trained personnel)
- Additional program costs for postnatal care are estimated at \$216 million in 2009, and at \$552 million in 2015²⁰

- Global Strategy estimates the additional program costs to scale up IMCI in 49 countries at \$0.3 billion in 2011, rising to \$2.7 billion in 2015 (excludes costs for malaria treatment)

- Global Strategy estimates cost of scaling up comprehensive family planning in 49 lowest-income countries at an additional \$1 billion per year from 2011–2015

ABBREVIATIONS: CHWs, community health workers; HSS, health systems strengthening; IMCI, integrated management of childhood illnesses; SBA, skilled birth attendant.

These gaps in coverage are particularly unfortunate as they include interventions which WHO estimates to be amongst the most cost effective of all RMNCH interventions (community-based postnatal care, e.g. treating neonatal pneumonia; case management of pneumonia and diarrhea; and family planning; see Appendix 5). For example, a Center for Global Development (CGD) report argues that “family planning is often referred to as a ‘best buy’—it is one of the most inexpensive and cost-effective of all health interventions.”²¹

The accelerated progress towards MDG 6 shows what is possible when global attention and development assistance are focused on achieving results through aggressive scale-up of control tools. Although Countdown’s Decade Report, based on data up to 2008, still found large gaps in coverage with prevention of mother to child transmission of HIV (PMTCT) and ITNs for children,⁸ more recent data show that scale-up is on a rapid trajectory.^{22,23}

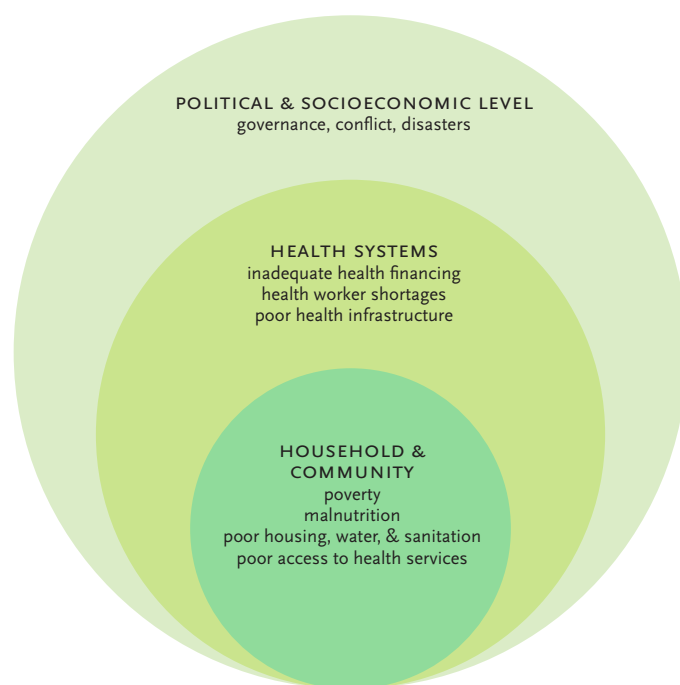
2.3

Country barriers to improving maternal and child health

Reaching MDGs 4 and 5 will be difficult without addressing the key underlying social and structural determinants of health at the country level, such as weak health systems (including shortages of skilled health workers) and political instability.

These underlying determinants hinder progress towards MDGs 4 and 5 through multiple, inter-connected pathways. For example, some determinants (e.g., health worker shortages) act as major barriers to scaling up RMNCH interventions, while others (e.g., lack of sanitation, malnutrition) increase maternal and child morbidity and mortality risk. The global burden of maternal, neonatal, and child deaths falls disproportionately upon SSA and Southern Asia in part because these regions show clustering of many of these determinants. The determinants can be broadly grouped into those acting at the household and community level; the health system level; and the wider socioeconomic and political level (FIGURE 5). They provide a glimpse of the complexity of the challenges involved at country level in improving the health of women and children.

FIGURE 5: Country barriers to improving RMNCH



Source: Countdown to 2015 Decade Report, 2010

Country Spotlight: Liberia's mortality trap

EXTREMELY HIGH MMR, TFR, IMR, AND CMR

Political/socioeconomic: Recent civil conflict

Health systems: Fewer than 3 doctors per 100,000 population

Household and community: Ranks 165th out of 172 countries on the Human Development Index

At the **household/community level**, poverty and gender discrimination are powerful predictors of child and maternal survival: poor households have over double the maternal and child mortality risk than that of wealthy households.² Poverty raises this risk through a variety of mechanisms, including malnutrition and food insecurity; poor housing, water, and sanitation (which increase the risk of many diseases, e.g., diarrhea); and poor access to, and limited demand for, health care services, due to geographic, cultural and financial barriers (e.g., user fees). High rates of female illiteracy and lack of income-earning opportunities for women also contribute to the “mortality trap”—for example, a mother’s low education level is a risk factor for child survival.²

At the **health systems level**, countries with high fertility and maternal and child mortality rates typically face a number of major systems challenges, creating gaps in the “home to hospital” continuum. These gaps include inadequate health financing; severe shortages of skilled health workers and managers; inadequate health care facilities, equipment, medicines, and other commodities; and poor ambulance services and roads. Countdown to 2015, which tracks health systems indicators, found that 53 out of the 68 Countdown countries are experiencing acute shortages of doctors, nurses, and midwives.⁸ Delivering essential health services requires at least 23 midwives, nurses, and doctors per 100,000 people, but only 29% of Countdown countries meet this requirement. Caesarean section (C-section) rates under 5% indicate that a country has inadequate access to emergency obstetric care services and suggests underlying health systems weaknesses. Countdown reports that 33 out of 51 countries that have data since 2000 had rural rates of C-section below 5% and 4 countries had rates below 1% (Niger, Ethiopia, Burkina Faso, and Chad).

At the broader **political and socioeconomic level**, factors such as the strength of national governance and political commitment, as well as conflicts and natural disasters, also have a powerful influence upon mortality rates. The World Bank examined the relationship between maternal mortality and “government effectiveness”²⁴ and found that high MMR-TFR countries rank consistently lower in government effectiveness than low MMR-TFR countries.¹⁰ Countries experiencing complex humanitarian emergencies also tend to have higher rates of maternal, neonatal, and child mortality.¹³ For example, several of the ten countries in sub-Saharan Africa with the highest death rates have recently experienced civil wars (e.g. Liberia, Sierra Leone, DRC).¹³ Improving RMNCH outcomes in these fragile states is clearly more challenging than improving such outcomes in a low-income country with a functioning government and a strong network of public and private health services. In conflict-affected fragile states in particular, the public health system is often severely damaged. Compared with more stable states, there is often a proliferation of poorly coordinated non-governmental organizations and vertical health projects.

Chapter 3: RMNCH Financing Flows and Resource Requirements

3.1

International financing for RMNCH

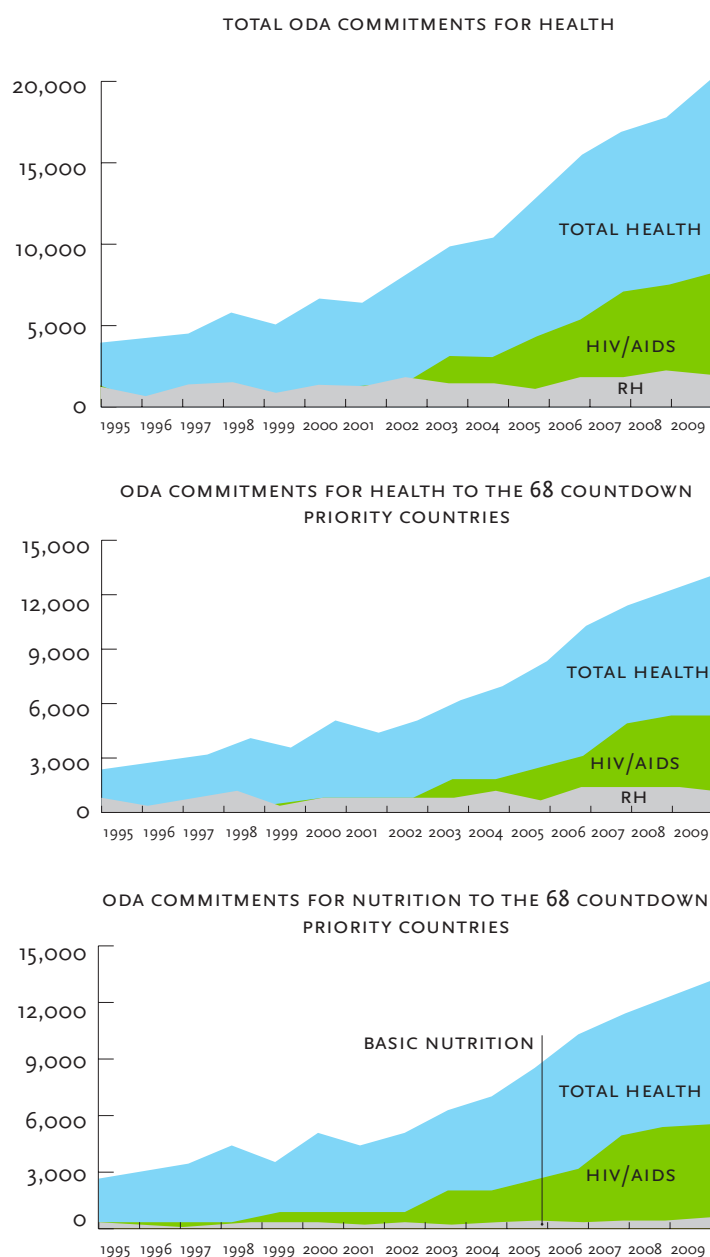
While international financing to RMNCH more than doubled in absolute terms in the 68 Countdown priority countries, the share of official development assistance (ODA) for health dedicated to RMNCH has remained constant since 2003. This indicates that improving the health of women and children has not been prioritized relative to other areas, most notably MDG 6.

A 2010 IHME report found that overall development assistance for health has risen dramatically, with donor disbursements increasing from \$5.3 billion in 1990 to \$23.8 billion in 2008 (and, according to preliminary data, to \$26.9 billion in 2010).²⁵ Much of this increase is related to funding for MDG 6. Funding for HIV/AIDS, TB, and malaria grew from 4.4% to 34.0% of all development health aid between 1990 and 2008, and funding for HIV/AIDS alone rose from 3% to 26% of total health aid in this period (from \$0.2 to \$6.2 billion).

Funding to RMNCH also increased, from \$0.95 billion in 1990 to \$3.1 billion in 2008. However, the share of RMNCH funding out of total development aid for health fell from 17% in 1990 to 13% in 2008 (this is partly explained by the very large rise in funding for HIV/AIDS; if this HIV/AIDS funding was removed from the analysis, the share of RMNCH funding out of total health aid would have been flat between 1990 to 2008). In more recent years (2003–2008), the share of funding for RMNCH remained relatively constant (12.5%–14.5% of total health aid).

While Countdown and IHME use different methods to estimate RMNCH funding²⁶, Countdown's analysis of donor spending arrives at a similar conclusion, showing that the ratio of RMNCH funding to official development aid (ODA) has remained relatively constant since 2003.²⁷ Countdown estimates that in the 68 Countdown priority countries, the actual amount of RMNCH funding rose by 120% between 2003 and 2008, from \$1.85 billion to \$4.08 billion.²⁸

FIGURE 6: Commitments to HIV/AIDS, reproductive health (RH), and nutrition compared to total health ODA (1995–2009)*



* RH includes population policy and administrative management, reproductive health care, family planning, personnel development for population and reproductive health. Source: OECD-DAC, Creditor Reporting System, 8 August 2011.

A separate analysis of OECD-DAC data conducted for this report shows that commitments to RH and nutrition grew much more slowly in the 1995–2009 period than total health ODA (FIGURE 6). As a consequence, the share of health ODA targeting RH fell in Countdown priority countries, from 25% in 1995 to 8.7% in 2009 (and from 30% to 10.1% in all developing countries). In the same time frame, the share of commitments to basic nutrition fell from 5.7% of health ODA to 2.4% in Countdown countries (and from 4.5% to 2.6% in all developing countries). HIV/AIDS commitments increased more than 30-fold in Countdown countries and by 20-fold in all developing countries.

Aid for family planning in particular has fallen steadily over the last two decades. As a proportion of total health ODA to all developing countries, funding for family planning fell from 8.2% in 2000 to 2.6% in 2009.³ On a per capita basis, aid for family planning has fallen in almost every recipient country. Disbursements to Countdown countries for family planning fell from \$723 million in 1995 to \$404 million in 2008.²⁹

Every year since 2003, child health expenditures accounted for more than two-thirds of all donor disbursements to RMNCH. Financing for RMNCH was largely allocated to integrated health projects, including health systems strengthening, MDG 6 interventions, and immunization.

Countdown's analysis shows that of the \$4.08 billion disbursed to RMNCH in 2008, 69.9% (\$2.85 billion) was spent on child health and 30.1% (\$1.23 billion) on maternal and neonatal health.

Nearly all donor support (91%) for RMNCH in 2008 went to funding specific health projects, rather than providing health sector support (7%) or general budgetary support (2%). Of all project aid, 30.6% went to integrated health projects (e.g., primary health care, hospital-based care, and HSS), 22.4% to MDG 6 interventions, and 19.7% to immunization. Only 10.4% of RMNCH project funds went to specific maternal and neonatal projects, 10.2% to broader RMNCH projects, and 2.4% to nutrition. Integrated Management of Childhood Illnesses (IMCI) is the only project type for which Countdown found a funding decrease, from \$8.5 million in 2003 to virtually no funding in 2008. However, this decline might be attributable to limitations in donor reporting.

Despite the overall increase in development assistance for RMNCH, there remains a massive funding gap, which the Global Strategy estimates at \$88 billion for the 2011–15 period just for the 49 lowest-income countries.³⁰ In addition to the funding gaps described earlier for care during childbirth, postnatal care, prevention and treatment of childhood pneumonia and diarrhea, and family planning, there is also a large financing gap for underlying health systems.

For the 2011–2015 period, the total additional program costs for RMNCH in the lowest-income countries amount to about \$25.5 billion, and the associated HSS costs amount to about \$62.4 billion. The Global Strategy estimates that family planning, maternal health, and immunization are the programmatic areas with the greatest need for additional finance (additional program costs ranging from \$4.9 to \$7.4 billion), with smaller gaps identified for HIV/AIDS, malaria, and IMCI (\$2.0 to \$2.7 billion).³⁰ Costing estimates created for the Global Campaign for the Health MDGs suggest that a large portion of the \$62 billion in RMNCH-related HSS costs (over 40%) is needed for interventions surrounding birth.²⁰

To have a major impact on the health of women and children, much more funding is required for improving countries' **health systems** both from domestic and international sources. Providing key RMNCH interventions depends on functioning health systems, and significant investments are needed to create and maintain the health infrastructure (e.g., construction of health facilities, functional referral systems) and to expand the skilled health workforce. The Global Strategy estimates that HSS costs related to the health of women and children amount to an additional \$62.4 billion in the 49 poorest countries from 2011 to 2015. Reaching MDGs 4 and 5 will require a major investment in training and deploying an estimated 2.6–3.5 million additional health workers (e.g., nurses, midwives, doctors, community health workers) by 2015.

On the positive side, sustained increased international and domestic funding has shown real impact in a number of areas along the continuum of care. Significantly increased coverage with key **childhood vaccines** has contributed to the fall in the CMR in recent years. There has also been significant progress towards the elimination of vertical transmission of HIV by 2015 through increased financing for **PMTCT**. The large rise

in funding for malaria control in recent years has supported aggressive scale up of control tools (e.g., ITNs, indoor residual spraying with insecticide) in many countries, which has been associated with large falls in the malaria burden.³¹

There are indications that targeting of donor financing to countries with a high burden of maternal and child mortality has improved, but donor support has still not been highly targeted to countries with the highest mortality rates. Funding for child health appears to be better targeted than funding for maternal and newborn health.

Countdown found that in 2008, countries with a greater need for funding (defined as higher maternal and child mortality and lower income levels) were more likely to receive more ODA per capita than countries with a lower need.²⁷ Countdown's analysis also indicates that the targeting of funding has improved over time: high mortality countries were increasingly likely to receive more ODA in the 2003–2008 period. However, a number of high-burden LICs (e.g., Chad, Niger) persistently received far less funding per capita than countries with much lower mortality rates and higher income levels. Funding for child health was better targeted to needs than was funding for maternal and newborn health. IHME found that 16 of the 20 countries with the highest maternal mortality in 2008 did not appear among the 20 countries that received the most health ODA between 2003 and 2008. IHME uses DALYs (disability-adjusted life years) attributable to diseases that impact RMNCH as an alternative measure for disease burden.²⁵ It finds that burden and funding volumes for RMNCH are not well matched. Measured by funding per DALY, several high-burden countries (e.g., Afghanistan) received funding that was disproportionately low compared to their needs, while a number of countries with much lower RMNCH-related DALYs and stronger economies (e.g., Turkey) received a much higher amount per DALY.

MDG 5 projects appear to be much smaller in scale than MDG 6 projects, an indication of higher fragmentation of aid to maternal health. RMNCH funding levels were highly unpredictable for many countries, including the poorest.

A recent study found that over half of all health projects exceeding \$10 million targeted HIV/AIDS, TB, and malaria over the 2002–2006 period, while only 9% of these projects focused on reproductive health and family planning, a proxy for MDG 5.³² Many small activities are likely to have high transaction costs for countries, and are more likely to suffer from lack of coordination between countries and development partners. Large activities are more likely to attract political attention at the country level.

The emergence of non-traditional donors (e.g. Brazil, China, and India), and their approach to channeling aid, appears to have added to the fragmentation of the international aid architecture and is a challenge to improving aid effectiveness. The 2011 OECD-DAC report on aid effectiveness raises serious concerns about the extent to which financial flows from non-DAC donors meet Paris Declaration principles. China and India are reported to be important health donors in Nepal, but they do not interact with traditional donors or involve themselves in aid coordination processes.

Countdown found that over the 2003–2008 period, several countries experienced sharp fluctuations in aid inflows to MNCH.²⁷ IHME's analysis found even higher volatility in year-to-year funding levels for MNCH, unlike the other focus areas in the IHME study. The volatility of aid and its short timeframes make it difficult to fund recurrent costs, particularly funding of primary health care facilities that are key to achieving RMNCH goals.³³

On a positive note, and in line with aid effectiveness principles, the proportion of RMNCH funding disbursed as grants, rather than as loans or credits, grew from 73.6% to 93% between 2004 and 2008. This change is mainly attributable to the World Bank's International Development Association (IDA), which increased the proportion of its funding disbursed as grants from below 10% in 2003 to over 30% in 2008.²⁷

3.2

Domestic financing for RMNCH in Countdown countries

Bridging the \$88 billion RMNCH funding gap will require a combination of increased international funding and increased domestic investment by Countdown countries. Middle-income countries (MICs) in particular need to expand domestic funding for RMNCH in line with their ability to pay. The expected GDP growth in MICs could generate sufficient domestic resources for these countries to finance their RMNCH needs without external assistance. While overall domestic health spending in LICs doubled between 1995 and 2006, given the size of the funding gap, it is likely that LICs will continue to rely on donor support. As such, increased government commitment to RMNCH financing will be required in the poorest countries to achieve further progress towards MDGs 4 and 5.

The Global Strategy estimates that the 68 Countdown countries allocated a total of \$58.5 billion in domestic financing to RMNCH in 2008.^{29,34} Most of this government funding came from MICs, with only about \$3.4 billion coming from the 49 poorest countries (donor support to these 49 countries amounted to \$3.1 billion in 2008).³⁵ If private, “out of pocket” expenditures are also taken into account, funding from national sources becomes even more significant, accounting for half or more of total RMNCH spending even in very LICs.³⁶

Based on estimates of growth in domestic GDP, and the assumption that this growth will translate into additional governmental RMNCH expenditures, the Global Strategy concludes that the governments of the 49 lowest-income countries will spend an estimated \$2.4 billion on top of current funding levels on RMNCH between 2011 and 2015. This amount is clearly insufficient to close the \$88 billion funding gap (of which \$62.4 billion is for HSS costs). Even if the poorest countries reallocate more of their own resources to RMNCH, they will continue to rely on donor funding. In contrast, the Global Strategy estimates that the governments of lower- and upper-middle income countries could spend as much as an additional \$59 billion for RMNCH between 2011 and 2015. The Global Strategy thus suggests that many MICs could mobilize enough domestic resources to finance their own RMNCH needs.

Estimates of domestic expenditure on RMNCH are currently unavailable, but a recent IHME report found that LICs and MICs have significantly increased their domestic government expenditures in recent years.³⁷ Domestic health spending doubled in LICs from \$7.96–\$9.03 billion in 1995 to \$17.81–\$18.07 billion in 2006. While this increase in domestic health spending is essential for achieving progress on RMNCH goals, IHME also found that health ODA given to LICs in sub-Saharan Africa is generally associated with these countries reducing their domestic spending on health. In other words, health ODA seems to be partially replacing domestic health expenditures instead of fully supplementing them. There were some exceptions (e.g., in Malawi, there was an association between increased health aid and increased domestic spending on health). But without increased investments by Countdown countries themselves, significant progress towards RMNCH cannot be achieved.

Chapter 4: The Global Health Financing Architecture for RMNCH

4.1

Introduction

The analysis presented in Chapter 3 found a mismatch between RMNCH financing flows and needs, which helps to explain the insufficient progress towards MDGs 4 and 5. Funding is also often not well targeted to address the three key gaps in coverage of interventions across the continuum of care: child-birth and the early neonatal period; prevention and treatment of childhood illnesses; and family planning.

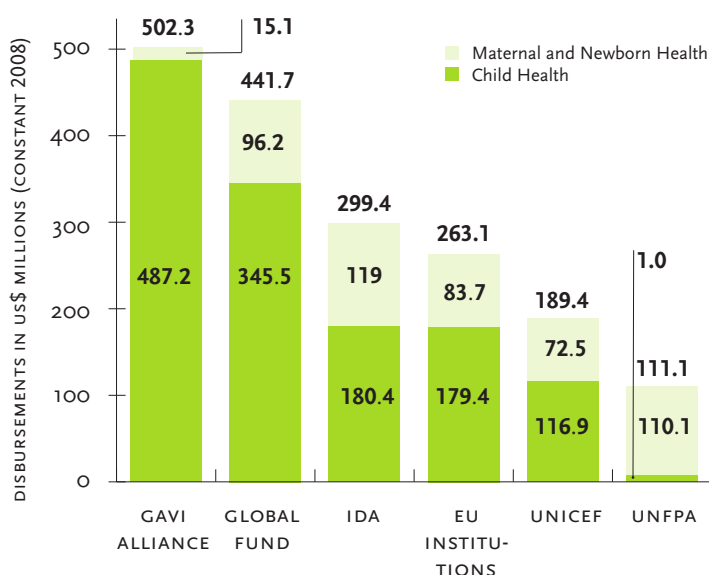
Why has this mismatch occurred? Chapter 4 examines the global health financing architecture to assess whether gaps and inefficiencies within it are at the root of this misalignment. The analysis particularly focuses on the key RMNCH donors and their investment priorities. It also assesses the impact to date of recent initiatives, starting in 2007 and culminating in the Global Strategy, to improve the aid architecture for RMNCH.

4.2

Who funds RMNCH?

The United States (US), the United Kingdom (UK), the GAVI Alliance (GAVI), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) were the main drivers of increases in volumes of RMNCH financing in the 2003–2008 timeframe. Other bilaterals (e.g., Canada, Norway) also substantially increased their financial contributions to RMNCH and are key driving forces behind the RMNCH agenda. Aid flows from the IDA to RMNCH fell between 2005 and 2008. Although comparable estimates on private donors are currently unavailable, it is safe to argue that the Bill & Melinda Gates Foundation is one of the largest RMNCH donors in the world.

FIGURE 7: Multilateral financing for RMNCH in 2008*

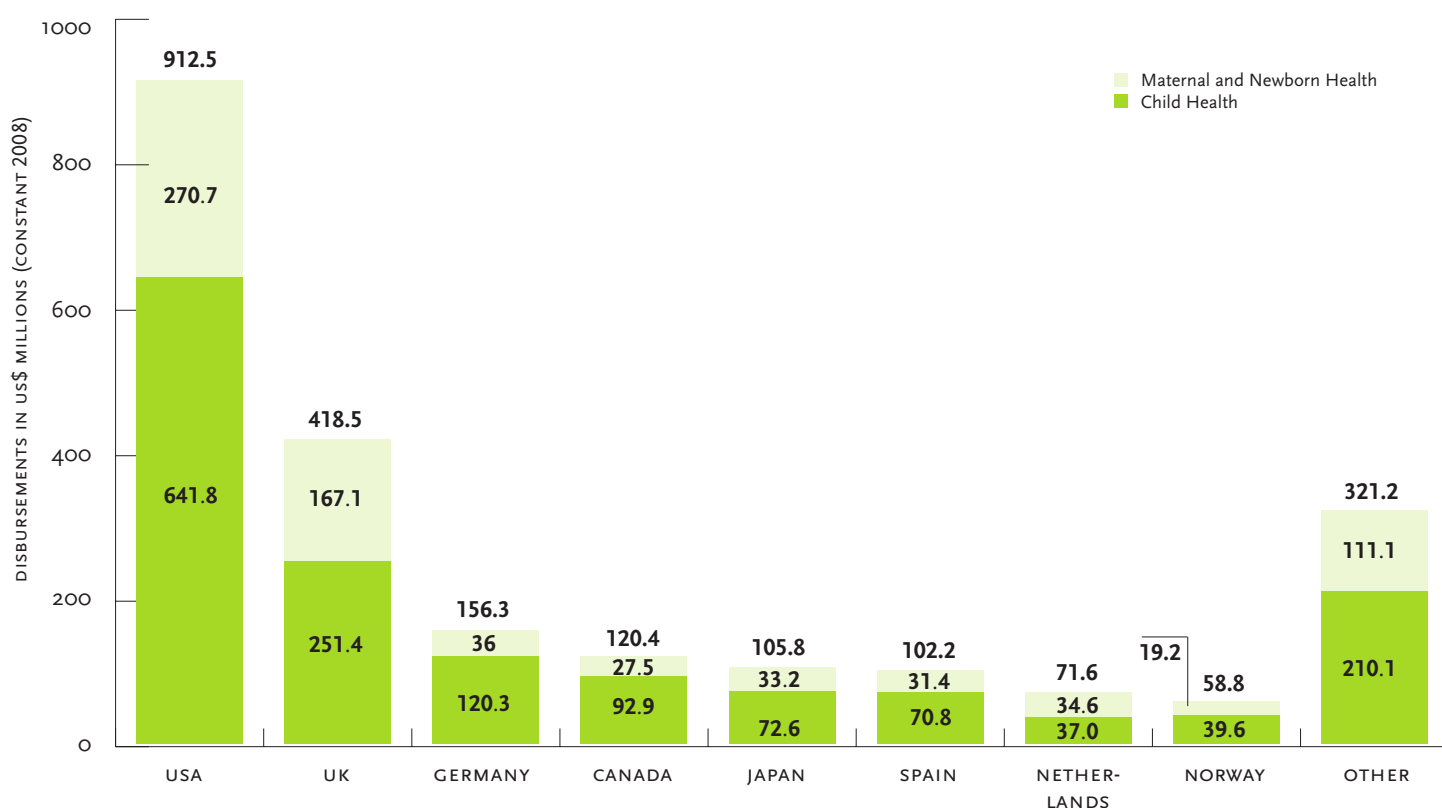


* Pre-pregnancy activities such as family planning are excluded. UNITAID and regional development banks are not included.
Source: Pitt et al. (2010).

Countdown estimates that just over half (55.6%) of the \$4.08 billion disbursed to RMNCH in the 68 Countdown countries in 2008 was bilateral funding, while 23.2% came from the Global Fund and the GAVI Alliance, and 21.2% from the World Bank and UN organizations.²⁷ While Countdown gives no breakdown of the funding that bilateral donors provide to relevant multilateral channels (such as the GAVI Alliance), TABLE 4 (on page 24) shows how much key bilaterals provide to multilaterals in addition to their bilateral support.

FIGURE 7 shows the breakdown of multilateral financing to RMNCH (excluding pre-pregnancy activities) in 2008 as reported to the OECD DAC and analyzed by Countdown. Of the multilateral financers, the GAVI Alliance and the Global Fund increased their RMNCH disbursements by a factor of nearly five between 2003 and 2008 (reaching disbursements of \$944 million in 2008). The two organizations more than doubled their share of total RMNCH disbursements in this time frame, from 10% to 23.2%.

FIGURE 8: Bilateral financing for RMNCH in 2008*



* Pre-pregnancy activities such as family planning are excluded.
Source: Pitt et al. (2010).

Although the traditional multilateral institutions (IDA, United Nations Children’s Fund [UNICEF], United Nations Population Fund [UNFPA], and the European Union [EU] institutions) also increased their financial contributions to women’s and children’s health between 2003 and 2005, their contributions then stagnated between 2005 and 2008. Accordingly, their share of overall RMNCH disbursements fell from 37.5% in 2003 to 21.2% in 2008.³⁸

Countdown found that bilateral aid to RMNCH increased by 136% in the 2003–2008 period, from \$962 million to \$2.3 billion. Eight donors accounted for 86% of all bilateral disbursements to RMNCH in 2008 (FIGURE 8). Bilateral donors have traditionally prioritized child health over maternal and neonatal health.

The US and UK governments stand out as by far the largest bilateral contributors (60% of all bilateral disbursements to RMNCH in 2008) in addition to their substantial contributions to multilateral financing channels for health. The next largest donors are the governments of Germany, Canada, Japan, and Spain. TABLE 4 outlines the investment priorities of these bilateral donors.

The “Point Seven” countries (the Netherlands, Norway, Sweden, Ireland, Denmark, and Luxembourg) and other smaller bilateral donors, including Belgium, also made important and increasing bilateral contributions to RMNCH between 2003 and 2008.²⁷ Some of them are also key financiers of GAVI and the Global Fund. Norway, together with Canada, is a key driver of the RMNCH agenda, and plays a major role in the coordination of global efforts to reach MDGs 4 and 5.

Although there are no global estimates of the contributions of private donors (e.g., foundations) to RMNCH, the Bill & Melinda Gates Foundation is one of the world’s largest donors to RMNCH. Its total contribution to global health amounted to \$13 billion between 1999 and 2010. This includes direct contributions to countries and research and policy institutions⁴² as well as major contributions to multilateral channels. Total pledges from the foundation to GAVI amount to \$2.5 billion (for 1999–2015), and pledges to the Global Fund total \$1.2 billion (for 2002–2015).

TABLE 4: Investment priorities of the largest bilateral donors to RMNCH

Donor	Chief Focus Areas	Support for Multilaterals	RMNCH Financing and Trends
UNITED STATES	<ul style="list-style-type: none"> HIV/AIDS and malaria US Global Health Initiative (GHI) aims to provide \$63 billion to global health from 2009–2014, of which HIV/AIDS and malaria programs are slated to receive 81% Congressional approval of the total \$63 billion appears unlikely: even if Congress approves the \$9.8 billion requested for the GHI for FY 2012, only 53% of the \$63 billion would have been spent between 2009–12³⁹ 	<ul style="list-style-type: none"> Largest donor to the Global Fund (total pledges of \$9.5 billion) Supports GAVI (total pledges of \$1.1 billion for the 2001–2014 period) 	<p>GHI disbursements in 2010 (\$8.9 billion total): 63% to HIV/AIDS, 13% to Global Fund, 8% to malaria, 12% to RMNCH (including nutrition), 3% to TB, 1% to other areas.³⁹</p> <p>From 2003–2008:²⁷</p> <ul style="list-style-type: none"> Countdown data suggest an increase in total funding for child health (\$223.1 million to \$641.8 million) and for maternal health (\$36.7 million to \$270.7 million) <p>From 2001–2008:³⁹</p> <ul style="list-style-type: none"> Share of total global health funding channeled to MCH fell from 17% to 6%; share channeled to family planning/RH fell from 21% to 5% (in absolute terms, funding for family planning/RH grew from \$376 million to \$396 million, and funding for MCH rose from \$295 to \$450 million) Share channeled to HIV and malaria increased from 50% to 87%, from \$760 million to \$5.5 billion (excluding Global Fund pledges)
UNITED KINGDOM	Strategic priorities are malaria, RMNH, HSS, HIV/AIDS, nutrition	<ul style="list-style-type: none"> Leading government donor to the GAVI Alliance, with total pledges of \$4.4 billion for 2011–2030. Between 2001–2010, the UK contributed over \$311 million to GAVI (\$137 million in direct contributions, \$152 million to IFFIm, and \$22 million to AMC) Third-largest donor to the Global Fund (total pledges of \$2.2 billion) 	<p>2008:⁴⁰</p> <p>37% of bilateral UK aid for health was spent on HSS, 8% on MNH, 6% on RH, 22% on HIV/AIDS, 16% on other infectious diseases (especially malaria), 7% on health research, and 4% on other areas</p> <p>From 2003–2008:²⁷</p> <ul style="list-style-type: none"> Funding for MNH grew \$36.7 million to \$167.1 million Funding for child health grew from \$158.5 million to \$251.5 million
GERMANY, CANADA, JAPAN, SPAIN	<ul style="list-style-type: none"> Germany has prioritized HSS, HIV/AIDS, sexual and reproductive health rights Canada has prioritized RMNCH in its health portfolio (62% of its total bilateral support was channeled to RMNCH in 2007).⁴¹ While the funding focus was more on child health between 2006–08,⁴¹ Canada's Muskoka commitments (\$1.1 billion) are largely geared towards maternal health Japan has prioritized HSS, MNCH with a focus on child health, HIV About 50% of Spain's health aid was spent on RMNCH in 2007⁴¹ 	<ul style="list-style-type: none"> Germany, Japan, and Canada are among the eight largest donors to the Global Fund. Spain is a significant Global Fund donor Canada is a leading donor to GAVI 	<p>2008:²⁷</p> <ul style="list-style-type: none"> Together, the four donors accounted for 21.4% of total bilateral aid to RMNCH

4.3

Misalignment between RMNCH financing flows and needs: is the aid architecture to blame?

Five features of the existing financing architecture for the MDGs can help to explain the poor alignment between RMNCH financing flows and needs. First, there has been no focused, coordinated approach to mobilizing and channeling resources for RMNCH and associated HSS until very recently. This is in stark contrast to the highly focused approaches to funding MDG 6 (through the Global Fund) and vaccination (through GAVI), which have been very successful at raising large amounts of funding for intervention scale-up. Second, donor governments have not sufficiently prioritized RMNCH and associated HSS in their funding, channeling much of their funding to MDG 6. A similar pattern can be observed when it comes to domestic health funding. Third, family planning and reproductive health programs vital to the health of women fell off donors' radar and have only recently been placed back on the development agenda. Fourth, the low priority given to maternal and child health until very recently was reflected in the lack of a mechanism to track RMNCH flows. Finally, there is no overarching consensus on how best to strengthen health systems to scale up RMNCH interventions.

Lack of a focused, coordinated approach to financing RMNCH

A dominant theme in the key informant interviews conducted for this report was that the slow progress towards MDGs 4 and 5 can be explained in part by the lack of a focused, coordinated approach to financing RMNCH. There are a variety of reasons why such an approach has not been adopted. There has not been the kind of strong, aligned, vocal civil society movement for RMNCH that has been seen for HIV/AIDS and, more recently, for malaria.⁴³ Nor has RMNCH been high on the political agenda, particularly compared with infectious

diseases. HIV/AIDS, as a threat to rich countries' security, has garnered far more attention, even so far as to be the subject of a UN Security Resolution in 2000 (the first time that the UN Security Council debated a health issue).⁴⁴ Furthermore, while there is now relatively widespread consensus on how to control HIV/AIDS, TB, and malaria, for a long time there was little consensus and a great deal of debate (often acrimonious⁴⁵) on how best to reduce maternal, neonatal, and child deaths. Improving RMNCH is complex and multi-faceted, much more so than tackling a single infectious disease. And, as shown in Chapter 3, funding for RMNCH interventions to date has often been piecemeal, with many different donors financing services and associated HSS through projects that were often small-scale and duplicative.

This lack of a dedicated and coordinated approach to financing RMNCH is in stark contrast with the highly focused approaches to funding MDG 6 (through the Global Fund) and vaccination (through GAVI), which have been very successful at raising large amounts of funding for intervention scale-up. GAVI has effectively scaled up vaccination coverage levels, and the Global Fund has dramatically increased coverage of key HIV/AIDS, TB, and malaria services. GAVI is a key contributor to MDG 4, and the Global Fund has positive "spillover effects" for MDGs 4 and 5 through funding key RMNCH interventions across the continuum of care (e.g. PMTCT, ITNs) and related HSS.

The gap in financing for HSS—particularly large-scale, long-term financing to build and maintain health infrastructure and pay health worker salaries—has serious consequences for RMNCH. While the Global Fund has significantly invested in health and community systems to enable better access to health services, its HSS investments have been largely specific to Global Fund target-diseases.⁴⁶ GAVI's HSS funds have also mainly been used for downstream support to overcome service delivery constraints (those that were impeding vaccine delivery and maternal and child health services) rather than for upstream support (e.g., sector reform and restructuring).⁴⁷ While both organizations have made contributions to HSS beyond immunization and the three Global Fund target-diseases, these have focused on upgrading health facilities and training existing health workers and community health workers, rather than on large capital investments in infrastructure or in training new skilled health personnel.

The World Bank, the third major multilateral financier of global health (along with the Global Fund and GAVI), has not stepped up to fill this void. Instead it has also placed a strong focus on communicable diseases, particularly HIV/AIDS,

which accounted for 43% of all of the Bank's health, nutrition, and population (HNP) commitments in the 2002–2006 period.⁴⁸ Until very recently, support to RH, HSS, and nutrition received much less attention. Furthermore, Bank support for HSS was largely directed towards MICs, rather than LICs.

There are a range of other multilateral funding channels for RMNCH within the UN system (e.g., UNFPA, UNICEF, and UNITAID) and beyond (the EU institutions, regional development banks⁴⁹), but all of them are too small-scale to fill the identified gaps (TABLE 5).

Donor governments have not sufficiently prioritized RMNCH

Although overall bilateral aid for maternal and newborn health almost tripled between 2003 and 2008, and doubled for child health (albeit from a low starting point), only a few bilateral donors have prioritized RMNCH within their global health budgets. The world's largest global health donor, the US government, allocates the lion's share of its bilateral global health financing to MDG 6 (HIV/AIDS in particular), while a much smaller share is channeled to MDGs 4 and 5. Two government donors that *have* prioritized RMNCH in their bilateral support to countries are the UK and Canada. Some bilaterals have also committed additional funding for HSS. In 2009–10, the UK, Australia, Norway, and the Netherlands pledged around \$900 million over 10 to 20 years to expand the International Finance Facility for Immunisation (IFFIm) to enable new HSS investments through GAVI.⁵⁰ The UK has also made other significant investments in HSS, but overall funding levels from bilateral donors still fall far short of HSS needs.

Family planning and reproductive health have fallen off the radar

Over the last decade, from 2000 to 2009, the proportion of health ODA spent on family planning services and supplies fell sharply, from 9.2% to 2.6%, suggesting that family planning was a low priority for donors.² The proportion spent on RH care (excluding family planning) also fell, from 8.2% to 6.0%. Tables 4 and 5 show the investment priorities of specific multilateral and bilateral donors—a lack of attention to RH and family planning is a recurring theme. Within the US budget for health, the share of total global health funding channeled to family planning/RH fell from 21% to 5% between 2001 and 2008 (in absolute terms, US funding for family planning/

RH remained flat; see Table 4).³⁹ RH and family planning also became less of a focus in the World Bank's health portfolio (TABLE 5).

The low priority of RMNCH is reflected in the poor tracking of RMNCH financing flows

A reflection of the relatively low priority placed on child and maternal health is that international tracking and ODA accountability structures within the OECD Creditor Reporting System (CRS) database do not include a category for maternal and child health.⁵¹ When donors report to the CRS database, they must choose a specific “purpose code” for their projects. CRS has 17 purpose codes for health (e.g., malaria control) but no discrete category for maternal and child health. This has presented a challenge to Countdown in trying to estimate how much donors were spending on maternal and child health and has made it difficult to track if donors are living up to their commitments. These gaps—and ways to address them—have recently been highlighted by the Commission on Information and Accountability for Women's and Children's Health (see section 4.4 below).

Lack of technical consensus

Another challenge in the financing of RMNCH is that there are diverging views on how to best strengthen health systems to meet the MDGs.⁵² This lack of clear consensus is a problem for three reasons. First, the RMNCH costing work has been hampered by a disagreement about the best methodology used to estimate the financing needs. Second, and more importantly, to scale up services, countries require guidance through internationally agreed standards. Third, the diverging views on HSS have created problems for impact assessment and for creating consensus around one results framework.

An example of these diverging views is the different sets of costing approaches used by WHO and the World Bank to calculate the costs and health impact of scale-up for the High Level Taskforce (HLTF) on Innovative Financing for Health Systems Strengthening. These approaches led to dramatically different cost estimates: WHO estimated that \$251.4 billion of additional funding would be needed between 2009 and 2015 to reach the health-related MDGs, whereas the World Bank estimated that \$111.6 billion would be required.⁵²

TABLE 5: Largest multilateral financing channels for global health

Multilateral Channel Support for RMNCH

GAVI	<ul style="list-style-type: none"> • By scaling up vaccines, key contributor to MDG 4 (commitments of \$5.9 billion up to 2015) • Financing window for HSS to deliver immunization and related MNCH services (commitments totaled \$568.1 million by end of 2010) • Disbursements of \$487.2 million to child health and \$15.1 million to maternal and newborn health in 2008²⁷
GLOBAL FUND	<ul style="list-style-type: none"> • Focuses on MDG 6: provides a fifth of all international financing for HIV/AIDS and around 60% for TB and malaria • Contributes to MDGs 4 and 5 by providing RMNCH interventions (e.g., condoms, PMTCT) and through HSS investments • Disbursements of \$441.7 million to MNCH in 2008²⁷
WORLD BANK	<ul style="list-style-type: none"> • Largest funder of RMNCH among the traditional multilaterals • RMNCH disbursements from IDA fell steadily from \$597.4 million to \$299.4 million between 2004 and 2008²⁷ • Share of RH commitments in overall health portfolio fell from 18% in 1995 to below 10% in 2007¹⁰ • Lending for family planning or for reducing high fertility accounted for only 4% of the health portfolio in the last decade, dropping by two-thirds between the first and second half of the decade¹⁰
UNICEF	<ul style="list-style-type: none"> • Increase in RMNCH disbursements from \$85 million in 2003 to \$189 million in 2008, two-thirds of which are allocated to child health²⁷ • Interventions supported include malaria treatment, ITNs, nutrition (e.g., vitamin A, promotion of exclusive breastfeeding), IMCI, immunization, community-based care, and support of children affected by HIV/AIDS • Focus on self-implemented projects (a different model to those of the financing instruments above)
UNFPA	<ul style="list-style-type: none"> • Only multilateral that spends more on MNH than on child health (in 2008, \$110 million on MNH and \$1 million on child health)²⁷ • However, RMNCH disbursements fell by \$36.9 million per year in the 2003–2008 period²⁷ • Focus on RH, supporting programs to promote safe pregnancy and childbirth, family planning, and the sexual and reproductive empowerment of women • Second largest funder of contraceptives after USAID (\$81.1 million out of \$238.8 million)
EU INSTITUTIONS	<ul style="list-style-type: none"> • Increase in RMNCH disbursements by a mean of \$42.8 million per year from 2003–2008 (total disbursements of \$263 million in 2008)²⁷ • Funding delivered through budget support (25% of all EU aid between 2003 and 2008), grants, and contracts
UNITAID	<ul style="list-style-type: none"> • Focus on MDG 6 (scaling up access to treatment for HIV/AIDS, TB, and malaria by negotiating price reductions for diagnostics and medicines and accelerating the pace at which these are made available) • Largest funder of pediatric HIV/AIDS drugs, funding three in four of all children on antiretroviral therapies (ARVs) globally • Other major financing areas: PMTCT, ITNs, and support for multidrug-resistant TB • Mobilized \$1.3 billion in funding for MDG 6 interventions, from 2007–2010

4.4

The road to the Global Strategy—assessment of recent efforts to enhance the volume and effectiveness of RMNCH financing

Many of the problems outlined above—the lack of a coordinated approach for mobilizing and channeling RMNCH financing, the insufficient levels of political attention towards RMNCH, and the resulting lack of progress towards MDGs 4 and 5—have begun to garner global attention. A broad coalition of political leaders, civil society, the United Nations, and private foundations and enterprises has made a concerted effort to place the health of women and children at the top of the development agenda. The process culminated in the Global Strategy in September 2010 (see FIGURE 9).

A first step on the road to the Global Strategy was the launch of the International Health Partnership and Related Initiatives (IHP+) in September 2007, which marked a renewed focus on health systems and the need to improve aid effectiveness (FIGURE 9). IHP+ was also involved in the creation of the HLTF, launched in September 2008, to lay out recommendations for mobilizing and channeling financing for health systems. Concurrently, WHO, UNFPA, UNICEF, and the World Bank made a joint announcement to intensify support to countries to achieve MDG 5. The group was nicknamed the “H4,” and it became the “H4+” when UNAIDS joined the initiative in July 2010. Focusing on 25 high-burden priority countries, the main objectives of the H4+ are to improve

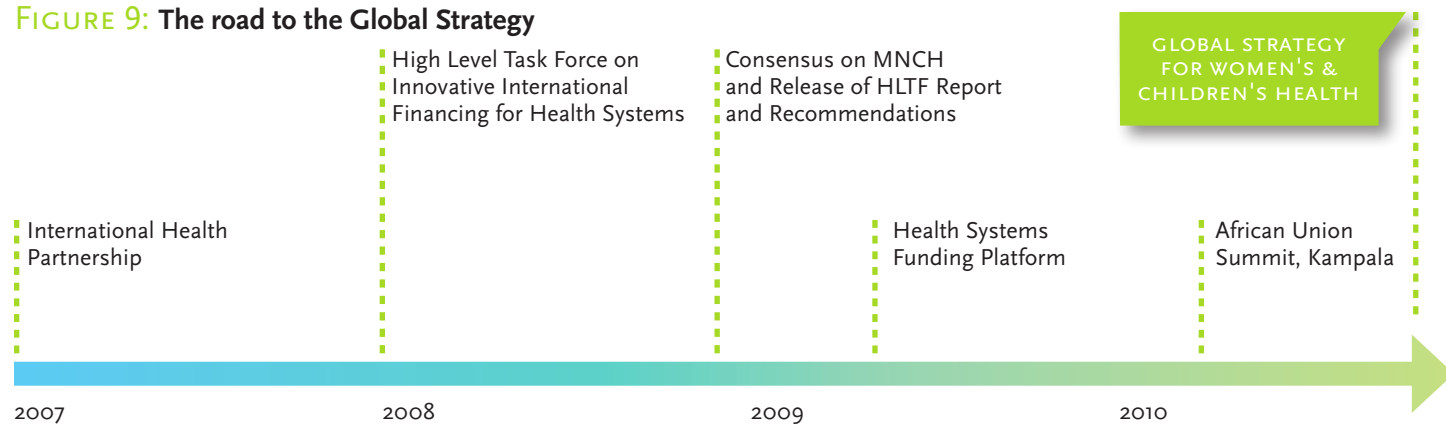
coordination at the country level and jointly raise the required resources (the H4+ is discussed in further detail below).

The HLTF presented its recommendations—including the creation of a joint Health Systems Funding Platform (HSFP) by GAVI, the Global Fund, and the World Bank—at a special session of the United Nations General Assembly in September 2009 (Healthy Women, Healthy Children). Concurrently, the Global Consensus on Maternal, Newborn and Child Health was announced, setting out key actions needed to achieve MDGs 4 and 5 and asking for contributions of \$30 billion to save the lives of over 10 million women and children by 2015 in the 49 lowest-income countries.

In April 2010, UN Secretary General Ban Ki-moon officially launched a global effort on women’s and children’s health in New York, following a meeting with 40 global leaders to help define a collective strategy for women’s and children’s health in the lead-up to the MDG Summit in September 2010. This strategy built on regional commitments and efforts, such as the Maputo Plan of Action and the Campaign on Accelerated Reduction of Maternal Mortality in Africa that was launched by the African Union (AU) in May 2009. There were two more milestones before the Global Strategy was eventually launched. At the G8 Muskoka Summit in July 2010, leaders of the G8 countries and other partners committed \$7.3 billion of additional funding for MNCH. And at the August 2010 AU meeting, AU heads of state adopted the “African Union Summit Declaration 2010 for Actions on Maternal, Newborn and Child Health,” and committed to strengthening their efforts to improve RMNCH. African leaders also appealed to donors of the Global Fund to extend the Global Fund’s mandate to child and maternal health.

In September 2010, the process culminated in the Global Strategy. The strategy aligned, for the first time, all actors

FIGURE 9: The road to the Global Strategy



relevant to financing and delivering RMNCH services around a single strategic approach linked to significant financial, policy, and service delivery commitments to achieve MDGs 4 and 5. In May 2011, 16 low-income and lower-middle income countries made additional financial and service delivery commitments to advance the Global Strategy. Seven countries committed to significantly increase their domestic health budget over the next years (to 12–15% of the overall government budget).

Placing a renewed focus on health systems and RMNCH? The International Health Partnership and the Health Systems Funding Platform

While the IHP+ has managed to create a forum for country level dialogue between governments and donors on national health strategies, it suffers from not being linked to a dedicated pool of funding for jointly assessed national strategies. To date, this funding is not being provided through the HSFP. Together with a resource-strapped secretariat, this has severely limited the impact of IHP+. Furthermore, while the broad

strengthening of health services and systems promoted by IHP+ should eventually also benefit RMNCH, a special focus on achieving rapid scale-up of RMNCH packages along the continuum of care within national health strategies is needed.

The **International Health Partnership and Related Initiatives (IHP+)** was initiated in 2007 by the UK's Prime Minister Gordon Brown, embracing related initiatives by Canada, France, Germany and Norway.⁵³ The IHP+ encourages LICs to develop comprehensive and integrated long-term national health plans as a mechanism to harmonize and align donor funding and to strengthen health services and systems. The vision for IHP+ was that these plans would increase country ownership and reduce aid fragmentation and associated transaction costs. In addition, once these plans were jointly assessed by donors, technical experts, and country stakeholders, they would inspire donor confidence and lead to significantly increased funding for HSS (an "aid orphan"). It was expected that this support for HSS, in turn, would also benefit the health of women and children.

To mobilize attention and financing towards HSS, key partners in IHP+, under the leadership of DFID, launched

Box 1: The Health Systems Funding Platform (HSFP)

OBJECTIVE

- Streamline HSS financing from existing funding organizations, particularly from the Platform financing partners: GAVI, the Global Fund and the World Bank (the HSFP is not a new global fund for HSS, nor does it involve pooling of HSS funding at the global level)

OPERATION

- Countries can only request funding for HSS interventions consistent with the mandates of Platform partners
 - Global Fund*: countries will be able to apply for funding for "cross-cutting" HSS interventions (those that contribute to improved outcomes related to two or all of the three target diseases)
 - GAVI*: HSS interventions need to be linked to immunization outcomes
 - The World Bank*: will continue to cover the full range of HSS support—but it provides loans not grants and has difficulties in creating demand for its health support
- Joint GAVI/Global Fund application forms for crosscutting HSS will be used to reduce transaction costs in the design/assessment of HSS funding requests
- Platform partners will finance JANS in 4–5 countries in 2011 (financing national health plans has become a standard GAVI

policy for providing HSS support; the Global Fund is funding health strategies on a pilot basis; the World Bank is committed to including the results of the JANS in its assessment of country applications)

FUNDING

- Three governments (Australia, Norway, and the UK) have pledged almost \$1 billion to the HSFP through an expanded IFFIm, which will be channeled through GAVI and will provide about \$475 million for GAVI's HSS programs between 2011 and 2015
- An additional \$515 million through 2022 is available from the Health Results Innovation Trust Fund (with a specific focus on women and children) at the World Bank
- Total funding for the HSFP falls very short of the estimated \$122 billion required for HSS in 49 LICs between 2011 and 2015 to reach MDGs 4–6 (of which an estimated \$62 billion is needed for RMNCH)
- Lack of funding for the Platform is aggravated by the Global Fund's financing gap
- It is unclear how much the World Bank will spend on HSS—the amount depends on country demand and on IDA's resource allocation system

the **High Level Taskforce on Innovative International Financing for Health Systems (HLTF)** at the UN Millennium Development Summit in 2008. Chaired by Gordon Brown and Robert Zoellick, the Task Force worked to identify the challenges and costs of HSS and new sources of finance to help countries achieve the health MDGs. Its recommendations, announced in 2009, reiterated support for country-led national health plans to make the allocation of existing and additional funds in countries more efficient. To ensure proper financing of these plans, the Task Force recommended setting up a joint **Health Systems Funding Platform (HSFP)** between GAVI, the Global Fund, and the World Bank (coordinated by WHO) and announced new commitments of \$5.3 billion.

The HSFP was launched in 2009. **BOX 1** shows its objectives, operation, and funding to date. The Platform has the potential to improve aid effectiveness and reduce transaction costs for funders and HSS recipients—including through harmonized application for HSS support, joint financing of national health strategies, and harmonized fiduciary and monitoring and evaluation frameworks.⁵⁴ However, its operationalization to date also points to at least three important constraints:

First, the HSFP is not a new global fund for health systems, nor does it involve pooling of HSS funding at the global level. Countries will only be able to request funding for HSS interventions that are consistent with the mandates of Platform partners (see **BOX 1**).

Second, while the Platform has the potential to improve aid effectiveness, its institutional arrangements remain complex, oriented around existing organizational structures of all three partners, and hard for countries to navigate. While joint GAVI and Global Fund application forms for crosscutting HSS were created to reduce transaction costs relating to HSS funding requests, all three agencies will continue to approve funding separately. Programs will also be managed separately, but can be based on a common fiduciary and M&E framework. GAVI introduced a rolling channel for approving HSS proposals to improve alignment with country cycles. The Global Fund has not yet complemented its rounds-based channel with a more flexible approach for HSS, which makes it difficult to leverage the full potential of the joint application process. The World Bank has committed to including the results of the jointly assessed national strategies (JANS) in its project appraisals.

Finally, as shown in **BOX 1**, the HSFP is under-financed. A pressing issue in this context is the future role of the Global Fund in supporting HSS related to MDGs 4 and 5. Based on

recent guidance from its Board, the Global Fund will only be supporting HSS interventions that are directly contributing to improved outcomes for least two (or all three) of its target diseases. Furthermore, the Global Fund Board decided in December 2010 that the Fund should not venture further into MNCH because this would divert resources from the original underfunded mandate. Instead, countries were encouraged to explore increased synergies between MNCH and HIV, TB, and malaria control in Round 11. Currently, the Global Fund is undergoing a process of reconsidering its overall strategy, in the context of which the scope of its mandate and its role in MNCH and HSS is again being examined. Several interviewees also mentioned that GAVI will likely move back to a narrower focus on immunization in its HSS funding. The resulting lack of funding for the HSFP has led to a situation in which the HSFP has not yet become what it could still be: a strong source of un-earmarked funding for the HSS components in JANS.

For countries going through the process of developing their national strategies and undergoing a joint assessment under the IHP+, it is thus still unclear “who is the postbox” for requests for additional financing, as one interviewee put it. Countries still face a multitude of bilateral and multilateral donors without a guarantee that substantial new and long-term funding for their national health plans will actually be available.

The lack of a clear linkage between the IHP+ process (national strategy development/assessment) and a pooled and significant source of long term funding, along with lack of capacity in the IHP+ Secretariat, may help to explain the relatively slow progress made in the development and the joint assessment of national health plans to date. Since the launch of IHP+ almost four years ago, only six countries (Nepal, Ethiopia, Uganda, Ghana, Vietnam, and Malawi) have completed a formal JANS process.⁵⁵ And so far, only in the case of Nepal and Ethiopia has the process led to a joint financing framework and pledges by multilateral and bilateral donors (either pooled or non-pooled) in accordance with this framework. Even in these two countries, however, key informants highlighted a certain level of disappointment that while donor funding might now be better coordinated (a significant achievement in itself) it has not nearly increased to a level that would come close to filling the financial gaps.

The IHP+Results report also indicates that there is still a major gap between the rhetoric of better aid effectiveness and the compliance of donors with the principles at the country level, and points to the fact that only a few donors use country systems (e.g., for financial management and results

monitoring).⁵⁶ Asking donors why this is the case, some mentioned that they still have to be convinced of a greater rigor in the development and assessment of the strategies and a stronger link to health outcomes, so that they meet donors' standards of accountability. The quality of the national strategies differed considerably, and may lack the specific measurements that funders need.

The impact to date of IHP+ in channeling additional resources specific to MNCH has been limited by a further challenge: it is not ensured that increased financing of national health plans automatically means increased financing for RMNCH. Key experts emphasized that it cannot be taken for granted that RMNCH will become a priority area in national health strategies; they stated that a mechanism is needed to ensure this prioritization of RMNCH at the country level. Three other challenges are as follows:

- A. IHP+ lacks full support from the largest donor—the US has committed to coordinating its funding with IHP+, but has not formally become a part of it or pooled its funding (e.g., it has not pooled funding in Nepal);
- B. given the critical role that the government has to play in development and implementation of the national health plan and in the orchestration of donors for funding the strategy, the prospect that the IHP+ could be successful in countries with weak governments is questionable (these countries also tend to have high child and maternal mortality rates); and
- C. the participation of civil society in IHP+ processes needs to be further strengthened.

An important achievement of IHP+, often referred to in the interviews, is that IHP+ has indeed empowered governments to resume stronger ownership of their national health plans. IHP+ has also facilitated a focused dialogue between governments and donors around these plans—a dialogue that did not exist before in many countries. IHP+Results considers the creation of these frameworks as an important step that may lead to better donor harmonization over the next few years.

Strengthening the support of the UN system and the World Bank to MDG 5—the H4+ and other recent initiatives

The H4+ is a promising initiative to leverage collaborative and coordinated action. However, the initiative should make its efforts more transparent to the global health community, including to countries which could benefit from its support. Separate from the collective efforts of the H4+, its partner agencies also launched their own efforts to strengthen their contributions to RMNCH.

On September 25, 2008 during the High-Level Event on the Millennium Development Goals, WHO, UNFPA, UNICEF, and the World Bank jointly announced intensified, harmonized support, initially to a group of 25 countries with very high maternal mortality, towards achieving MDG 5. The

Box 2: Core functions to be undertaken by H4+ agencies based on comparative advantages

WHO: Policy guidance, setting norms and standards, research, and monitoring & evaluation

UNFPA: Reproductive health commodity security, support to implementation, human resources for sexual and reproductive health including maternal and newborn health, and technical assistance for building monitoring and evaluation capacity

UNICEF: Financing, support to implementation, logistics & supplies, and monitoring & evaluation

WORLD BANK: Health financing, inclusion of MNCH in national development frameworks, strategic planning, investment in inputs for health systems (including fiduciary systems and governance), and taking successful programs to scale

UNAIDS: HIV/AIDS surveillance, monitoring and evaluation, technical support to programs for HIV/AIDS prevention, treatment and care, and country level coordination

group was nicknamed “H4” (Health 4), and, when UNAIDS joined the initiative, it became known as “H4+.”

Based on their comparative advantages (BOX 2), the four organizations committed to assisting countries in the development of (a) MNCH/RH needs assessments, and (b) costed, MDG-driven and performance-based national health plans, working through the IHP+ in compact countries. Coordinated support to countries was to also focus on: rapidly mobilizing required resources; addressing the need for skilled health workers (particularly midwives); overcoming financial barriers to access; strengthening M&E systems; and tackling the root causes of maternal mortality and morbidity.

Based on a mapping of the support that the four agencies were providing in the 25 priority countries, the H4+ then agreed upon each agency’s contribution to accelerated implementation of maternal and newborn care in the 25 priority countries in an operational plan (2009–2011). Canada provided \$50 million over five years (2011–2016) to improve global coordination of the five agencies, and to provide targeted technical support for maternal and newborn health in five LICs (DRC, Sierra Leone, Uganda, Zambia, and Zimbabwe).

Unfortunately, it is unclear to what extent the H4+ agencies have made progress towards fulfilling their commitments, as there is publicly available information on the implementation of this initiative on the agencies’ websites or the IHP+ website. Stakeholders interviewed for this report requested more transparency from the H4+ initiative.

Separate from the collective efforts of the H4+, the **World Bank** has started to reinvigorate its commitment to health systems and reproductive health. HSS is a key priority area of the World Bank’s 2007 HNP strategy,⁵⁷ and in 2009, almost half of its financing for health was allocated to HSS (\$1.4 billion out of a total of \$3.1 billion for HNP in 2009 was committed to HSS, up from \$700 million out of \$2.8 billion in 2007).⁵⁸ In late 2008, the World Bank launched its “Health Systems for the Health MDGs Program.”⁵⁹ The program provides technical assistance (TA) to countries in the implementation of their national health strategies, beginning with 14 IHP+ countries, of which twelve are in Africa and two in South-East Asia. The Bank also established two regional HSS hubs in Africa (Dakar, Senegal; Nairobi, Kenya) to assist HNP operations in the region, particularly in the areas of health finance, human resources, governance, supply chain management, and infrastructure planning. It created the Health Systems Global Expert Team that brings together health systems experts from across the Bank

to offer advice to health ministries and project teams on issues such as health insurance policy and implementation, health financing reforms, and health system organization.⁵⁹ With support from Norway and the UK (US\$515 million through 2022), the Bank also created the **Health Results Innovation Trust Fund** to support results-based financing approaches in the health sector for achievement of the health-related MDGs, particularly MDGs 1c, 4, and 5.⁶⁰

In 2010, the World Bank released its Reproductive Health Action Plan aimed at achieving better progress on MDG 5 from 2010–2015 in 57 countries that have a high burden of maternal deaths and high fertility. Using a health systems approach, the Action Plan aims to improve women’s access to quality family planning and other reproductive health services, skilled midwives, emergency obstetric care, and postnatal care for mothers and newborns. One year after the plan was launched, the World Bank had approved health projects with RH components in ten countries⁶¹, and two specific RH projects in Mali and Burkina Faso are in preparation. **The share of the total HNP lending channeled to RH increased from 11% in 2010 to 28% in 2011** (in total, from \$491 to \$830 million).⁶² In moving forward, the Bank has identified two major challenges in the implementation of its Action Plan: (1) to better incentivize country demand for RH, including family planning, at country level; and (2) to ensure full leverage of the Bank’s multi-sectoral advantage to improve RH outcomes; the Bank has not used this leverage to full advantage in the past.^{48,62}

UNFPA has also launched new RMNCH initiatives in recent years. In 2008, UNFPA launched the **Maternal Health Thematic Fund (MHTF)** to provide country level funding for improved family planning and for skilled care during pregnancy and birth (with a special focus on midwifery and emergency obstetric and newborn care).⁶³ The MHTF is supported by two separate multi-donor thematic trust funds: the Thematic Fund for Maternal Health and the Thematic Fund for Obstetric Fistula.⁶⁴ Both funds, have remained small-scale and are very under-financed (compared with the resources required). The entire MHTF had an operating budget of \$27 million and expenditures of \$21 million in 2010. Resources required for the MHTF were estimated at a total of \$504 million over the 2008–2011 period, with \$138 million needed in 2010 and \$269 million needed in 2011. UNFPA attributes this lack of funding to the global financial crisis, which has limited the ability of many funding governments to commit resources to aid as they did before. A recent CGD report high-

lights another concern about UNFPA, a lack of accountability for both financial resources and program results.⁶⁵

UNFPA's Global Program to Enhance Reproductive Health Commodity Security (GPRHCS) was launched in 2007 to strengthen country capacity in reproductive commodity planning and supply chain management and to provide financing for the actual procurement of commodities.⁶⁶ The GPRHCS is supported by five bilateral donors through a multi-donor trust fund.⁶⁷ Through this trust fund, in 2009, UNFPA provided \$63 million for the purchase of contraceptives, \$7 million for other reproductive health commodities (e.g., oxytocin, intravenous antibiotics), and \$17 million for capacity building. The GPRHCS could potentially be leveraged further by donors to contribute to increased access to contraceptives and other SRH commodities.

Scaling Up Nutrition Movement

The Scaling Up Nutrition (SUN) movement is a recent initiative to improve coordination in the nutrition field and to support countries in the development of quality-assured nutrition strategies.

Launched in 2009, the SUN movement brings together over 100 organizations (e.g., USAID, the Canadian International Development Agency, UNICEF, the UN World Food Programme, WHO, the World Bank) to reduce maternal and child undernutrition.⁶⁸ SUN aims to increase nutrition assistance in alignment with country-owned plans, based on the SUN Framework and SUN Road Map. This framework was designed to be integrated into national-level priorities and planning. It promotes good nutritional practice, the provision of micronutrients for young children and their mothers, food fortification, and therapeutic feeding for malnourished children. SUN itself is not financing nutrition plans, but aims to mobilize additional financing for countries' nutrition plans.

The SUN Transition Team, chaired by the UN Secretary General's Special Representative for Food Security and Nutrition, is tasked with bringing the SUN Road Map to fruition. This team is focusing on arrangements through which national authorities can request, and then access, financial and other support to scale-up nutrition according to country needs. The operational costs are covered by the Bill & Melinda Gates Foundation, Japan, and the World Bank.

Every Woman, Every Child: Global Strategy for Women's and Children's Health

The Global Strategy for Women's and Children's Health has mobilized high-level political attention and significant financial and policy commitments for MDGs 4 and 5. This is an important achievement given the previous fragmentation of the policy, advocacy, and finance community. Financial commitments to the Global Strategy amount to at least \$43.4 billion, but it is unclear how much of this funding is new and additional. Even if a significant portion is new and additional, a large financing gap would persist. This appears particularly true for scaling up interventions around the time of childbirth and the postnatal period and the integrated management of childhood illnesses, which will likely remain seriously underfinanced.

Perhaps the most important gap in the Global Strategy is that it remains unclear exactly how new RMNCH funding will be channeled. Implementation and accountability mechanisms for the Global Strategy also need to be strengthened, especially at the country level. The work of the Commission on Information and Accountability for Women's and Children's Health is a good start, but greater efforts are needed to implement the Commission's recommendations, particularly when it comes to the strengthening of health information systems and accountability mechanisms within countries.

According to a recently published report by PMNCH69, financial commitments to the Global Strategy amount to at least \$43.4 billion (not including the value of non-monetary commitments). Fifteen donor governments committed \$14 billion, 39 LICs \$10.0 billion, and five MICs \$6.8 billion. The remaining \$12.6 billion was committed by NGOs, foundations, the business community, health care professional associations, UN and other multilateral organizations, and global health partnerships. In addition to the monetized contributions, extensive service delivery and policy commitments were made, particularly by LICs.

Regardless of what proportion of the \$41.4 billion is considered as additional funding, it would still fall short of the \$88 billion that the Global Strategy estimates will be needed to scale up MDG 4 and 5 interventions in the 49 lowest-income countries over the 2011–2015 timeframe.

When looking at the allocation of financial, policy and service delivery commitments, PMNCH found that commitments will target further scale-up across all health-related MDGs, but with different levels of attention to different MDGs.⁷⁰ Child health (particularly PMTCT) figures prominently in the commitment documents, and was also prominent in the interviews with donors. Yet only five implementing countries explicitly referred to IMCI, and no donors mentioned IMCI, highlighting the risk of continued under-funding of IMCI. Furthermore, as many OECD countries count (or are considering counting) their contributions to GAVI and the Global Fund as part of their Global Strategy commitments, it is likely that there will be additional (or at least sustained) funding for RMNCH interventions that are related to HIV/AIDS, TB, malaria, and immunization.

Overall, financing for MDG 5 still appears to lag behind financing for MDGs 4 and 6, although there are indications that financing for family planning will increase significantly. Several key donors and countries mentioned family planning as a focus area. There are also indications that country governments in particular will place a stronger focus on scaling up skilled birth attendants (SBAs) and the training of midwives and other skilled health workers. Sixteen high-burden countries have committed to training and deploying an additional 24,000 midwives/SBAs and 21,000 other professional health workers by 2015. This will be an important increase in the health workforce, but it will still be very small relative to the actual health workforce needs. The Global Strategy estimated that about 2.6 to 3.5 million additional health workers will be required to reach the health MDGs. And, according to the UNFPA's 2011 midwifery report, an additional 111,880 skilled midwives are needed in 38 countries, and 350,000 additional midwives are needed in 58 countries.⁷¹

Within MDG 5, it is thus likely that childbirth and postnatal care interventions (i.e., high impact/low coverage interventions) will remain significantly underfinanced. Investment costs for scaling up interventions around these two periods along the continuum of care are very high due to HSS requirements, but no multilateral mechanism or agency, and no donor, has emerged to take decisive leadership in the financing of these interventions. Nutrition, including the promotion of early and exclusive breastfeeding, might also continue to be severely underfunded. Few stakeholders explicitly referred to nutrition in their commitments or subsequent interviews.

Another important finding of PMNCH's analysis relating to the Global Strategy commitments is that **it does not provide clarity on the channeling of the financial commitments**. The PMNCH report notes that: "while it is clear that the Global Strategy is not a new global financing mechanism for MDGs 4 and 5, many of those interviewed called for guidance on how to access funding committed to advancing the Global Strategy."⁶⁹

An important achievement when it comes to the implementation arrangements for the Global Strategy was the creation of the **Commission on Information and Accountability for Women's and Children's Health (COIA)** in December 2010. The COIA was to set up mechanisms to ensure that resource pledges to the Global Strategy are delivered, and to ensure progress towards the Global Strategy's goals. The COIA developed a set of eleven core indicators for measuring progress towards the RMNCH goals outlined in the Global Strategy, and promoted these as part of a single global mechanism for reporting on RMNCH outcomes. In addition, it has recommended actions to strengthen mechanisms for tracking and reporting domestic and external financial resources for RMNCH, and it has established an action plan to improve health information systems in countries. While the COIA concluded its work in May 2011, an independent Expert Review Group (ERG) is currently being set up that will report regularly to the UN Secretary General (UNSG) on the results and resources related to the Global Strategy and on progress in implementing the COIA's recommendations. The ERG will be supported by a small secretariat hosted by WHO.⁷² A draft work plan for implementing the COIA's recommendations was released in July this year.⁷³ Norway has committed \$10 million to support it, and aims to convince other donors to also contribute to the implementation of the work plan. According to the budget in the draft work plan, the "average catalytic resources" required to improve information and accountability in each of the 49 target countries amount to \$1.25 million (a total of \$61.25 million). This means that an additional \$51.25 million would be needed.

Interviewees indicated that the creation of the COIA's global accountability framework will go some way in tracking the behavior of both donors and countries. At the same time, interviewees argued that the COIA is very much focused on the global level and it is still unclear whether and how country mechanisms, so central to the successful implementation of the Global Strategy, will be strengthened to enhance accountability for women's and children's health.

Chapter 5: Options for Strengthening the Financing Architecture for MDGs 4 and 5

5.1

Approach to option development and assessment

Chapter 4 described recent progress and improvements, but also remaining gaps and inefficiencies, in relation to the global financing architecture for MDGs 4 and 5. Chapter 5 now lays out a range of potential options to address these remaining architectural barriers in order to accelerate progress on women's and children's health. The options focus on addressing coverage gaps in the 49 high-burden LICs of the Global Strategy that are likely to continue to rely on donor funding in order to reach MDGs 4 and 5, in addition to increasing domestic financing for RMNCH. Increased domestic financing efforts by MICs, although critical, are not the focus of this report. Options presented draw on:

- A. ideas and opinions expressed in interviews with 55 decision-makers and stakeholders from donor organizations, recipient countries, civil society, UN organizations, financing institutions, foundations, and academia;
- B. an appraisal of the policy discussions and debates about options to improve the global financing architecture in publicly accessible literature;
- C. a review of innovative approaches for achieving rapid scale up of health services; and
- D. an in-depth examination of the literature on financing approaches and performance of key organizations in global health.

In developing the options, the explicit focus of the analysis was on how the global *financing* architecture for MDGs 4 and 5 could be improved (rather than the global architecture as a whole). This focus means, for example, that while issues such as TA were considered, they are not covered in any great detail.

Interviewees expressed a wide spectrum of opinions on ways to improve the architecture for raising and channeling resources to RMNCH, and a range of options was also laid out in the published literature.⁷⁴ These options were systematized and narrowed down to the three options introduced below (Section 5.2). They reflect the ideas and recommendations most

often referred to by the interviewees and in the literature (see Appendix 6 for a summary of relevant articles). They include a number of innovative yet pragmatic suggestions, which lie between radical change and tweaking of the status quo.

5.2

Presentation of options

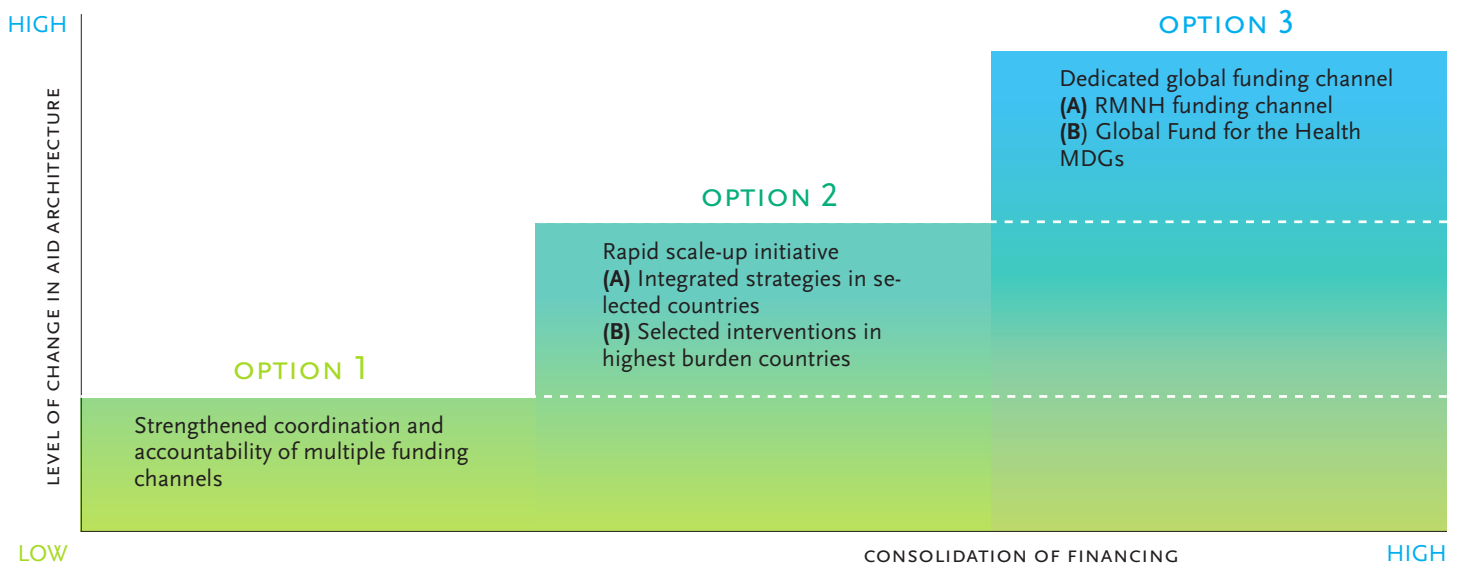
The options presented below can be described along two key dimensions. The first one is **the level of consolidation of global financing for RMNCH** implied by the option—a low level refers to a decentralized system with multiple channels of financing, and a high level refers to a centralized global financing approach. The second dimension is the **level of change to the current global aid architecture for RMNCH** that would be required to successfully implement the option.

Conceiving of potential options in this way results in the “options staircase” shown below (FIGURE 10). It includes three main options, two of which have sub-options associated with them. The options are not mutually exclusive. Rather, they build on each other, as symbolized by the staircase.⁷⁵

OPTION 1 is built on the premise that the current gaps and inefficiencies in financing RMNCH can be addressed through strengthening coordination between—and fully exploiting—the funding mandates of the existing, multiple multilateral and bilateral funding channels for RMNCH. Associated implementation and accountability mechanisms for the Global Strategy at the global and country level would also need to be enhanced.

OPTION 2 embraces the strengthened coordination model of Option 1, but posits that making faster progress towards RMNCH will, in addition, require a strategic scale-up effort with dedicated financing targeted at opportunities for rapid impact. **OPTION 2A** aims to prove the concept that if LICs with jointly assessed, costed national health plans had access to pooled donor funding for RMNCH-related elements of these plans, then rapid scale up and progress could be achieved. **OPTION 2B** maintains that a narrower approach is needed in the short term, especially in the highest burden LICs. This narrower approach would focus on scaling up coverage of selected high impact interventions, which are compatible with (and support) the longer term development of strong, integrated national health plans and systems.

FIGURE 10: Options “staircase”



OPTION 3 goes a step further still. It maintains that, while improved coordination between existing donors is important (Option 1), and a narrowly focused scale-up initiative can galvanize momentum to show that rapid progress is possible

(Option 2), these efforts alone will not suffice. Option 3 thus proposes the creation of a dedicated global funding channel.

A more narrowly defined version of this option (**OPTION 3A**) focuses on the creation of a dedicated financing channel for reproductive, maternal and neonatal health only (child health could be covered through existing financing arrangements). The comprehensive version of Option 3 (i.e. **OPTION 3B**) proposes the creation of a fully integrated global funding channel for all the health MDGs. A more detailed description of each option is given below.

Option 1: Strengthen coordination and accountability of multiple funding channels at the global and country level

Underlying Rationale: RMNCH is intrinsically linked to functioning health systems—if these are strengthened, maternal and child mortality rates will fall. The international community, through IHP+ and other initiatives, has taken important first steps in supporting national governments in developing strong, country-owned, and jointly assessed national health plans (in a few cases, these plans are also associated with joint financing agreements). In addition, donors and countries have

pledged significant amounts of funding within the Global Strategy that could be used to finance these new plans. While there is a need to strengthen implementation arrangements for the Global Strategy to ensure its impact, these arrangements could be reasonably “light touch.” Thus Option 1 proposes strengthening, fully leveraging, and improving the accountability of existing mechanisms to finance RMNCH as part of national health plans, as described below.

Strengthening the ‘implementation architecture’ of the Global Strategy:

- **Enhance IHP+ capacity linked to clear performance targets:** Speeding up the development of jointly assessed, costed national health strategies (with strong RMNCH plans) would require a stronger IHP+, so that it can (a) better support and facilitate this multi-partner process, and (b) proactively communicate with countries. An evaluation of its work to date should help IHP+ to further enhance its way of working and to strengthen the catalytic and coordinating role of this virtual, multi-stakeholder partnership. A modest increase in IHP+ secretariat staff linked to clear deliverables (including annual targets on the number of countries using the JANS and on how many are supported in their efforts by IHP+) would also likely to be required. In addition, donors to the IHP+ should agree on their own clear performance standards (see ‘funders’ forum’ below).

- *Complement the annual report from the ERG with a more regular accountability mechanism:* The annual report by the independent ERG on progress in implementing the Global Strategy will be essential in ensuring that RMNCH stays high on the political agenda. However, following the dissolution of the Commission on Information and Accountability, additional capacity needs to be created to follow up on the Commission's recommendations and to track progress on implementing Global Strategy commitments on an ongoing basis. WHO is currently taking the lead on this task, but a number of interviewees raised the question of whether this function would not be better placed within the UNSG's office or within PMNCH, given that they represent broader constituencies. In addition, while the ERG focuses on the results and resources related to the Global Strategy and on progress in implementing the recommendations, more needs to be done to strengthen country mechanisms to enhance accountability for women's and children's health. It would thus be important that other donors (i.e., in addition to Norway) provide funding to support the implementation of the Commission's recommendations at the country and global levels.
- *Strengthen the capacity of UN organizations to deliver on their core mandates:* WHO, UNICEF, and UNFPA would return to a focus on their core skills of normative guidance and TA in the development and implementation of RMNCH plans. The H4+ could be an important mechanism in this process, assuming that it can become more transparent (it is currently not easy to understand who is doing what in which countries) and that it is funded adequately to conduct its work. To finance TA, a catalytic fund could be explored, modeled after the Fast Track Initiative's Education Program Development Fund.⁷⁶ Funding could be used to finance TA provided by UN organizations, as well as by other TA providers.
- The World Bank would further strengthen its efforts to fully implement its HNP strategy, which commits to a greater focus on funding health systems, as well as its Reproductive Health Action Plan. This would require incentivizing country demand and strong support from the Bank's leadership and country directors. Through their policy dialogue with governments, including treasuries and health ministries, these directors play a key role in ensuring that HSS and RH are prioritized in domestic resource allocation.
- The Global Fund would maximize its impact on RMNCH and associated HSS within its *existing* mandate, e.g., by fully scaling up all four prongs of PMTCT, malaria treatment/prevention, identification and treatment of TB in pregnant women and children, and training/financing of community health workers. HSS funding by the Global Fund and GAVI would remain focused on the delivery of interventions to fight the three Global Fund target diseases and immunization services. However, both organizations would ensure that their HSS support maximizes positive spill-over effects on other HSS elements.
- A small number of interviewees argued that the UN organizations should take on an enhanced role in RMNCH—in particular, that UNICEF and UNFPA could play a greater role in financing and procuring RMNCH drugs and commodities. There could also be a role for UNITAID in reducing prices for priority RMNCH commodities and in driving the development of new medicines adapted to the needs of women and children.

Clarifying the division of labor and maximizing the impact of existing multilateral funders on RMNCH: Under Option 1, existing multilateral financiers would concentrate on fully exploiting their existing funding mandates, and would agree on a clearer division of labor based on their comparative advantages:

Improving coordination and transparency of bilateral funding: A central premise of this option is that bilateral donors will take individual and collective responsibility for delivering on their Global Strategy commitments, by: (a) significantly increasing their country-level financing for RMNCH, (b) aligning this funding with national priorities, and (c) harmonizing their efforts with other donors. In doing so, bilateral donors would 'reward' LICs that have undergone a solid JANS process with increased funding for their national health plans. An annual 'funders' forum' of key bilaterals (and potentially multilateral and private donors) could be a means to increase coordination and transparency

of RMNCH financing. In this forum, donors would inform each other about their funding priorities and activities, share best practices, identify potential gaps left by their collective efforts (such as donor orphan countries or diseases), agree on potential joint initiatives to address these gaps, and hold each other accountable.

Country access to funding and accountability: In addition to increasing their domestic financing for RMNCH, LICs in particular would still need to access funding for RMNCH from multiple bilateral and multilateral donors under this option. And they would need to “orchestrate” these different funders.

- Countries would request funding from donors through their jointly assessed, costed national health plans or strategies, which include RMNCH as one priority area. Plans would include precise outcome and impact targets/indicators, and clearly lay out the government’s contribution to financing the plan.
- Country-level discussions between the government, donors and non-state actors would identify domestic and international sources of financing for the national health strategy ensuring that different areas within national health plans or strategies are not overfunded or underfunded.

The COIA called for the creation of national, inclusive coordinating bodies for health. If established, these mechanisms (which could be built on the National AIDS Commissions or Global Fund Country Coordinating Mechanisms) could go a long way towards coordinating all relevant stakeholders, ensuring harmonized funding, tracking of progress, and holding governments, donors, and non-state actors alike accountable.

Option 2 (A/B): Strengthen coordination arrangements plus implement a focused scale-up initiative to rapidly accelerate progress towards MDGs 4/5 by 2015

Underlying Rationale: Option 2 supports the premises and recommendations of Option 1 in principle, but it maintains that Option 1 in itself will not result in fast enough progress to reach MDGs 4 and 5. A catalytic, targeted scale-up initiative focused on achieving rapid impact is also needed, based on two potential approaches.

The first (Option 2A) focuses on *a small number of high burden LICs that have developed jointly assessed, costed national*

health plans with a strong RMNCH component. It aims to prove the concept that if these countries had access to pooled donor funding for RMNCH-related elements of these integrated plans, and optimal technical support for their implementation, critical interventions along the continuum of care would be rapidly scaled up.

The second (Option 2B) maintains that while a fully integrated, health systems approach to improving RMNCH makes sense, a slightly narrower approach is needed in the short term, especially in many of the highest burden countries which might not have these strategies fully in place. This approach focuses on *selected, low coverage, high impact interventions, which are compatible with (and support) the longer term development of strong, integrated national health plans and systems.*

The scope of both initiatives, in terms of the number of countries that can access funding from them, could be extended if the initiatives prove to be effective instruments for scaling up access to RMNCH services. Including a larger number of high-burden countries could achieve a higher impact but would also imply higher costs for the provision of RMNCH services. A key rationale for Option 2 is that it is highly targeted and strategic in nature—with a very clear focus on the highest opportunities for impact for the resources invested.

Key features of Option 2A: In addition to having the features of Option 1 above, Option 2A would require creation of a dedicated pool of funding to finance RMNCH scale-up and related HSS within a subset of countries. Eligibility would be limited to LICs that: (a) have jointly assessed, costed national health plans (with RMNCH roadmaps) in place, and (b) have been invited to apply for financing of these plans by the Global Fund, GAVI, and the World Bank under the HSFP. As of October 2011, five countries met these criteria.⁷⁷ An additional criterion for receiving financing from this funding pool could be the willingness of these countries to spend a greater proportion of their domestic and IDA funding on RMNCH (see below). The funding pool would allow countries to rapidly complement funding from the HSFP and its own domestic financing, and to fill critical remaining resource gaps in relation to RMNCH, such that rapid scale up should be possible.

Funding modalities: Supportive donors would pledge contributions to a multi-donor trust fund as part of their Global Strategy commitments; dedicated funding for operational research would also be required, to capture lessons from rolling out Option 2. The funding period would initially be

for three years (2013–2015), with the potential for renewal if the option proves successful.

The fund could be hosted and managed by the World Bank (under the umbrella of the HSFP), and could be leveraged as a way to stimulate countries to spend a greater portion of their IDA on RMNCH. A condition for accessing this funding pool could be an agreement by countries that when they receive additional financing from this new trust fund, they will allocate a portion of IDA to RMNCH (e.g., for every two dollars contributed by the trust fund, countries would allocate one dollar of their IDA funding envelope). Alternatively, the fund could be managed by the Global Fund, similar to the way in which the Global Fund has managed Phase 1 funding for the Affordable Medicines Facility-malaria (AMFm).

Country access to funding: Based on their JANS, eligible countries would prepare: (a) a joint application to GAVI and the Global Fund for funding of HSS related to the delivery of immunization and HIV, TB, and malaria services, and (b) a funding proposal to the trust fund at the World Bank to finance remaining gaps in program and HSS costs relating to RMNCH, gaps that cannot be financed through other means. Applications should clearly show how this funding from the trust fund would synergize with the domestic financing and other donor funding that the country already has, or is planning to access (e.g., Global Fund malaria and cross-cutting funding, GAVI immunization and related HSS funding, bilateral donor funding, etc.). To lay the foundations for long-term sustainability, countries should clearly show how they intend to co-finance RMNCH and related HSS through IDA and domestic resources.

In doing so, countries should receive focused support by a group of partners, with the mission to ensure the integration of strong, ‘fundable’ RMNCH scale-up plans within national health strategies. The Roll Back Malaria Harmonization Working Group—or the TA mechanisms of the “The Education for All-Fast Track Initiative” (recently renamed the “Global Partnership for Education”)—could serve as a model for such a concerted support effort.

In doing so, countries should receive focused support by a group of partners, with the mission to ensure the integration of strong, ‘fundable’ RMNCH scale-up plans within national health strategies. The Roll Back Malaria Harmonization Working Group could serve as a model for such a concerted support effort.

Key features of Option 2B: Option 2B would complement Option 1 with an accelerated scale-up initiative of a different nature, potentially hosted by the Global Fund. It would focus on rapidly scaling up coverage with key intervention

packages along the continuum of care that: (a) would have a large impact on maternal and child mortality, (b) are currently low coverage, and (c) would be highly synergistic and integrate with existing investments of the Global Fund. Alternative hosts could be the World Bank, regional development banks, or UNICEF/UNFPA, especially if the initiative had a strong focus on commodities. GAVI is unlikely to be an appropriate host given its primary focus on child immunization.

Funding modalities: Country eligibility for this initiative could be defined in different ways. One approach would be to list the 10 LICs with the highest MMR and the 10 LICs with the highest CMR. A comparison of these two lists shows that eight countries appear on both lists (i.e., these eight countries have very high child mortality *and* very high maternal mortality). Adding the remaining two countries from each list would give a group of 12 countries in total, and these could be considered as eligible for the initiative.⁷⁸ Many of the countries in this group have not been prioritized by donors to date,⁷⁹ and a subset of them could be described as fragile. An alternative to focusing on countries with the highest maternal and child mortality *rates* would be to focus on LICs with the highest *absolute* numbers of maternal and child deaths (see Table 2, p. 12). The choice between the two approaches depends on a number of factors, including financial resources available (focusing on the latter set of countries would be vastly more expensive), definition of impact (reduction of mortality rates within countries versus absolute numbers of deaths averted across countries), and the importance of focusing on those countries that otherwise do not receive a lot of donor attention.

Interventions that would lend themselves well to this focused scale-up initiative are: family planning, skilled birth attendance, and prevention and treatment of diarrhea and pneumonia. As described in Chapter 2 of this report, these are all low coverage, high impact, and highly synergistic with the Global Fund’s other investments in HIV/AIDS, TB, and malaria. Adding antibiotics for pneumonia and oral rehydration therapy and zinc for diarrhea to the Global Fund’s current investments, for example, would bring the Global Fund close to supporting a basic integrated child health package (with vaccination and micronutrients covered largely by GAVI and UNICEF), as shown in an earlier analysis.¹⁵ A similar argument can be made for family planning and skilled birth attendance, such that Option 2B would not fund isolated interventions but work towards expanding existing Global Fund financing towards more comprehensive packages of care for women and children.

To fund Option 2B, supportive donors would contribute to a dedicated pool that could be managed by the Global Fund; the funding period would initially be 3 years (2012–2015) and could be extended if the initiative is successful. There are a number of arguments in favor of the Global Fund hosting and managing this funding pool, including: (a) the opportunity to leverage synergies with existing Global Fund investments (e.g., around PMTCT or malaria treatment), and (b) the fact that the Global Fund is a preexisting funding mechanism that has proven highly successful in funding high impact interventions and related commodities. A key condition would be that the Global Fund finds a way to dramatically accelerate its funding process for this RMNCH funding pool.⁸⁰ The Secretariat would also need to closely monitor whether the Global Fund's Country Coordinating Mechanisms (CCMs) are incorporating sufficient RMNCH expertise and whether they are adequately fulfilling their functions in the design and implementation of RMNCH programs. If hosted by the Global Fund, the pool would have to be kept strictly separate from regular Global Fund funding for HIV, TB, and malaria programs to avoid cannibalization of funding for the Global Fund's core mandate.

Country access to funding: Country Coordinating Mechanisms (CCMs) would prepare a proposal for scaling up all, or a subset of, the eligible interventions, demonstrating linkages and synergies with existing Global Fund investments. CCMs in focus countries would need to include RMNCH stakeholders and experts, and decision-making would have to be fully inclusive.⁸¹ Proposals would have to be submitted outside of the normal Rounds-based system (since Round 12 is only scheduled to be launched in 2013). The proposals would be reviewed by a subset of the Global Fund's Technical Review Panel (TRP) with RMNCH expertise and approved by the Global Fund Board. Progress would be closely monitored, building upon existing Global Fund M&E processes.

Prior to launch, a baseline study would be conducted, and a follow-up evaluation would then be conducted after 2–3 years of funding to assess whether the initiative is having an impact. The two-year evaluation will provide a basis for deciding whether to continue, expand, or phase out funding.

Option 3 (A/B): Creation of a dedicated global funding channel to support RMNCH

Underlying Rationale: While progress has been made in recent years in raising additional financing for RMNCH and in improving the way these resources are allocated, there are

still fundamental gaps and inefficiencies in the RMNCH financing architecture. The Global Strategy, while critical in mobilizing momentum and resources for RMNCH, has not been able to address some of these fundamental challenges and gaps.

Even if better coordination and rapid-scale up in a few countries were to be realized, these alone will not be enough to achieve the global progress that is needed on RMNCH. Achieving such progress will require a dedicated multilateral channel for RMNCH linked to an existing institution. The experience of GAVI and the Global Fund has shown that having such a dedicated financing mechanism is critical to mobilizing the required resources, bringing together all relevant actors, and pushing for a sustained global and country level focus on achieving measurable results. Following this overall premise, two possible versions of Option 3 are described below. These differ mostly in their scope and to some degree in their financing approach.

Option 3A focuses on the creation of a global funding channel *specifically for reproductive, maternal, and neonatal health (RMNH)*. Significant progress in improving child health has been made over recent years thanks to the focus of national governments, a dedicated multilateral financier (GAVI), the UN (especially UNICEF), and a number of key bilateral donors on child health. However, progress has been much slower on RMNH. In the context of an environment where resources for multilateral financing are constrained, the creation of a pooled, global financing channel should thus focus on RMNH rather than child health.

Option 3B goes further, proposing the creation of a Global Fund for all Health MDGs. Supporters of this option argue that a consolidated and sufficiently resourced Global Fund for all Health MDGs would significantly reduce the current fragmentation of the global aid architecture. Rather than creating another vertical channel for RMNCH, the integrated MDG funding channel could address countries' needs in a more holistic way, improve targeting and equity in access to finance, and substantially reduce transaction costs for donors and countries.

Key features of Option 3A (global RMNH funding channel): Under this option, donors to the Global Strategy (and potentially others) would agree to pool a significant portion of their aid commitments in a dedicated funding channel, which would complement existing funding mechanisms for the health MDGs. Many interviewees expressed support for linking such a dedicated funding channel to an existing institution.⁸²

Funding modalities: All 49 countries under the Global Strategy would be eligible to apply for funding from the RMNH channel (this list could be reduced to 35 countries by focusing solely on those countries that still have low-income status today). There are theoretically a number of institutions that could incorporate an RMNH funding channel into their existing financing activities. Possibilities suggested in the interviews and/or literature included: (a) opening a separate dedicated financing window for RMNCH within the Global Fund; (b) establishing a multi-donor trust fund for RMNH and related HSS at the World Bank; and (c) linking the RMNH funding channel to existing trust funds at UNFPA (these trust funds were described in Chapter 4). Among the interviewees who supported Option 3A, support was spread equally between hosting such a dedicated financing channel for MDG 5 within the Global Fund and creating a dedicated RMNH financing pool at the World Bank. Very few interviewees expressed support for considering a global RMNH funding mechanism hosted within the UN system. Interviewees questioned the comparative advantage of the UN organizations in taking on large-scale health financing, and the suitability of particular UN agencies for hosting an RMNH funding channel.

If hosted within the Global Fund (and this option is now discussed), the likely arrangement would be to open up a *financing window for RMNH*, leveraging synergies with existing Global Fund financing. Supportive donors could then use this window to channel parts of their Global Strategy commitments (and additional resources) through this dedicated RMNH pool which would be kept separate from ‘regular’ funds for HIV/AIDS, TB, and malaria.⁸³ Funding provided for cross-cutting HSS programs would reach beyond the narrow focus on MDG 6 to also include MDG 5. If the Global Fund were to host of the RMNH funding pool, the World Bank would continue to play a significant role in financing underlying HSS through its IDA mechanism, as would bilateral donors.

Country access to funding: Countries would use a variation of the established application processes for HIV/AIDS, TB, and malaria to now also request funding from the dedicated RMNH pool. As with the three Global Fund target diseases, applications for funding from the dedicated RMNH pool could be for specific programs or to fund parts of national reproductive and maternal health strategies. Countries would also be able to apply to the Global Fund for cross-cutting HSS programs relating to MDG 5 and 6 under the HSFP. CCMs and the TRP would need to be augmented to include

the necessary expertise and ownership for RMNH. The same would apply to the Global Fund’s Secretariat and Board. As already emphasized under Option 2B, the Secretariat would need to intensify its efforts in monitoring CCM membership and performance.

Key features of Option 3B (creation of a Global Fund for the Health MDGs): The most likely scenario for implementing this option would be the gradual expansion of the Global Fund’s mandate to cover all MDGs and associated HSS. It could also eventually include a partial or full merger with GAVI.

Funding modalities: In this fully integrated funding approach, donors would contribute to one common pool to finance integrated scale-up efforts related to all health MDGs (rather than separate windows for each MDG). Bilaterals in particular would now have the opportunity to channel parts of their financial commitments through the Global Fund for the Health MDGs. The scope of HSS funding provided would also need to be defined further. For example, it is conceivable that an expanded Global Fund would finance HSS critical for the delivery of packages of care related to MDGs 4–6, whereas the World Bank would maintain a focus on broader HSS elements, especially on financing and governance issues, thus complementing the Global Fund for the Health MDGs. Close cooperation between both organizations (the World Bank and the Global Fund) would be desirable, to ensure synergies and coordinated approaches in financing. WHO, UNICEF, UNFPA and UNAIDS would be key technical partners to this expanded Global Fund at the country level, with a potential special role of UNICEF and UNFPA in the global procurement of drugs and commodities.

The Global Fund’s governance, Secretariat and TRP composition, and also its business model and core policies would need to be reviewed and adapted to support this expanded financing scope, even more so than in Option 3A. For example, depending on its role in HSS funding, the Global Fund would need to consider whether it required a country presence. Interviewees suggested that a mechanism similar to the Transitional Working Group that first developed the Global Fund’s core business model would likely be required to review and recommend changes to this very model.

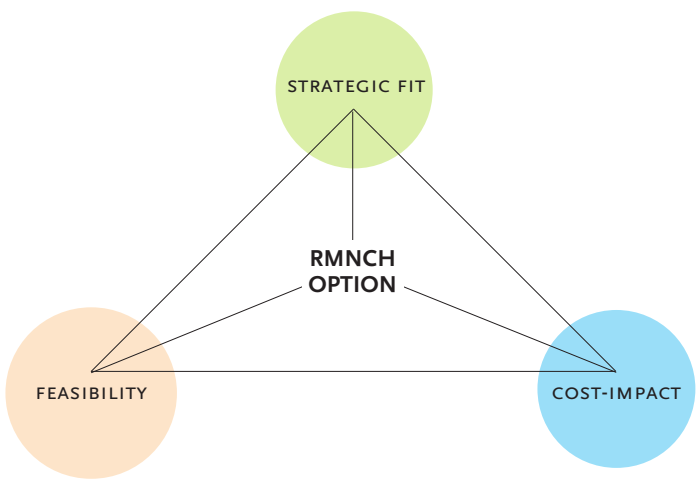
Country access to funding: At a minimum, CCMs would need to be adapted to ensure appropriate representation of all constituencies at the country level relevant to the expanded financing mandate. CCMs would then be able to apply for funding for integrated programs covering all MDGs and related HSS.

Chapter 6: Option Assessment

This chapter assesses the potential of the options to achieve rapid progress towards MDGs 4 and 5 in the short term at bounded cost and limited risk, while building the foundation for longer-term, structural improvements to the system.

An analytical framework was used to assess the institutional options for improving the global RMNCH financing architecture. This framework was developed based on: (a) an analysis of selected key documents on development financing, and (b) a review of other business case assessments.⁸⁴ It is presented below (FIGURE 11) and includes four dimensions against which the business case for each option is assessed: strategic fit, cost, impact, and feasibility.

FIGURE 11: Assessment framework for RMNCH architectural options



The table below further describes the operationalization of the four assessment categories.

The following assessment of the options takes into account quantitative data to the degree that they exist, especially when it comes to the cost-impact dimension. The analysis draws mostly on WHO and World Bank cost-impact data, developed in the context of the High Level Task Force and then recalculated for the Global Strategy. In addition, WHO’s Department of Health Systems Financing graciously provided cost-impact data for the subsets of countries in options 2A, 2B, and 3A that were used as a starting point for the cost-impact analysis of the different options. It is important to stress that

TABLE 6: Operationalization of assessment categories

Criteria	
STRATEGIC FIT	<ul style="list-style-type: none">Degree of strategic fit between the financing approaches, and comparative strengths and weaknesses of the option’s suggested lead institutions and their suggested role going forward?
COST- IMPACT	<ul style="list-style-type: none">Additional costs for implementing the suggested option? Medium term efficiency gains expected (=cost savings)? Potential of the option to significantly accelerate health impact/ progress towards MDGs 4 and 5 (reduction of maternal/neonatal and child mortality) as compared to the status quo?Contribution to increased aid effectiveness?
FEASIBILITY	<ul style="list-style-type: none">Likelihood of gathering the necessary level of political support of key decisionmakers (donors, countries, heads of agencies) to implement the option?Possibility of rapid implementation (taking into account required changes in business model; governance; capabilities/capacities of involved organizations)?

a range of methodological constraints make it extremely difficult to: (a) provide anything but indicative estimates, and (b) compare cost-impact across options. In addition, the analysis did not take into account the interactions and compounding effects between existing health investments and the additional investments associated with implementing the option. Cost-impact estimates also vary significantly depending on the countries (and interventions) included in the calculation. Using alternative methods (e.g., the Lives Saved Tool⁸⁵) for cost-impact estimates could also lead to varying figures. The cost-impact figures below are thus intended to provide no more than a rough indication of costs and benefits of the different options. Should there be a decision to pursue one or several of the options further, a more detailed modeling effort would be needed.

In addition to existing quantitative data, the assessment draws heavily on qualitative evidence from the interviews conducted for this study, evaluations and strategy/policy documents of key institutions/financing mechanisms, as well as journal articles on the global financing architecture for health.

Assessment of Option 1: Strengthened Coordination and Accountability of Multiple Funding Channels

The assessment of Option 1 indicates that there a range of opportunities to improve the effectiveness and efficiency of the existing aid architecture by: (a) improving the coordination and division of labor among the multiple existing funding channels for RMNCH, (b) fully leveraging the financing mandates of existing multilateral financiers, and (c) strengthening IHP+ and the accountability/implementation infrastructure for the Global Strategy. If implemented rigorously and swiftly these improvements could contribute substantially to accelerating progress in RMNCH. However, it is unlikely that improving the performance of the current system alone will be enough to sustain the urgency and discipline of donors, countries, and agencies alike, and to provide the leadership and resources required to really ‘change the game’ on RMNCH over the next years.

Strategic fit: In contrast to the other options discussed below, Option 1 depends on various actors to deliver on specific roles. It is not entirely clear, for example, that the very

loose structure of IHP+, at least as currently defined, shows a high strategic fit with its envisioned role as a stronger engine of progress on jointly assessed national health plans under Option 1. Another key actor in Option 1 is the World Bank, which would need to fully embrace an expanded role in financing RMNCH and large-scale HSS in the context of national health plans. While this fits well with its latest HNP strategy and its Reproductive Health Action Plan, the Bank to date has shown a mixed track record in RMNCH and HSS and would need to find a way to drive demand from countries.⁴⁸ The Global Fund and GAVI can be expected—resources and ongoing reform efforts permitting—to more fully exploit their financing mandates around RMNCH-related interventions within HIV/AIDS, TB, malaria, immunization, and associated HSS.

Cost-Impact: The additional costs required to implement Option 1 would be limited, as the prime focus is on strengthening *existing* mechanisms. Investments would, however, be required to conduct a rapid evaluation of IHP+ and to strengthen the IHP+ secretariat’s capacity to truly orchestrate and catalyze faster development and assessment of national health plans (including strong RMNCH roadmaps). Additional finance for enhanced TA to countries would also be needed (potentially through a TA Fund modeled after the Fast Track Initiative), in order to accelerate the development of high quality national health plans and associated results frameworks. Further resources would be required to strengthen the capacity within the UNSG’s office (or PMNCH, or WHO) to support and conduct ongoing monitoring of the implementation of Global Strategy commitments (as well as the recommendations of the Commission). Some additional costs would also need to be borne by the multilateral financiers (the Global Fund, GAVI, and the World Bank) to more clearly define their division of labor when it comes to RMNCH, and by bilaterals to more closely coordinate their efforts in the context of a funders’ forum as described above. Most importantly though, both donors and implementing countries would need to keep to and further expand their substantial financial commitments made in the context of the Global Strategy. Thus, while additional costs for strengthening coordination and accountability within the current system are expected to be relatively modest, overall investment levels required would have to remain high and need to be expanded further.

If this option were properly implemented, it should have a positive impact on the health of women and children as well as on aid effectiveness, even though the health impact of implementing the suggested improvements is hard to quantify.

Indeed this is one of the key weaknesses of this option: it is intrinsically hard to measure its ‘success’ (in terms of the reduction of maternal, neonatal, and child mortality). At a minimum, the number of countries that have jointly assessed, costed, *and adequately financed*, national health plans with strong RMNCH elements should rise rapidly. However, it is not clear that this option would really lead to the kind of mobilization of resources and stakeholders, and the kind of focused attention and discipline, that would be needed to rapidly reduce maternal and child deaths. It is also uncertain whether: (a) RMNCH would get adequately prioritized, and (b) funding would be targeted to the highest burden LICs for scaling up the most effective interventions.

Feasibility: Politically, it should be relatively easy to gather support for this option in principle, as it is closest to the status quo. However, it is less clear whether all stakeholders will be willing to actually make the rapid changes to their own operating and financing practices required for the option’s successful implementation. This is compounded by the fact that there is no single powerful entity and mechanism to hold stakeholders accountable for their commitments. It should thus not be taken for granted that this option in itself could be “game changer.”

Assessment of Option 2: Rapid Scale-Up Initiatives

Option 2A: Financing of gaps relating to RMNCH in jointly assessed, integrated national health strategies

The objective of Option 2A is to test the idea that a global funding pool dedicated to filling RMNCH financing gaps in national health plans could significantly contribute to scale-up of RMNCH in countries. The preliminary assessment of this option shows a high strategic fit with the World Bank as the agency to host the funding pool for this initiative. Additional costs for the initiative are estimated as moderate to medium, given: (a) the focus on a small number of LICs, and (b) the expected synergies with the co-financing by these countries from their domestic, Global Fund, GAVI, and World Bank resources. If the initiative is a success, it

should lead to rapid scale up of RMNCH interventions in the five countries supported and to reduced transaction costs.⁸⁶ However, it may be challenging to roll out the initiative to a larger set of countries. Such roll-out may be constrained by the slow pace at which high quality, jointly assessed national health plans become available (especially in those high burden countries that are fragile states). The feasibility of rapid implementation in the initial set of countries should be medium to high (given that strategies are ready to go, the HSFP is set up, and the creation of a trust fund is straightforward). Political support is expected to depend on a number of factors, including the existence of a rigorous performance and evaluation framework for the initiative.

Strategic fit: There is a very good strategic fit between the World Bank’s approach, experience, and comparative strengths and its suggested lead role in the initiative. Within its HNP portfolio, the World Bank has strengthened its RMNCH and HSS focus, and is also seen by many to have a comparative advantage when it comes to HSS financing. If set up correctly, placing this funding pool within the Bank could create further incentives for the five eligible countries to spend more of their IDA funding envelopes on health (through the matching requirement described above). Furthermore, the Bank is a lead partner within the IHP+ and the HSFP (both of which are critical to this initiative) and has longstanding experience with sector-wide approaches and in managing trust funds.

Cost-Impact: Start up and ongoing management costs for this initiative are expected to be moderate, given the World Bank’s experience in setting up trust funds. Initial estimates, which need further refinement, indicate that program and health systems costs for the initiative would lie in the range of \$450–600 million for these five countries for the 2013–2015 period. This estimate assumes that the initiative would finance 20% of the total additional costs for the program and associated health systems costs for maternal health, family planning, and IMCI. In addition, it is assumed that the initiative would aim to contribute to achieving 50–70% of universal coverage targets in the selected countries within its three year time

horizon (Appendix 7 sets out the details for the cost-impact calculation).

Estimating the health impact of the initiative is challenging. The impact of this initiative will be heavily dependent on whether it can act synergistically with other donors, most notably the three multilateral funders (the Global Fund, GAVI, and the World Bank). These three funders would consider funding HSS costs in the national health plans of the five countries included in the initiative, in accordance with the funders' respective mandates. An initial assessment suggests that between 2013 and 2015, an estimated 5,000–7,000 maternal deaths, 100,000–150,000 child deaths, and 40,000–60,000 newborn deaths could be averted in the five countries. In addition, between 530,000 and 750,000 unplanned births could be averted. The impact estimates are based on the assumption that complementary funding for immunization, PMTCT, and malaria prevention/treatment will be provided by other financiers (e.g. GAVI, the Global Fund). If the initiative leads to additional IDA lending for RMNCH in the targeted countries—which it should—the impact could increase further.

If successful, the initiative would fulfill the ultimate aid effectiveness goal of linking funding to jointly assessed national health plans in the five countries. It would lower transaction costs for recipients and funders alike (especially if plans are linked to joint financing agreements and results and M&E frameworks), increase accountability, and further align funding with country priorities.

Feasibility: Rapid start-up of this initiative should be possible given that the five countries already have jointly assessed national plans, based upon which they are expected to have submitted HSS funding proposals to the Global Fund and GAVI by early 2012. In the meantime, the World Bank could establish the donor trust fund for the initiative. Countries could then apply for funding from this trust fund as early as mid-2012 to address RMNCH-related financing gaps that remain after the Global Fund and GAVI have made their commitments. In doing so, countries would commit to augment any resources received from the trust fund through their IDA funding. The political feasibility of this option will depend on whether a number of key donors that are supportive of the national strategy approach and of the HSFP are willing to contribute sufficient funding to the initiative's trust fund. A prerequisite would be that the trust fund's investments would have to be linked to a clear results framework and rigorously

evaluated, so that donors and recipients could decide on whether this could be a model to expand on in the future.

Option 2B: Rapid scale-up initiative: selected interventions

The Global Fund's investment approach and portfolio makes it well suited in principle to take the lead in a rapid scale-up initiative focused on integrating certain RMNCH interventions into its existing portfolio. The goal would be to arrive at more complete integrated packages of care in a subset of the highest burden countries. The initiative is expected to be highly cost-effective, because it strategically targets high impact, low coverage interventions that are highly synergistic with the Global Fund's existing investments, and it focuses on LICs only, with the highest maternal and child mortality rates. In addition, the initiative would reach countries that have received comparatively little donor attention to date.

Given that the initiative would not require any significant changes to the Global Fund's core structures, it should be feasible to implement the initiative rapidly, if the necessary attention and urgency can be created in the Global Fund in the context of its ongoing reform efforts. To ensure political support for this initiative, it would be critical to keep the RMNCH funding pool separate from financing for the Global Fund's core mandate. Establishing the scale-up initiative at the World Bank could be an alternative.

Strategic fit: There are strong synergies between the Global Fund's existing investments, its financing approach, and the scale-up of the low coverage, high impact interventions proposed for financing in Option 2B (IMCI, family planning, and skilled birth attendants). As pointed out above, the Global Fund already finances childhood HIV/AIDS, malaria prevention and treatment, and a range of nutritional and other support. If the prevention and treatment of pneumonia and diarrhea were added to this mix, the Global Fund would be

supporting a basic integrated child health package (with vaccination and micronutrients provided by GAVI and UNICEF, respectively). Similarly the Global Fund is already financing a health workforce and commodities to provide contraception, treatment of sexually transmitted infections, and PMTCT services to HIV-infected women. As has already happened in a number of countries, these entry points could be leveraged to provide broader support for family planning. Finally, the Global Fund could build on its existing experience in scaling up access to services at the community level. It also has some experience in scaling up access to skilled birth attendants (as shown in Ethiopia).

Cost-Impact: The costs for setting up an earmarked pool of funding, as well as the management structures for the initiative within the Global Fund, are expected to be moderate, and comparable with those of the AMFm.⁸⁷ Program costs (including HSS costs) are comparable to those in Option 2A. For the 2013–2015 period, an estimated \$520–650 million would be needed for scaling up access to the three intervention areas in the 12 LICs with the highest maternal and child mortality rates. As in Option 2A, the cost and impact estimates are based on two assumptions: (a) the scale-up initiative would contribute to reaching 50–70% of universal coverage targets for the three interventions areas (i.e., more funding would be needed to reach universal coverage; see Appendix 7), and (b) it would finance roughly 20% of the total program and health systems costs to get to these coverage levels.

If successful, the initiative could have a significant impact on the health of women and children in the highest burden countries. According to a preliminary analysis, an estimated 5,600–7,800 maternal deaths, 270,000–380,000 child deaths, and 65,000–95,000 newborn deaths could be averted between 2013 and 2015. In addition, about 290,000–410,000 unplanned births could be prevented. The initiative would also help to: (a) target a number of countries that otherwise do not receive a lot of donor attention, and (b) scale up interventions in those countries that are currently very poorly provided (see analysis in Chapter 2). Similar to Option 2A, the estimate of averted deaths in the 12 countries assumes the existence of and synergies with funding for malaria and HIV made available through the Global Fund and other donors as well as funding for immunization provided by GAVI. Compared to Option 2A, the impact on maternal mortality and particularly on child mortality is expected to be somewhat higher, given

the targeting of a larger number of countries and of low coverage, high impact interventions.

The initiative falls short of funding a fully integrated national health plan. However, it could still have a positive impact on aid effectiveness by moving the Global Fund closer to financing integrated packages of care at several points across the continuum of care. This would lead to a more efficient use of funding while still allowing the setting and measurement of clear program targets. Furthermore, the diagonal approach used by the initiative—that is “the proactive, supply-driven provision of a set of highly cost-effective interventions on a large scale that bridges health clinics and homes”⁸⁸—could also work in countries that do not yet have high-quality, jointly assessed national plans and a strong government to orchestrate multiple donors. Assuming that more donor funds for these three interventions (IMCI, family planning, and skilled birth attendance) areas are channeled through the new initiative, it would also have the potential for reducing the number of projects at the country level.

Feasibility: Given the strong synergies with existing Global Fund investments, implementing this focused initiative should be feasible, even in the context of ongoing reform efforts following the recommendations of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanism in September 2011.⁸⁹ Meeting specific implementation requirements should also be possible in principle (and indeed well-aligned with the direction of reform efforts), including: (1) strengthened RMNCH expertise and capacity in the Secretariat and TRP, (2) fast-tracking initiative applications outside of the rounds-based system, and (3) augmenting CCM membership to also include RMNCH experts and stakeholders. Broad participation, strong collaboration with the H4+, and effective fulfillment of CCM functions (e.g., in grant design and oversight) would be required.

Political support for this initiative will likely depend on the Global Fund progressing swiftly in its internal reforms. Interested donors could fund the initiative, while others on the Global Fund Board could remain neutral. And while resource requirements for the initiative are substantial, they would still be modest when compared to the overall commitments made by donors in the context of the Global Strategy (and the overall resource needs). A rigorous evaluation framework linked to the initiative would be needed to assess its impact and to ensure donor buy-in.

Assessment of Option 3

Option 3A: Global RMNH Funding Channel

A global funding channel focused on RMNH could go a long way in accelerating impact on maternal and neonatal mortality. Hosting the channel at the Global Fund would allow exploitation of strong synergies with the Fund's current portfolio in some areas, but would also require changes in the Fund's financing model, core structures, and capacity. The World Bank should be kept in mind as an alternative host, should this option be explored further by the RMNCH community. Costs for implementing Option 3A would be substantial, and there is also skepticism about creating a channel for RMNH separate from child health funding. Overall feasibility of this option is thus assessed to be fairly low at this point in time.

Strategic fit: If a dedicated RMNH channel were to be hosted and managed by the Global Fund, there would be strong synergies between existing Global Fund financing and the financing of both RH and ANC services. Financing the training of skilled birth attendants and equipping them with drugs/commodities for interventions surrounding childbirth and postnatal care also fits with the Global Fund's business model. However, providing the large-scale HSS support necessary to ensure 24/7 access to emergency obstetric care services (with all of its associated benefits for RMNH) is not a good fit with the Global Fund's financing model.

Cost-Impact: The Global Fund would need to significantly scale up its RMNH expertise (e.g., in the Secretariat, TRP, and CCMs), and would need to add additional capacity in the Secretariat to manage this new financing window. Adjustments to its financing model would also be required, depending on the scope of HSS financing for MNH. Start-up costs would thus be expected to be fairly high, whereas ongoing management costs should benefit from significant synergies with the existing portfolio. Assuming that the MNH channel would take on 20% of the total costs for family planning and maternal health in the 49 Global Strategy countries

(2013–2015), and that it would focus on achieving substantial progress but not universal coverage, costs would lie in the range of \$3.4–4.2 billion.

If the Global RMNH Funding Channel was fully financed and rapidly launched, the health impact on maternal and neonatal mortality could be significant: between 47,000 and 66,000 maternal deaths and 167,000 and 234,000 neonatal deaths could be averted. In addition, between 2.0 and 2.7 million unwanted births could be averted. The channel could also have a positive impact on aid effectiveness by consolidating financing sources, reducing fragmentation, and enabling integrated funding for RMNH. A drawback of this option is that funding for child health (other than neonatal health), which is intricately linked to maternal health, would still be financed separately and through multiple sources.

Feasibility: It appears unlikely that this option could be implemented in the near future. Integrating another major funding channel into the Secretariat's operations would be a major task, which would be hard to shoulder, concurrent with the Global Fund's ongoing reform efforts. Two other inter-linked obstacles are: (1) the significant investments required to resource an RMNH channel, and (2) the lack of political support for this option by key donors on the Global Fund's Board.

Option 3B: Global Fund for the Health MDGs

Although there is a reasonable strategic fit between the Global Fund's current financing approach and portfolio and an expanded financing mandate covering all health MDGs, it would not be politically and organizationally feasible to implement this option in the short term. And while the eventual impact of a Global Fund for the Health MDGs could be very high, it would likely take a significant amount of time for financing to start flowing. A Global Fund for the Health MDGs would need massive financial resources, meaning that donors would need to decide to channel a large portion of their Global Strategy contributions, and of their other contributions, through this expanded Global Fund.

Strategic fit: The strategic fit between the Global Fund's current financing approach, expertise, and comparative strengths and a significantly expanded role under Option 3B is very strong in some areas and much weaker in others. There are strong synergies between key RMNCH services (e.g., ANC, IMCI, SRH) and the MDG 6 services already funded by the Global Fund (e.g., malaria services, PMTCT). The Fund's business model also includes elements that are critical to achieving success in scaling up RMNCH services, such as the involvement of non-governmental actors. The fit appears much weaker when it comes to financing sector-wide and upstream HSS (e.g., large infrastructure investments, sector reform). Many interviewees argued that the Global Fund has very little experience in these areas and country presence would almost certainly be needed.

Cost-Impact: Start-up costs associated with adapting the Global Fund's current business model and organizational structures so that they become suitable for an expanded mandate would be substantial. These costs would, however, be much lower than if a Global Fund for All Health MDGs were created from scratch. At the same time, medium-term opportunities for organizational efficiencies through a consolidated financing portfolio focused on all three MDGs, as well as a potential merger with GAVI, could likely be exploited. The additional resource needs of a Global Fund for the Health MDGs for the financing of programs related to MDGs 4–6 and associated HSS would be very high. Even if the Global Fund for the Health MDGs only aimed at contributing

towards reaching 50–70% of the universal coverage target by 2015, and if it only contributed a fifth of the funding to get there, it would still require funding of \$7–9 billion in addition to the funding for MDG 6.

Given the time required for the Global Fund for the Health MDGs to start operating, scale up is initially expected to be slow, but it would then be expected to accelerate rapidly. It could potentially save the lives of 1.5–2.1 million children, 340,000–480,000 neonates, and 60,000–85,000 mothers. It could also help to prevent 3.2–4.6 million unwanted pregnancies.

Feasibility: The feasibility of this option, at this current point in time, is very low. The Global Fund currently does not have the organizational capacity to take on such a significant expansion of its mandate, given its various ongoing reform efforts. Option 3B would also most likely imply significant changes to the business model (e.g., country presence) and to the governance of the Global Fund, which would be hard to implement in the short term. Political support for this option by key donors on the Global Fund's Board is also very low (although implementing countries tend to be more supportive). There is still strong resistance to co-mingling of MDG 6 funds with MDG 4/5 funds within a broader stakeholder group.

This report started out by describing the progress made towards MDGs 4 and 5 over the past 10 years, while also pointing to the remaining coverage, financing and aid effectiveness gaps that prevent the more rapid advancement of the health of

Chapter 7: Conclusions and Recommendations

women and children. It identified a range of structural and political barriers in the global financing architecture (e.g., no dedicated RMNCH financing channel, lack of sufficient prioritization of RMNCH and associated HSS by donors and country governments, no mechanism to track RMNCH funding flows) that contributed to a situation in which financing for large parts of RMNCH fell very far behind other health priorities and was not always channeled in the most effective and efficient manner.

Recent efforts, culminating in the Global Strategy, sought to address this neglect of RMNCH. One of the strategy's biggest achievements is that it placed the health of women and children back at the very top of the global health agenda. According to a recent report by PMNCH, the strategy succeeded in mobilizing unprecedented levels of global and domestic public and private resources for RMNCH—at least \$43.4 billion, although it is unclear how much of this funding is new and additional. It also triggered a range of policy and service delivery commitments that—if implemented—could contribute significantly to progress on RMNCH. Finally, the Global Strategy's Commission on Information and Accountability succeeded in establishing a set of 11 core indicators to track RMNCH resources and results along with an annual global process to review and comment on progress.

Yet, despite its great success in mobilizing political attention and resources, the Global Strategy left a range of issues unaddressed that predated its release. It is precisely these issues that could prove challenging to its successful implementation. The strategy remains relatively silent on the implementation and accountability mechanisms to ensure that global and domestic financial commitments are rapidly translated into rapid action at the country level. It says little about how exactly the additional resources can be accessed by countries, how the development of high quality, jointly assessed national health plans with strong RMNCH components will be accelerated, and how fragmentation in financing these plans will be reduced in the future. And it does not describe and push for a more clearly defined division of labor amongst multilateral financiers and bilateral financiers when it comes to financing RMNCH and the targeting of resources to countries and priority areas.

The options introduced in the second part of this report aim to address these open questions and remaining gaps through a range of solutions focused clearly on the lowest income countries. The approaches they suggest are not mutually exclusive

(nor collectively exhaustive), but rather build on each other and become more ambitious with each step. Option 1 requires very little change to the actual structure of the global financing architecture and focuses on strengthened *coordination rather than consolidation* of existing financing channels. At the other end of the spectrum, Option 3 proposes a global consolidation of financing channels requiring significant changes to the global financing architecture for RMNCH. Option 2, with its two sub-options A and B, is positioned in the middle. It supports the central premise of Option 1: improved coordination of financing channels, along with strengthened accountability mechanisms, is an essential condition for translating Global Strategy commitments into action. But seeing coordination alone as insufficient, it also proposes *complementing* these efforts with an innovative, catalytic scale-up initiative targeting opportunities for achieving rapid progress in a short period of time.

A summary of the preliminary assessment of the options (as laid out in detail in Chapter 6) is provided in [TABLE 7](#).

The preliminary assessment of options found that strengthening coordination, division of labor and accountability of existing channels of financing (Option 1) could go some way in accelerating progress on RMNCH. However, it is unlikely to bring the urgency, new resources, and strong leadership required to be a “game changer” in RMNCH. At the other end of the spectrum, the establishment of a consolidated global financing channel (whether focused on RMNCH or on all health MDGs, i.e. Options 3A or 3B), as suggested by a range of stakeholders, does not appear politically or organizationally feasible, at least in the short term.

The most promising approach, one with significant potential for impact and learning, appears to be Option 2, which combines Option 1 with one (or a blend of both) of the two rapid scale-up initiatives. If implemented rigorously, this combination would allow the global community to capture opportunities for increased efficiency, streamlining, and accountability of the current system, while testing—on a smaller scale—the potentially innovative and highly impactful approaches offered by Option 2.

There are pros and cons of both Options 2A and 2B, as outlined in the assessment above. They aim to address slightly different issues with different approaches. Option 2A focuses on the financing of gaps relating to RMNCH in the context of

TABLE 7: Summary assessment of options to improve the global aid architecture for RMNCH

	Strategic Fit	Cost-Impact	Feasibility
OPTION 1 Strengthened coordination and accountability of multiple funding channels	<ul style="list-style-type: none"> Unclear if IHP+ could play strong coordinating role; expanded World Bank role fits with latest strategy (but mixed track record); Global Fund and GAVI likely to exploit financing mandates around RMNCH 	<ul style="list-style-type: none"> Modest additional cost to strengthen existing mechanisms; but high overall investment levels Likely to improve aid effectiveness; health impact hard to quantify Prioritization of RMNCH and high burden countries not guaranteed 	<ul style="list-style-type: none"> Political support likely (option close to status quo; consistent with aid effectiveness principles) Unclear if stakeholders will make the changes to their operating/financing practices required for success
OPTION 2 Rapid scale-up initiatives	<ul style="list-style-type: none"> High strategic fit with World Bank as agency to host funding pool 	<ul style="list-style-type: none"> Moderate implementation costs for initial 5 countries; co-financing from Global Fund/GAVI/World Bank under HSFP Impact in 5 countries could be significant Roll-out to more countries may be constrained by slow pace of national health plan development 	<ul style="list-style-type: none"> High feasibility of rapid implementation in initial 5 countries, but not necessarily in additional countries Requires rigorous evaluation framework to garner donor support
A) Integrated strategies in selected countries	<ul style="list-style-type: none"> World Bank is a lead partner within IHP+ and HSFP 		
B) Selected interventions in highest burden countries	<ul style="list-style-type: none"> Strong synergies between the Global Fund's financing approach and scale-up of proposed interventions Funding would be separate from/additional to core mandate funding 	<ul style="list-style-type: none"> Initial implementation cost in 12 LICs comparable to 2A; higher expected number of deaths averted and slightly lower number of unwanted births averted), focused on countries without much donor attention 	<ul style="list-style-type: none"> Feasibility depends on rapid implementation of Global Fund internal reforms, and applications outside Round system
OPTION 3 Dedicated global funding channel	<ul style="list-style-type: none"> Strong fit with some aspects of Global Fund portfolio/approach, but changes to financing model, core structures, and Secretariat would be required World Bank could be alternative host 	<ul style="list-style-type: none"> High start-up costs; ongoing operational costs benefit from synergies with existing portfolio. High program/HSS costs but impact could also be significant⁹⁰ 	<ul style="list-style-type: none"> Low feasibility, given operational constraints and lack of sufficient political support by donors
A) RMNH channel			
B) Global Fund for the Health MDGs	<ul style="list-style-type: none"> Fit with Global Fund's current financing approach/expertise is strong in some areas but weak in others (e.g., broad HSS financing) Significant changes (e.g. country presence) likely to be required 	<ul style="list-style-type: none"> High start-up costs; medium-term efficiencies; very high program/HSS costs Impact could be highest of all options; initial scale up expected to be slow; aid effectiveness and accountability benefits likely 	<ul style="list-style-type: none"> Currently very low feasibility: lack of support from key Global Fund donors, limited Secretariat capacity to take on significant expansion of mandate

fully integrated, jointly assessed national health plans, leveraging the HSFP as a key funding mechanism. Option 2B focuses on the highest burden LICs, many of which are considered as fragile and may not be well suited to the approach taken by 2A. Option 2B thus takes a somewhat narrower approach, proposing the integration of high impact, low coverage interventions into existing financing activities of the Global Fund in these countries in order to leverage synergies and arrive at more complete *packages* of interventions to benefit women and children.

Further analysis would be required to assess both options in more detail. However, if a choice had to be made, Option 2B would appear somewhat more attractive than Option 2A on initial review, for four reasons:

- It is likely to have a higher impact on RMNCH at about the same cost (i.e. Option 2B is likely to be more cost-effective).
- It is strategically focused on the subset of LICs with the highest child and maternal mortality ratios globally and on scaling up packages of interventions with very low coverage and high impact. Many of these countries do not currently receive sufficient donor attention.
- It is synergistic and allows for integration with the current investments and the performance-based funding approach of the Global Fund.
- It could significantly contribute to removing health system bottlenecks in countries where these systems are very weak.

The feasibility of implementing and gathering political and financial support for Option 2B should thus be explored further.

A combination of the complementary approaches in Option 2A and 2B would also be possible, and would be more ambitious than just focusing on one of these options. In this combination, Option 2A would focus on financing RMNCH

elements of strong, jointly assessed national health plans for those LICs that have them and can orchestrate the financing of these plans. Option 2B would concentrate on financing specific high impact interventions in a subset of the highest burden, poorest countries that do not have jointly assessed integrated plans readily available.

In conclusion, focusing on Option 2, which combines the important coordination and optimization efforts under Option 1 with testing of catalytic and innovative approaches on a small scale, appears to be a promising and pragmatic path forward. This report thus recommends testing of interest in this option among key RMNCH stakeholders in follow up consultations and upcoming meetings, including the Fourth High Level Forum on Aid Effectiveness, Busan, Korea.

If there is stakeholder support for pursuing Option 2 further, the specific parameters of this option will need to be rapidly fleshed out based on consultations with governments, public and private donors, UN organizations, multilateral financiers and civil society. These parameters include the scope of financing, eligible countries, hosting organization, financing modalities, measures of success and evaluation approach. It will also be important to validate and further refine the preliminary financial and impact estimates for Option 2 that are included in this report. By the end of the year, a more advanced version of Option 2 should then be made available to those donors who are potentially interested in providing funding support. With strong support of donors and implementing countries, the strategic approach provided by Option 2 could have a transformative impact upon RMNCH, potentially addressing many of the weaknesses in the current aid architecture and thus facilitating more rapid implementation of the Global Strategy.

Appendix 1: Key Informants Interviewed*

NAME	POSITION	AFFILIATION/ ORGANIZATION
Kaosar Afsana	Coordinator, Health Programme	BRAC
Cristian Baeza	Director, Health, Nutrition & Population	The World Bank
Anurita Bains	Senior Advisor, Office of the Executive Director	The Global Fund to Fight AIDS, Tuberculosis and Malaria
Protik Basu	Managing Director	Office of the UN Secretary- General's Special Envoy for Malaria
Amie Batson	Deputy Assistant Administrator for Global Health	United States Agency for International Development
Christoph Benn	Director, External Relations	The Global Fund to Fight AIDS, Tuberculosis and Malaria
Zulfiqar A. Bhutta	Professor & Chairman, Department of Paediatrics & Child Health	The Aga Khan University (Prof. Bhutta is also Executive Committee member of the International Paediatric Association)
Marieke Boot	Policy Officer, DG Development	European Commission

NAME	POSITION	AFFILIATION/ ORGANIZATION
Olga Bornemisza	Senior Technical Officer for Health Systems Strengthening	The Global Fund to Fight AIDS, Tuberculosis and Malaria
Leonard Chavane	Deputy National Director of Public Health	Ministry of Health, Mozambique
Sadia Afroze Chowdhury	Senior Health Specialist, Health, Nutrition, & Population	The World Bank
Bernadette Daelmans	Medical Officer, Department of Child and Adolescent Health	World Health Organization
Lola Dare	Chief Executive Officer	Center for Health Sciences Training and Research and Development
Gary Darmstadt	Director, Family Health	Bill & Melinda Gates Foundation
Benedict David	Principal Advisor Health and HIV	Australian Agency for International Development
James Droop	Senior Policy Advisor, Human Development	UK Department for International Development

NAME	POSITION	AFFILIATION/ ORGANIZATION
Helen Evans	Deputy CEO	GAVI Alliance
Helga Fogstad	Assistant Director, Department for Global Health, Education and Research	Norwegian Agency for Development Cooperation
Julio Frenk	Dean	Harvard School of Public Health
Stefan Germann	Director, International Global Health Partnership & Health Research Unit	World Vision
Amanda Glassman	Director, Global Health Policy	Center for Global Development
Jennifer Goosen	Director, Maternal, Newborn and Child Health	Canadian International Development Agency
Barry Green	Managing Director, Finance and Operations	GAVI Alliance
Kara Hanson	Head of Global Health and Development and Reader in Health System Economics	London School of Hygiene & Tropical Medicine
Richard Horton	Editor-in-Chief	The Lancet

NAME	POSITION	AFFILIATION/ ORGANIZATION
Johannes Hunger	Senior Policy Analyst, Strategy, Performance and Evaluation Cluster	The Global Fund to Fight AIDS, Tuberculosis and Malaria
Michel Kazatchkine	Executive Director	The Global Fund to Fight AIDS, Tuberculosis and Malaria
Nicole Klingen	Acting Sector Manager, Health, Nutrition, & Population	The World Bank
Dan Kress	Deputy Director, Policy and Finance	Bill & Melinda Gates Foundation
Ruth Levine	Director, Global Development & Population Program	Hewlett Foundation
Jacqueline Mahon	Senior Policy Advisor, Health Systems & Aid Effectiveness	United Nations Population Fund
Purnima Mane	Deputy Executive Director Programme	United Nations Population Fund
Michael Mbizvo	Director, Department of Reproductive Health and Research	World Health Organization
Anders Nordström	HIV/AIDS Ambassador, Department for Multilateral Development Cooperation	Department for Multilateral Development Cooperation

NAME	POSITION	AFFILIATION/ ORGANIZATION
Nkeiru Onuekwusi	Head, Child Health Division	Federal Ministry of Health, Government of Nigeria
Gorik Ooms	Research Associate, Department of Public Health	Institute of Tropical Medicine, Antwerp
Joy Phumaphi	Executive Secretary	African Leaders Malaria Alliance
Oliver Sabot	Executive Vice President, Global Programs	Clinton Health Access Initiative
Peter Salama	UNICEF Representative in Zimbabwe	United Nations International Children's Fund
Rotimi Sankore	Coordinator	Africa Public Health Alliance/15% Plus Campaign
Finn Schleinmann	Senior Health Specialist (International Health Partnership+ Core Team)	The World Bank
Joachim Schmitt	Officer, Health, Population Policy	Ministry for Economic Cooperation and Development
Julian Schweitzer	Principal	Results for Development Institute
Sudha Sharma	Secretary of Health	Ministry of Health and Population, Nepal

*Devi Sridhar, University of Oxford, gave a written response.

NAME	POSITION	AFFILIATION/ ORGANIZATION
Jeremy Shiffman	Associate Professor, Department of Public Administration and Policy	American University
Lucy Simiyu	National Partnership Platform Coordinator	Kenya AIDS NGOs Consortium
Ian Smith	Advisor to the Director-General	World Health Organization
Mary Ellen Stanton	Maternal Health Team Leader	United States Agency for International Development
Ann Starrs	President	Family Care International
Karin Stenberg	Technical Officer, Department for Health Systems Financing	World Health Organization
David Stevenson	Director, General Global Initiatives Directorate, Multilateral and Global Programs Branch	Canadian International Development Agency
Todd Summers		Independent Consultant
Martin Taylor	Health Policy Specialist	MannionDaniels
Neghist Tesfaye	Head, Family Health Department	Ministry of Health, Ethiopia
Marijke Winrocks	HIV/AIDS Ambassador, Netherlands	Dutch Ministry of Foreign Affairs

Appendix 2: Semi-structured Questionnaire

QUESTION 1: Why have we seen comparatively slow progress in scaling up coverage of key RMNCH interventions in a number of areas?

QUESTION 2: Which challenges and bottlenecks at country level would you point to when it comes to scaling up packages of care for women and children?

QUESTION 3: How would you rate the performance of the global aid architecture to date in mobilizing and effectively channeling financial resources to RMNCH? Which gaps and inefficiencies in the current global health financing architecture contribute to the inadequate progress towards MDGs 4 and 5?

QUESTION 4: To what extent do you expect recent donor commitments in the context of the Muskoka Initiative and the Global Strategy for Women's and Children's Health to translate into increased funding for previously underfinanced RMNCH interventions and related health systems strengthening?

QUESTION 5: What is the potential (and what are the limits) of other recent initiatives to improve the global health financing architecture related to women and children (e.g. the IHP+, the Health Systems Funding Platform, the H4+, Commission on Information and Accountability)?

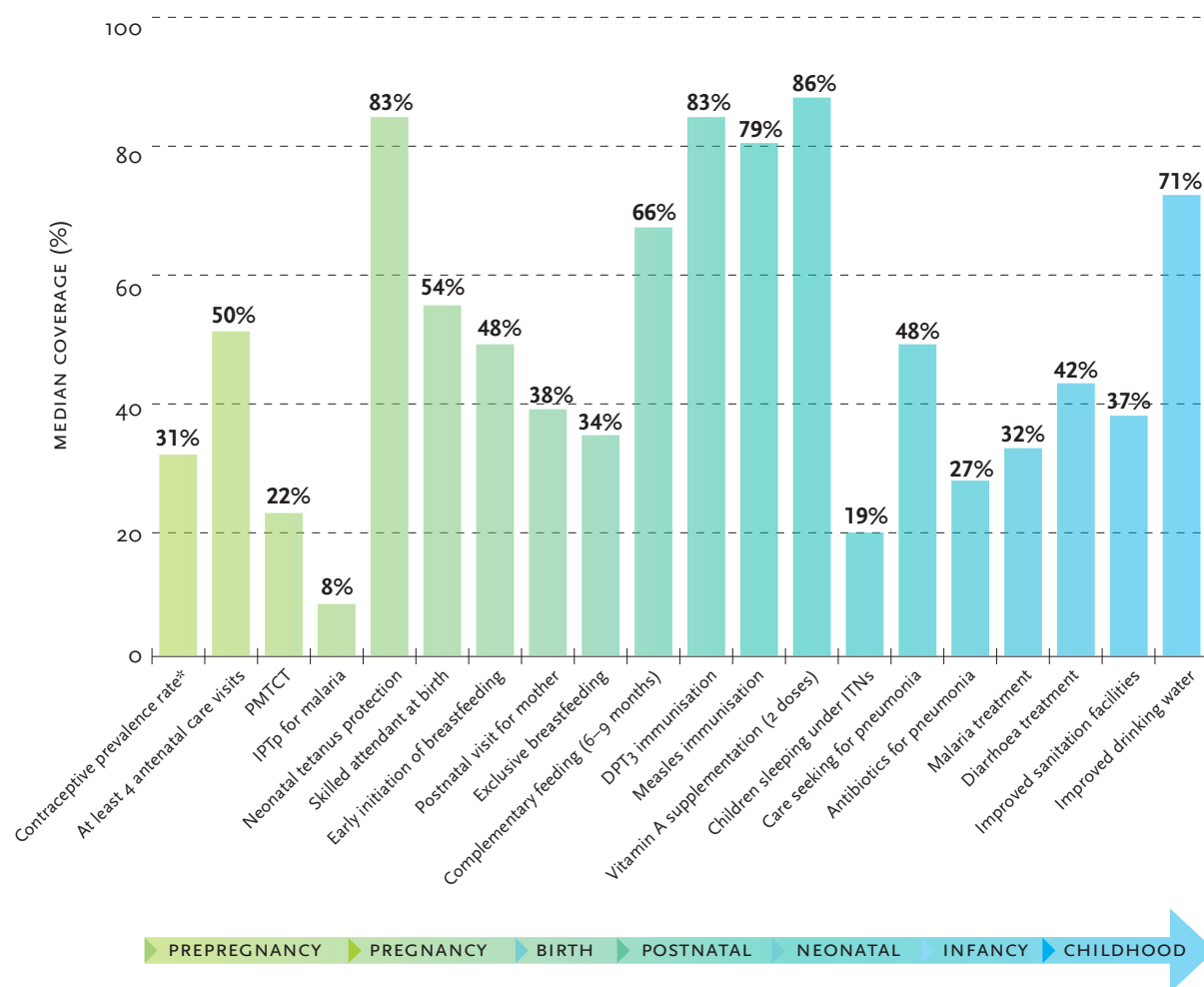
QUESTION 6: Which opportunities for improving the global health financing architecture do you see that could help to achieve rapid progress towards MDGs 4/5? What would your favored option look like concretely and why?

QUESTION 7: Against which criteria should potential options be tested?

Appendix 3: Estimated Impact of Different RMNCH Packages Upon Mortality

HIGH IMPACT	RATIONALE
Childbirth package	<ul style="list-style-type: none"> • 42% of maternal deaths are in the intra-partum period—strategies aimed at reducing maternal deaths must focus on childbirth. • Facility-based package would have the highest impact, but there is evidence that selected interventions can be safely delivered by community-based health workers.⁹¹ • Package could reduce risk of postpartum hemorrhage (PPH) by 67% (PPH causes over 1/3 of maternal deaths).⁹² • Up to 19–34% of neonatal deaths could be averted by scaling up childbirth care to 90% coverage in 60 countries.¹⁷ • Childbirth care reduces risk of intra-partum stillbirths.
Child care package	<ul style="list-style-type: none"> • Scaling up 23 preventive/therapeutic child health interventions to 99% coverage in 42 LICs could avert 63% of child deaths.⁹³ • Neonatal interventions are responsible for 18% out of the 63% figure, suggesting that the infant/child interventions alone could avert 45% of child deaths in these 42 countries.
INTERMEDIATE IMPACT	RATIONALE
Reproductive health package	<ul style="list-style-type: none"> • Scaling up comprehensive RH services to 95% coverage in 49 lowest-income countries could avert up to 32% of maternal deaths and 10% of newborn, infant, and child deaths.⁹² • Universal access to safe abortion to full extent of the law could prevent nearly all deaths (70,000) from unsafe abortion annually.
Postnatal care package	<ul style="list-style-type: none"> • Early postnatal period, particularly the first 24 hours after birth for the mother and the first week of life for the neonate, is a high risk period (75% of all neonatal deaths are within the first week of life). • Full postnatal package of interventions that includes emergency neonatal care could avert up to 17–39% of neonatal deaths.¹⁷ • Impact of this package on maternal deaths is unclear.
LOW IMPACT	RATIONALE
Antenatal care package	<ul style="list-style-type: none"> • Several of the individual interventions are of high efficacy (e.g. tetanus toxoid vaccination reduces risk of neonatal deaths from tetanus by 90%), but the overall impact of scaling up an ANC package on maternal health is unclear • Impact is likely to be low compared with scaling up other types of packages. • Lancet Maternal Survival Series steering group concluded that ANC packages have only a “limited potential to affect maternal mortality ratios.”¹⁶ • Maternal care during pregnancy can help to prevent antepartum stillbirths (particularly care that targets high blood pressure, infections, and poor fetal growth). • Overall impact on neonatal mortality is lower than childbirth package or postnatal package: Darmstadt and colleagues estimated that scaling up an ANC package would avert only 5–10% of neonatal deaths.¹⁷

Appendix 4: Coverage of Key RMNCH Interventions Tracked by Countdown to 2015



*Target rate is not 100%.

Source: Countdown to 2015 Decade Report

Appendix 5: Cost-effectiveness of RMNCH Interventions

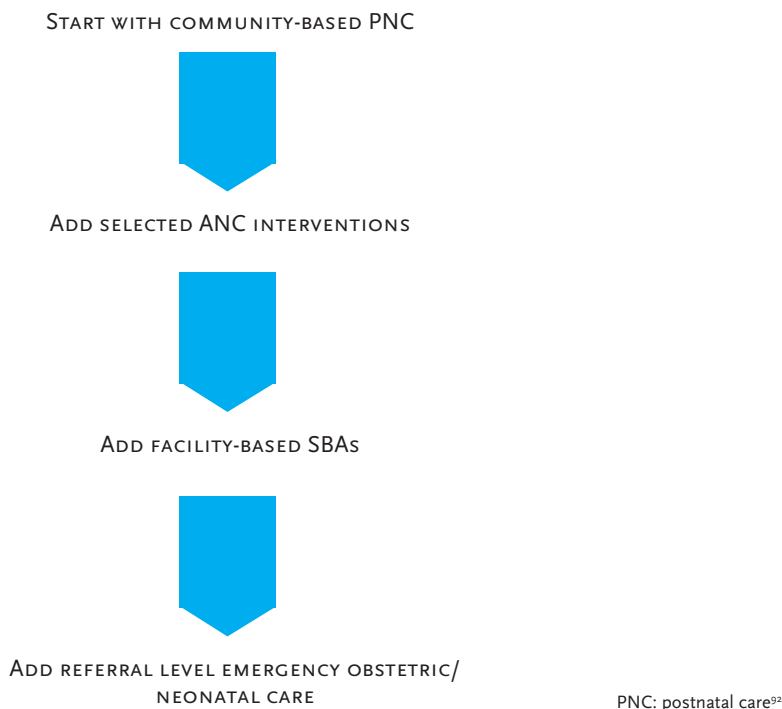
One way to prioritize which interventions to scale up first is to rank them according to their estimated cost effectiveness. A ranking exercise by WHO found that postnatal care is the most cost effective MNH intervention, and that fortification of processed food staples with vitamin A and zinc is the most effective child health intervention. Data from the Disease Control Priorities Project and the World Bank suggest that family planning is highly cost effective and compares favorably with maternal care packages.

The most relevant estimates on cost-effectiveness are those provided by WHO's CHOICE (Choosing Interventions That Are Cost Effective) MDGs Team, which examined the costs versus benefits of 21 MNH interventions and 9 child health interventions when scaled up in SSA and South East Asia.⁹⁴ The team had insufficient data on reproductive health interventions (family planning, abortion services) to include these

in their analysis. The authors present the results as an “optimal expansion path”—i.e., they rank the interventions that would be purchased at given levels of resource availability, if cost effectiveness were the only consideration. The expansion path is not intended to be used in a formulaic way, but rather as a way of summarizing the best evidence on cost-effectiveness for use in decision-making.

The figure below shows the results for MNH interventions. The expansion path suggests that scaling up community-based postnatal care (e.g., treating neonatal pneumonia) is the most cost-effective intervention and would be prioritized first, followed by selected antenatal care interventions (e.g., tetanus toxoid), then interventions delivered by a skilled birth attendant (SBA) in a health facility (e.g., normal delivery by the attendant), and then by more complex interventions that require referral to a higher level health facility (e.g., management of obstructed labor).

: “Optimal expansion path” for scaling up MNH interventions in SSA and SE Asia based on cost-effectiveness alone



The table below summarizes the cost-effectiveness of these packages of MNH interventions in SSA. WHO's Choice MDGs team considered all of the packages of interventions shown in the table to be “highly cost effective,” because they cost less than the GDP per capita to avert each disability-adjusted life year (DALY). As discussed in Section 2.2, the overall impact of ANC on mortality is relatively low compared

with other interventions (in part because of the high coverage); however, many ANC interventions are very low cost, making them highly cost effective. The authors also found that in SE Asia, two interventions were not cost effective (because of high costs and low effectiveness)—antibiotics for preterm rupture of membranes and antenatal steroids for preterm births. These would therefore not be prioritized based on cost effectiveness.

Cost-effectiveness of MNH interventions along the “optimal extension path” in SSA.⁹⁴

MNH PACKAGE	AVERAGE COST EFFECTIVENESS RATIO (\$ PER DALY AVERTED)	INCREMENTAL COST EFFECTIVENESS RATIO (\$ DALY AVERTED)
Community-based PNC (treatment of neonatal pneumonia; support for breastfeeding mothers; support for low birth weight babies)	7	8
Community-based PNC + selected ANC interventions (tetanus toxoid, screening for pre-eclampsia; and screening for and treatment of bacteriuria and syphilis)	12	27
Community-based PNC + selected ANC interventions + facility-based SBAs (normal delivery; active management of 3rd stage of labor; initial management of PPH)	18	40
Community-based PNC + selected ANC interventions + facility-based SBAs + referral level emergency obstetric/neonatal care (treatment of severe pre-eclampsia; emergency neonatal care; management of obstructed labor, breech presentation, and fetal distress)	28	73

WHO's Choice MDGs team conducted a similar analysis for 9 selected child health interventions. The most cost effective was fortifying processed food staples with the micronutrients vitamin A and zinc; this was followed by case management of pneumonia and diarrhea and measles vaccination, and then by vitamin A and zinc supplementation. The team found that provision of supplementary food and counseling on nutrition was *not* cost effective. Overall, the analysis suggests, based on cost-effectiveness alone, that food fortification should be given very high priority.

In order to assess whether reproductive health interventions are likely to be cost-effective, estimates are available from two sources: *Disease Control Priorities in Developing Countries 2006* (DCCP), which gives the cost-effectiveness of a range of

different packages of RMNCH interventions,⁹⁵ and the World Bank's 1993 *World Development Report*, which presented a set of services (the "essential health package") that would make the most efficient use of scarce health resources.⁹⁶ The table below compares the cost-effectiveness ratios from the DCCP for a variety of different approaches to improving RMNCH. It shows that family planning is highly cost-effective (in S Asia, it is the most cost-effective of the different packages examined by the DCCP; in SSA, it compares favorably with different maternal care packages). *The World Development Report* also found family planning to be highly cost-effective, costing only \$15–150/DALY averted, compared with \$30–250/DALY averted for antenatal and childbirth care.

DCCP estimates of the cost-effectiveness of different RMNCH interventions, including family planning

PACKAGE	COST EFFECTIVENESS RATIO (\$ PER DALY AVERTED)
Increased primary maternal care coverage with routine antenatal, intrapartum, and postnatal care	132 (S Asia), 88 (SSA)
Improved quality of comprehensive emergency obstetric care	127 (S Asia), 87 (SSA)
Improved overall quality of maternal care so that women are offered full range of basic and emergency obstetric services and nutritional supplementation	147 (S Asia), 83 (SSA)
Improved overall quality of maternal care and coverage	152 (S Asia), 86 (SSA)
MCH package: includes family planning, antenatal care, and comprehensive obstetric care	1,060 (S Asia), 924 (SSA)
Neonatal package: healthy home care practices (e.g., exclusive breastfeeding, warmth protection, clean cord care, care seeking for emergencies); if birth outside facility, includes clean delivery kit	349 (S Asia), 345 (SSA)
MCH + neonatal package (combined MNCH package)	839 (S Asia), 789 (SSA)
Family planning: IUD, sterilization, condoms/other barriers, implants, oral contraceptives	117

Appendix 6: Mapping of Options for Strengthening the RMNCH Financing Architecture Discussed in the Literature

Options assigning a key role in RMNCH and associated HSS financing to the Global Fund and/or GAVI

	RECOMMENDATIONS/ SUGGESTED FEATURES	SOURCE
Global Fund mandate expansion	Expand the mandate of the Global Fund, or create a new global fund for maternal and child health.	Costello A, Osrin D. The case for a new Global Fund for maternal, neonatal, and child survival. <i>Lancet</i> 2005; 366: 603–05.
	Expand the Global Fund's mandate to finance maternal, newborn, and child health.	Horton R. Maternal mortality: surprise, hope, and urgent action. <i>Lancet</i> 2010; 375:1581–82.
	Turn the Global Fund into a Global Fund for all health-related MDGs.	Lancet—Editorial. The Global Fund: replenishment and redefinition in 2010. <i>Lancet</i> 2010; 375: 865.
	Morris quotes Minister Tedros as championing “a bold new proposal to broaden the Global Fund's mandate and consolidate it into a fully financed Global Fund for the Health MDGs.”	Morris K. Tedros Adhanom Ghebreyesus—a Global Fund for the Health MDGs. <i>Lancet</i> 2010; 375:1429.
	Transform the Global Fund into a Global Health Fund. The transformation of the Global Fund into a ‘diagonal’ and ultimately perhaps ‘horizontal’ financing approach should happen gradually, and be accompanied by measures to safeguard its exceptional features.	Ooms G, et al. The ‘diagonal’ approach to Global Fund financing: a cure for the broader malaise of health systems? <i>Globalization and Health</i> 2008; 4:6
	Expand the Global Fund's mandate to also cover MDGs 4 and 5.	Sachs J. Funding a global health fund. At: http://www.guardian.co.uk/commentisfree/2010/mar/25/global-health-fund-funding-tb-aids
	Explores <i>which</i> components of the MNCH agenda would offer the greatest “fit” with the Global Fund's financing approach and the greatest health impact at limited costs.	Schrade C, et al. Packages of Care—A Pragmatic Approach to Exploring an Enhanced Role for the Global Fund in Maternal, Newborn and Child Health (MNCH). E2Pi Working Paper, December 2010. At: http://globalhealthsciences.ucsf.edu/pdf/e2pi-packages-of-care.pdf
GAVI mandate expansion	Suggests that “between the three agencies, the ‘health system’ could be covered: GAVI extending its coverage to include a broader Maternal and Child Health agenda, the Global Fund adding the neglected tropical diseases and global epidemics to its brief, and the World Bank covering generic finance and systems issues.”	Hill PS, et al. The Health Systems Funding Platform: Is this where we thought we were going? <i>Globalization and Health</i> 2011; 7:16.

Merger of GAVI and the Global Fund into a Global Health Fund

Recommends that the Global Fund and GAVI gradually move towards becoming one global fund for all the health MDGs. As a first step the Global Fund and GAVI boards should review their architecture to provide greater support to national health plans, including co-financing non-disease-specific human resources.

Recommends merging GAVI and the Global Fund into a new single Global Health Fund with added responsibilities for HSS.

“A proposal could be to consider the Global Fund and GAVI as a conduit for additional resources for health systems and achieving MDG 4, 5 and 6 while maintaining a focus on results.”

Cometto G, et al. A global fund for the health MDGs? *Lancet* 2009; 373: 1500–02.

See also: Cometto G, et al: Towards a global fund for the health MDGs? *Lancet* 2009; 374: 1146.

Sachs, J. MDGs in 2010: charting the way, in: Commonwealth Finance Ministers Reference Report. London, UK: Commonwealth Secretariat, 2010.

Taskforce on Innovative International Financing for Health Systems. Working Group 2: Raising and Channeling Funds. Progress report to Taskforce, 13 March 2009.

Options assigning a lead role to the World Bank in RMNCH and associated HSS financing

RECOMMENDATIONS/ SUGGESTED FEATURES

Global Fund and the World Bank to establish a clear division of labor based on the comparative advantages of each organization: rapid scale-up of disease-specific programs for the Global Fund, and long-term development of fundamental health infrastructure for the World Bank.

Leverage the World Bank’s comparative advantage to “look at a whole country, rather than just at the health sector or a particular disease” and to “to work on the vexing but vital issue of how to improve the functioning of health systems (...).”

The World Bank itself argues that it should have a comparative advantage in HSS and RMNCH financing.

SOURCE

Shakow A. Global Fund—World Bank HIV/AIDS Programs. Comparative Advantage Study, Geneva, 2006.

Levine R, Buse K. The World Bank’s New Health Sector Strategy: Building on Key Assets. *J R Soc Med.* 2006; 99(11): 569–572.

The World Bank, The World Bank’s Reproductive Health Action Plan 2010-2015.

Options assigning a lead role to a strengthened HSS platform to support costed and jointly assessed national health strategies

RECOMMENDATIONS/ SUGGESTED FEATURES

Argues that the case for joint funding is overwhelming but says that the Platform risks doing little more than coordinating disease-specific funding. Recommends that the Platform funding agencies undertake steps to structurally reform themselves.

Argues that despite not being “the imagined outcome,” the Health Systems Funding Platform constitutes positive progress. Its performance so far should encourage additional funding as it might point to the right direction in how to increase integration of health systems support.

Lays out the operational framework and benefits of the Platform, but finds that further work and alignment of existing structures is required to realize the full potential of the Platform.

SOURCE

England, R. The GAVI, Global Fund, and World Bank joint funding platform. *Lancet* 2009, 374: 1595–1596.

Hill PS, et al. The Health Systems Funding Platform: Is this where we thought we were going? *Globalization and Health* 2011;7:16.

Schäferhoff M, et al. The Health Systems Funding Platform—A Primer. 2011. E2Pi policy brief. At: <http://globalhealthsciences.ucsf.edu/pdf/e2pi-the-health-systems-funding-platform.pdf>

Appendix 7: Method for Calculating the Costs and Health Impacts of the Options

The cost-impact analysis of the option assessment draws on quantitative data that was provided by the WHO's Department of Health Systems Financing.⁹⁷ WHO provided cost/impact data on maternal health, family planning, and IMCI plus the associated health systems costs (based on percentage of program costs) for three different sets of countries: 5 countries for Option 2A, 12 countries for Option 2B, and 49 countries for Option 3A. For Option 3B, the cost-impact data provided by the Global Strategy were used. It is important to note that the WHO data were only used as a starting point and that a number of additional steps were undertaken to estimate how much funding would be required for the different options, and the likely public health impact of each option.

First, a similar approach as in the Global Strategy was used: the calculations drew upon two different costing models, WHO's normative costing and the Marginal Budgeting for Bottlenecks (MBB) approach used by the World Bank. For the Global Strategy, WHO's cost/impact estimates were combined with the MBB *medium scenario*⁹⁸ (both estimates were originally calculated for the HLTF). Based on the data received from the WHO, the MBB baseline value, was calculated and the median of the WHO and the MBB values was then drawn (for the Global Strategy, the median of the WHO and MBB estimates was also used).⁹⁹

Second, while the WHO's cost-impact data relate to scaling up to universal coverage levels, the calculations for Option 2 and 3 assume that only 50–70% of this universal coverage target could feasibly be implemented in remaining years up to 2015. It was further assumed that achieving these coverage levels would require 40–50% of the estimated costs to achieve universal coverage (following the argument that costs for initial scale-up are lower and that they increase significantly the closer one gets to reaching universal coverage).¹⁰⁰ Third, it was assumed for Options 2–3 that they would finance 20% of the total additional program and associated health systems costs required to achieving these coverage levels.

Finally, for Option 2B, we also needed to calculate the costs for scaling up skilled birth attendants only (rather than the full package of maternal health interventions). However, cost-impact estimates for scaling up access to skilled birth attendants in isolation from other maternal health interventions are not included in WHO's calculations. Therefore the costing was based on the assumption that 35% of the total costs for maternal health (program and associated health systems costs) would be needed for improving access to skilled care at birth.

REFERENCES

1. This MDG target was added in 2005.
2. United Nations. *The Millennium Development Goals Report 2011*. New York: UN, 2011.
3. MDGs Progress Chart 2011. At: <http://unstats.un.org/unsd/mdg/News.aspx?ArticleId=60>.
4. UNICEF. *Levels and Trends in Child Mortality. Report 2011*. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. At: http://www.unicef.org/media/files/Child_Mortality_Report_2011_Final.pdf
5. For alternative maternal and child mortality data, see: Lozano, R et al. Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. *Lancet* 2011; 378:1139-65.
6. WHO, UNICEF, UNFPA, World Bank. Trends in Maternal Mortality, 1990–2008. At: <http://www.who.int/reproductivehealth/publications/monitoring/9789241500265/en/index.html>.
7. Hogan MC, et al. Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. *Lancet* 2010; 375:1609-23.
8. WHO, UNICEF. Countdown to 2015 Decade Report. Geneva: WHO and UNICEF, 2010. At: <http://www.countdown2015mnch.org/reports-publications/2010-report>.
9. For the 2012–15 period, the number of Countdown countries has increased to 74 countries.
10. World Bank. *Better Health for Women and Families: The World Bank's Reproductive Health Action Plan 2010–15*. Washington, DC: World Bank, 2010.
11. Neonatal pneumonia accounts for 4% of all child deaths, and neonatal diarrhea for 1% of all child deaths (outside the neonatal period, pneumonia causes 14% of deaths, malaria causes 8% of deaths, and diarrhea causes 14% of deaths; see Figure 3).
12. Lengeler, C. Insecticide-treated bed nets and curtains for preventing malaria. *Cochrane Database of Systematic Reviews 2004*, Issue 2. Art. No.: CD000363.
13. Kinney MV, et al. Sub-Saharan Africa's mothers, newborns, and children: where and why do they die? *PLoS Med* 2010;7(6): e1000294.
14. DFID. *Choices for Women: Planned Pregnancies, Safe Births, and Healthy Newborns*. London: DFID, 2010.
15. Evidence to Policy Initiative (E2Pi). *Packages of Care: A Pragmatic Approach to Exploring an Enhanced Role for the Global Fund in MNCH*. Working Paper, December 2010. At: <http://globalhealthsciences.ucsf.edu/pdf/e2pi-packages-of-care.pdf>.
16. Campbell OMR, et al. Strategies for reducing maternal mortality: getting on with what works. *Lancet* 2006; 368:1284–99.
17. Darmstadt GL, et al. Saving newborn lives in Asia and Africa: cost and impact of phased scale-up of interventions within the continuum of care. *Health Policy Plan*. 2008;23:101–117.
18. Yeboah-Antwi K, et al. Community case management of fever due to malaria and pneumonia in children under five in Zambia: a cluster randomized controlled trial. *PLoS Med* 2010;7(9): e1000340.
19. Coverage with hand washing ranged from 3% (Ghana) to 42% (India); coverage with rotavirus vaccination was 0% in 67 countries (it is 71% in Brazil), even though it is now expected to be scaled up with GAVI financing. See: Walker CLF, et al. Scaling up diarrhea prevention and treatment interventions: A Lives Saved Tool analysis. *PLoS Med* 2011;8(3): e1000428.
20. Office of the Prime Minister of Norway. *The Global Campaign for the Health MDGs, First Year Report*. Oslo: Office of the Prime Minister of Norway, 2008.
21. Ashford L. *Resource Flows for International Population Assistance and UNFPA*. Background paper prepared for the Center for Global Development Working Group on UNFPA's Leadership Transition, Washington, DC, 2010.
22. Flaxman AD, et al. Rapid scaling up of insecticide-treated bed net coverage in Africa and its relationship with development assistance for health: a systematic synthesis of supply, distribution, and household survey data. *PLoS Med* 2010;7(8): e1000328.

23. UNAIDS Outcome Framework: Business Case 2009–2011. At: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/20101031_JC1965_PMTC.en.pdf.
24. Government effectiveness measures “the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government’s commitment to such policies.” See: The World Bank. *World Development Indicators 2007*. Washington, D.C. p. 262. At: <http://data.worldbank.org/sites/default/files/wdi07fulltext.pdf>.
25. IHME. *Financing Global Health 2010. Development Assistance and Country Spending in Economic Uncertainty*. Seattle: University of Washington, 2010.
26. For example, Countdown includes, but IHME excludes, funding for MDG 6 that is allocated to women, neonates, and children. IHME on the other hand includes, but Countdown excludes, family planning. Furthermore, Countdown focuses on official development assistance (ODA) to health, while IHME includes other official flows (e.g., IBRD loans).
27. Pitt C, et al. Countdown to 2015: assessment of official development assistance to maternal, newborn, and child health, 2003–08. *Lancet* 2010; 376:1485–96.
28. Countdown estimates that disbursements to MNCH in *all* developing countries increased from \$2.63 billion to \$5.39 billion between 2003 and 2008. The increase from \$2.63 billion to \$5.39 billion reflects a 105% increase, but no change relative to overall health ODA, which also increased by 105% from 2003 to 2008.
29. Presern C, de Francisco A. *Parliamentarians Taking the Lead: Maternal, Newborn and Child Health*. PMNCH Presentation, 2011. At: <http://www.who.int/pmnch/media/membernews/2011/Roundtablepptfinalrev1.pdf>.
30. Financial Gaps Working Group. FAQs on Estimates of Financing Gap and Health Impact of the Global Strategy, 2011. At: http://www.who.int/pmnch/activities/jointactionplan/100922_faq_finance.pdf.
31. See: <http://www.rollbackmalaria.org/ProgressImpactSeries/report3.html>.
32. Piva P, Dodd R. Where did all the aid go? An in-depth analysis of increased health aid flows over the past 10 years. *Bull World Health Organ*. 2009;87:930–9.
33. Lane C, Glassman A. *Smooth and Predictable Aid for Health*. A Role for Innovative Financing? At: http://www.brookings.edu/-/media/Files/rc/papers/2008/08_global_health_glassman/08_global_health_glassman.pdf.
34. This figure is based on the assumption that 25% of all government expenditures for health are spent on RMNCH. It excludes funding from international sources channeled through governments.
35. Of these 49 lowest-income countries, 43 were also Countdown countries in the 2008–2010 period.
36. While estimates of domestic funding will be available for a subset of Countdown countries in late 2011, currently there are only limited data on domestic RMNCH expenditures. In Malawi, half of the funding for reproductive and child health comes from international sources, about 30% from the government, and 20% from private sources. In Ethiopia, external resources also account for nearly half of all RMNCH funding, about a third comes from private sources, and the remainder comes from government expenditures. Of total child health funding in Ethiopia, 40% comes from private sources, 35% from external sources, and 25% from the Ethiopian government (see reference 29).
37. IHME found that, on average, for every \$1 of health aid given directly to governments, those governments decreased their own health spending by a range of 43 cents to \$1.14.
38. Neither UNAIDS nor UNDP allocated substantial funding to RMNCH (funding is below \$2 million).
39. Kaiser Family Foundation. U.S. Global Health Policy Fact Sheets: U.S. Funding for the Global Health Initiative (GHI): The President’s FY 2012 Budget Request, 2011. At: <http://www.kff.org/globalhealth/upload/8160.pdf>; Kaiser Family Foundation. The U.S. Global Health Initiative: A Country Analysis, 2011. At: <http://www.kff.org/global-health/upload/8140.pdf>.
40. DFID. Health Portfolio Review 2009, at <http://www.dfid.gov.uk/Documents/publications1/health-portfolio-review-rpt-2009.pdf>.
41. Web appendix to Pitt et al. (see reference 27). At: <http://www.elsevier.es/sites/default/files/elsevier/mmc/600/600v376n9751/600v376n9751-13187474mmc1.pdf>.
42. One study showed that more than 60% of the Gates Foundation’s global health funding in 2005 supported research, which would be excluded from Countdown’s definition of RMNCH activities; see

- Sridhar D, Batniji R. Misfinancing global health: a case for transparency in disbursements and decision making. *Lancet* 2008; 372: 1185–91.
43. In recent years, there has been an explosion of malaria advocacy groups, such as Malaria No More and Nothing But Nets; see: The PLoS Medicine Editors. Time for a “third wave” of malaria activism to tackle the drug stock-out crisis. *PLoS Med* 2009;6(11): e1000188.
 44. Feldbaum H, et al. The national security implications of HIV/AIDS. *PLoS Med* 2006; 3(6): e171.
 45. Montagu D, et al. Where do poor women in developing countries give birth? A multi-country analysis of Demographic and Health Survey data. *PLoS ONE* 2011;6(2): e17155.
 46. Macro International Inc. *Evaluation of the Global Fund Partner Environment, at Global and Country Levels, in Relation to Grant Performance and Health System Effects, including 16 Country Studies*, June 2008; Macro International Inc. *The Impact of Collective Efforts on the Reduction of the Disease Burden of AIDS, Tuberculosis and Malaria*, 2009; TERG. *The Five-Year Evaluation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Synthesis of Study Areas 1, 2 and 3*, May 2009.
 47. HLSP. *GAVI Health Systems Strengthening Support Evaluation 2009 Volume 1: Key Findings and Recommendations*, October 8, 2009.
 48. Independent Evaluation Group (IEG). *Evaluation of World Bank Group support to Health, Nutrition and Population (HNP)*. Washington, DC: World Bank, 2010.
 49. Regional development banks also finance RMNCH, but their RMNCH contributions are not included in Countdown’s analysis because the banks did not report disbursements to the CRS database during the analysis period (2003–2008). IHME collected data on the overall global health funding from three regional development banks (the Inter-American Development Bank, the African Development Bank, and the Asian Development Bank), and estimated that total health disbursements of these three banks grew from \$181.4 million in 1990 to \$316 million in 2010. Yet IHME does not specify how much of this funding is targeted towards RMNCH.
 50. GAVI estimates that the expanded IFFIm will generate an additional \$475–500 million for HSS for the period 2011–2015.
 51. Schäferhoff M, et al. Financing maternal and child health—what are the limitations in estimating donor flows and resource needs. *PLoS Med* 2010;7(7): e1000305.
 52. The first analysis was conducted by WHO in collaboration with UNAIDS and UNFPA. This costing was based on a facility-based approach, emphasizing the building of new health centers and hospitals and the need for more nurses and midwives. The other analysis was conducted by an interagency group coordinated by the World Bank and UNICEF, with collaboration from UNFPA and PMNCH. The World Bank’s costing approach, known as marginal budgeting for bottlenecks (MBB), favors a delivery strategy that emphasizes full scale up of community based services before expanding clinical services. Building on health data reported by developing countries, MBB identifies important health systems constraints (bottlenecks) and then calculates the cost of strategies to remove programmatic and health systems bottlenecks, and their returns in terms of health outcomes. The World Bank calculated three scale-up scenarios, and the \$111.6 billion relates to the medium scenario used for the HLTF report. See: Taskforce on Innovative International Financing for Health Systems (2009). *Constraints to Scaling Up and Costs*. Working Group 1 Report.
 53. The “+” symbol attached to the IHP signals the bringing together of a range of other initiatives that were established at around the same time as the IHP, all of which aim to accelerate the achievement of the health-related MDGs in line with the Paris Declaration. These include: Providing for Health, Harmonization for Health in Africa, Innovative Results-Based Financing, Deliver Now for Women and Children, Health Metrics Network, and Global Health Workforce Alliance.
 54. Evidence to Policy Initiative (E2Pi). *The Health Systems Funding Platform—A Primer*. Evidence to Policy Initiative (E2Pi), Policy Brief, March 2011. At: <http://globalhealthsciences.ucsf.edu/pdf/e2pi-the-health-systems-funding-platform.pdf>.
 55. Other countries are also using the JANS tools more informally at different stages of plan development and implementation (e.g., Rwanda, Mali). It is expected that a few more countries will go through the JANS process in 2011 (e.g., Kyrgyzstan).
 56. IHP+Results is an independent consortium of research and advocacy organizations mandated to provide an annual assessment of the results of the IHP+. The report is available at <http://ihpresults.net>.
 57. World Bank. *Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results*. Washington, DC: World Bank, 2007.

58. Authors' calculation based on World Bank HNP statistics. At: <http://go.worldbank.org/851WC143G0>.
59. World Bank. *Implementation of the World Bank's Strategy For Health, Nutrition, and Population (HNP) Results: Achievements, Challenges, and the Way Forward*. Progress Report, Washington, DC: World Bank, 2009.
60. See: <http://www.rbhealth.org/rbhealth/content/health-results-innovation-trust-fund>
61. These countries are DRC, Mozambique, Nigeria, Swaziland, Bangladesh, Pakistan, Iraq, Yemen, Argentina, and Brazil.
62. The World Bank, Human Development Network. *The World Bank's Reproductive Health Action Plan 2010–2015. Year 1 Implementation and Progress*. Washington, DC: World Bank, 2011.
63. UNFPA. *Annual Report 2010*; see also: UNFPA. *Strategic Work Plan for 2008–2011*.
64. Donors to the Thematic Fund for Maternal Health are Australia, Luxembourg, Netherlands, Norway, Spain, Sweden, and private donors. Donors to the Thematic Fund for Obstetric Fistula are Iceland, Canada, Luxembourg, Spain, and private donors.
65. Center for Global Development. *Four Recommendations for Action*. Report of the CGD Working Group on UNFPA's Leadership, Washington DC, 2010. CGD's report also emphasizes that UNFPA is a relatively small organization that depends on its national partners to deliver its programs. Implementing and oversight agencies are usually government ministries. In the poorest countries, where UNFPA commits most of its resources (e.g., Sudan, DRC, and Ethiopia), government accounting systems are extremely weak. At the same, UNFPA has created complex reporting processes to monitor its projects that are seen as transaction-cost heavy and burdensome for countries.
66. See: <https://www.unfpa.org/public/home/supplies/pid/3591>.
67. These donors are: Netherlands, UK, Spain, Canada, and Luxembourg (in order of size).
68. Background information on SUN can be found here: <http://www.thousanddays.org/partners/scaling-up-nutrition-info/>.
69. The Partnership for Maternal, Newborn & Child Health. *Analysing Commitments to Advance the Global Strategy for Women's and Children's Health*. The PMNCH 2011 Report. Geneva, Switzerland: PMNCH, 2011.
70. To analyze the targeting of commitments to specific interventions across the continuum of care, the authors of the report counted how often those making a commitment explicitly referred to an intervention (or intervention area) in their commitments or subsequent interviews. As highlighted in the report, this method comes with some caveats. For example, if stakeholders refer to a specific intervention in their commitment, this may not necessarily be accompanied by the large financial investments that may be required for that particular intervention.
71. UNFPA. *The State of World's Midwifery 2011: Delivering Health, Saving Lives*. New York: UNFPA, 2011.
72. Annual reports of the ERG are planned to be made public in September of each year in order to be available for consideration in advance of the UN General Assembly. The terms of reference for the selection of ERG members is now available online (the open call for nominations ended on August 14, 2011). See: <http://www.everywomaneverychild.org/pages?pageid=74&subpage=75>
73. http://www.everywomaneverychild.org/userfiles/Workplan_Commission_Draft_July2011.pdf.
74. The interviews always began with an unguided question on the preferred option of the interviewee to address perceived gaps/inefficiencies in the financing architecture for RMNCH.
75. Maintenance of the status quo was not included as an option because this would not help to address the gaps and inefficiencies in the aid architecture that are outlined in Chapter 3 of this report. The status quo was also not once suggested in the interviews.
76. This fund was established in 2004 to provide TA for the preparation and implementation of sound education plans. At: <http://www.educationfasttrack.org/financing/epdf/>.
77. These five countries are Ethiopia, Kyrgyzstan, Malawi, Nepal, and Uganda.
78. These 12 countries are Afghanistan, Burkina Faso, Burundi, Central African Republic, Chad, DRC, Guinea-Bissau, Liberia, Mali, Niger, Sierra Leone, and Somalia.

79. Countdown's analysis suggests that, for example, Niger is a major donor orphan when it comes to RMNCH financing; see reference 27.
80. In funding Round 9, the average time between approval of Global Fund grants and grant signing was 11.2 months (see: <http://www.theglobalfund.org/en/performance/kpi/2010/>). The grant assessment and approval process would also need to be accelerated (i.e., funding would need to be channeled outside the rounds-based channel).
81. Spicer, N et al. National and subnational HIV/AIDS coordination: are global health initiatives closing the gap between intent and practice? *Globalization and Health* 2010; 6:3.
82. While the creation of a completely new financing institution focused solely on reproductive, maternal, and neonatal health is theoretically an option, not one of the interviewees seriously suggested it as desirable or feasible. The reasons given included the significant costs involved in setting up a new organization and the further complexity this would add to an already complicated financing architecture.
83. The Affordable Medicines Facility—malaria (AMFm) is a donor-funded global price subsidy to increase access to artemisinin-based combination therapies. It is hosted and managed by the Global Fund and is financed by UNITAID, the UK, and the Bill & Melinda Gates Foundation, who provided financing for an earmarked AMFm funding pool. This separate funding pool ensures that AMFm funding is not co-mingled with other Global Fund resources.
84. UK Treasury Departments. *Appraisal and Evaluation in Central Government*. 2003 (updated in 2011). See: http://www.hm-treasury.gov.uk/d/green_book_complete.pdf.
85. For more information on the Lives Saved Tool, see: <http://www.jhsph.edu/dept/ih/IIP/list/>.
86. The five countries are listed in reference 77.
87. The administrative costs for the AMFm in 2009 totaled \$6.6 million (this includes the costs for nine staff members).
88. Sepúlveda, J. Foreword, in: Jamison DT, et al. (eds). *Disease Control Priorities in Developing Countries* 2006. Washington, D.C.: World Bank, 2006.
89. High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria: *Turning the Page from Emergency to Sustainability*. Final Report, 19 September 2011. The panel was established in March 2011 after the Global Fund's Office of the Inspector General reported misappropriation of Global Fund grant funds in a number of countries. It recommends improving financial oversight, simplifying grant application processes, and the creation of a robust risk management framework.
90. The total number of deaths averted in Option 3A is lower compared to Option 2B as key child interventions (IMCI) are included in 2B.
91. Lassi ZS, et al. Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes. *Cochrane Database of Systematic Reviews* 2010, Issue 11. Art. No.: CD007754.
92. United Nations. *Global Strategy for Women's and Children's Health. Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn, and Child Health*. Geneva: WHO, 2010.
93. Jones G, et al. How many child deaths can we prevent this year? *Lancet* 2003;362:65–71.
94. Tan-Torres Edejer T, et al. Achieving the millennium development goals for health: cost effectiveness analysis of strategies for child health in developing countries. *BMJ* 2005; 331:1177; Adam T, et al. Achieving the millennium development goals for health: cost effectiveness analysis of strategies for maternal and neonatal health in developing countries. *BMJ* 2005;331:1107-10.
95. Jamison DT, et al (eds). *Disease Control Priorities in Developing Countries* 2006. Washington, D.C.: World Bank, 2006.
96. World Bank. *World Development Report 1993*. Washington, D.C.: World Bank, 1993.
97. Special thanks goes to Karin Stenberg.
98. The World Bank calculated three different scale-up scenarios (high, medium, low); the medium scenario was eventually used for the High Level Task Force and the Global Strategy.
99. To calculate the baseline for the MBB costs, it was assumed that the MBB costs would equal 65% of WHO program costs and 37% of WHO health systems costs. This percentage is consistent with the difference in estimates for the Global Strategy. We used the same method for calculating the MBB baseline for the impacts.
100. John, B, Tan Torres, T. Costs of scaling up health interventions: a systematic review. *Health Policy and Planning* 2005; 20:1: 1–13.