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

Round 1 - Priorities for the Global Strategy

2nd April 2015
# Table of Contents

Acknowledgements ............................................................................................................. i

Acronyms ............................................................................................................................... ii

Executive Summary ............................................................................................................... iii

1. Introduction ......................................................................................................................... 1

2. Contextual and strategic issues ............................................................................................ 4

   2.1 The Global Strategy and the Every Woman Every Child platform .............................. 4
   2.2 Propulsion beyond 2015 ............................................................................................... 4
   2.3 A commitment to the most vulnerable ......................................................................... 5
   2.4 Principles of the Global Strategy ................................................................................ 5
   2.5 Agency: The role of the Law, Consent, and Autonomy ............................................ 5
   2.6 Old drum, New beat: Health workers remain a key challenge ................................ 6
   2.7 Taking the longer view: The life course approach ....................................................... 7

3. Reflections on the Global Strategy thematic areas ............................................................. 8

   3.1 Priorities for the updated Strategy: A significant step change .................................. 8
   3.2 Leadership ................................................................................................................... 9
   3.3 Health systems strengthening and universal health coverage .................................. 12
   3.4 Financing .................................................................................................................... 14
   3.5 Adolescents ................................................................................................................ 18
   3.6 Health-influencing sectors (Social and Economic Determinants of Health) ........... 20
   3.7 Humanitarian settings ................................................................................................. 23
   3.8 Human rights .............................................................................................................. 24
   3.9 Innovation ................................................................................................................... 27
   3.10 Monitoring and Accountability ................................................................................. 29

4. Conclusions and Recommendations .................................................................................. 36

   4.1 A compass for the post 2015 world .......................................................................... 36
   4.2 Balancing unfinished business and new challenges ................................................. 36
   4.3 Future-proofing the Strategy ..................................................................................... 36
4.4 Enlarge the tent: Humanitarian Situations .................................................................37
4.5 #Adapt: Meeting the needs of #Adolescents ..........................................................38
4.6 Systems: Health care workers still the frontline challenge ......................................38
4.7 Financing, UHC and the Global Strategy ..................................................................38
4.8 Information, Monitoring and Accountability ................................................................39
4.9 Research, evidence, knowledge and dissemination ..................................................39

Appendix A: List of respondents and consultation events ............................................41
A.1 Organisations .............................................................................................................41
A.2 Networks and Organisational responses ..................................................................50
A.3 Consultation Events ..................................................................................................51
A.4 Demographics of Survey Respondents and Event Contributors ............................52

Appendix B: Preliminary thoughts on lessons learned & future priorities ........54
Appendix C: Perspectives on the Global Financing Facility .........................................58
Appendix D: Consultation Survey ..................................................................................63

Table of Figures

Figure 1: Priority areas for HSS investments to improve country-level RMNCAH services .................................................................................................................................14
Figure 2: Priority areas for the Global Strategy to support and incentivise sustainable financing for RMNCAH services .............................................................................15
Figure 3: Priority outcomes for adolescents that the Global Strategy should address 18
Figure 4: Priority areas for partnerships to influence health determinants ...............21
Figure 5: Priorities for women, children and adolescents in emergencies ................23
Figure 6: Human rights related barriers to full access of RMNCAH services ..............25
Figure 7: Accountability and monitoring arrangements for the next five years ..........30
Figure A.4.1: Event and network contributors by constituency ..................................52
Figure A.4.2: Survey respondents by constituency .........................................................53
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**ACRONYMS**

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<tr>
<th>Acronym</th>
<th>Full description</th>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<td>ART</td>
<td>Academic, Research and Training institutions</td>
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<td>CAG</td>
<td>Consultative Advisory Group</td>
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<td>NatNGO</td>
<td>National Non-Governmental Organisation</td>
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<td>CoIA</td>
<td>Commission on Information and Accountability for Women’s and Children’s Health</td>
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<td>CRVS</td>
<td>Civil Registration and Vital Statistics</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>D&amp;F</td>
<td>Donors and Foundations</td>
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<td>ECOWAS</td>
<td>Economic Community of West African States</td>
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<td>FGM/C</td>
<td>Female Genital Mutilation/ Female Genital Cutting</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>GFF</td>
<td>Global Financing Facility</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>Human Resources for Health</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<td>HSS</td>
<td>Health Systems Strengthening</td>
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<td>iERG</td>
<td>Independent Expert Review Group</td>
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<td>IntNGO</td>
<td>International Non-Governmental Organisation</td>
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<tr>
<td>LGBTQI</td>
<td>Lesbian, Gay, Bi-sexual, Transgender, Queer, Intersex</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>NCD</td>
<td>Non-Communicable Disease</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>PMNCH</td>
<td>Partnership for Maternal, Newborn &amp; Child Health</td>
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<td>RMNCAH</td>
<td>Reproductive, Maternal, Newborn, Child and Adolescent Health</td>
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<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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EXECUTIVE SUMMARY

This report has been developed to contribute to the process of updating the Global Strategy for Women’s, Children’s and Adolescents’ Health, in advance of its launch in September 2015 alongside the new Sustainable Development Goals (SDGs). This report aims to synthesise the views of more than 4,550 organisations and individuals (Appendix A), who discussed and provided input through a wide-ranging consultation process, coordinated by the Partnership for Maternal, Newborn & Child Health (PMNCH) at the request of the office of the United Nations Secretary General.

PMNCH would like to convey its thanks to the thousands of participants for their thoughtful and comprehensive inputs to this consultation process. This report has been developed to provide a timely input into the first draft of the Global Strategy, expected for release in early May 2015. PMNCH will take a further round of consultations on the first draft of the Global Strategy during the month of May 2015 through the consultation web-hub: (www.WomenChildrenPost2015.org).

Summary of main findings

Overall, the findings confirmed much of what was already suspected, as well as the main evidence emerging from the preliminary consultation published in January 20151. This report confirms that:

- There was strong support for an updated Global Strategy, often seen as synonymous with the Every Woman Every Child implementation platform, and high expectations that it will build on the previous Strategy, galvanise a sharpened sense of purpose and maintain global and national momentum for women, adolescents and children.

- The themes identified by the Global Strategy Working Groups resonate with this global audience.

- Equity must remain one of the principles of the updated Global Strategy. Indeed, there were very strongly expressed views across all consultation feedback about the value of women’s and children’s lives, their rights to services, equality, and dignity.

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• The new focus on adolescent health, intersectoral working and humanitarian settings are widely appreciated and resoundingly endorsed.

A number of interesting issues arose across the consultation:

• The Strategy was seen as an important mechanism for building leadership and accountability at national, sub-national and global levels. There is an urgent call for the development of implementation tools and processes, especially in anticipation of the ‘domestication’ of the Global Strategy;

• There was some trepidation that hard won attention to neglected challenges (newborn lives, stillbirths, sexual and reproductive health and rights) might be put at risk depending on where both the Global Strategy and the larger global policy process around the SDGs land later in 2015;

• Respondents provided a clear endorsement for the Strategy to continue with and to amplify its poverty lens. There was an even stronger endorsement for the need to embrace the social and economic determinants of health challenges for women, adolescents and children, especially where these required simultaneous interaction of multiple sectors (for example, to address stunting or violence);

• There were mixed views about the extent to which the Strategy should focus on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) ‘core business’ as opposed to embracing whole-of-life issues. There was wide acknowledgement that the health challenges facing women and children were complex and increasingly extend beyond the RMNCAH core agenda;

• Financing for development and humanitarian assistance must be brought together in new ways. Each country needed to develop its own approach to building sustainable domestic financing to ensure universal coverage of basic services without causing financial hardship.

In light of these findings, a number of recommendations are made:

• **Balancing unfinished business and new challenges** – The Strategy will have an important role in ensuring that RMNCAH priorities continue to be at the centre of global and national health efforts, as well as safeguarding policy focus and financial resources on continuing priorities, including newborns and stillbirth, safe abortion and family planning, and maternal and child survival (unfinished business). However, the Strategy should also be clear about the complexities of health traditionally viewed as intersectoral challenges yet which require a proactive health response: stunting (which requires health, environment, water, sanitation,
hygiene, and nutritional gains to be addressed), gender-based violence and adolescent pregnancy are just three examples.

- **Future-proofing the Strategy** - The Strategy should take a life course approach and think broadly about context, trajectories, emerging science and up-coming challenges, such as reaching populations in urban slums, the growing burden of non-communicable diseases, aging populations and climate change. Currently, the global debate often seems to polarise the two sets of health challenges, placing diseases of poverty and non-communicable diseases in opposition to one another. The Strategy can make an important contribution to the process of bringing these two spheres together, reflecting the growing evidence about synergies between diseases of poverty and chronic health conditions, without detracting from either.

- **Enlarge the tent: Humanitarian situations** – Women, young people and children caught up in humanitarian situations and rapid onset and complex emergencies have acute needs including for services, protection and voice. For many, displacement and dislocation results in loss of security, dignity and autonomy, in addition to a range of practical problems. There are already agreed policy and programming approaches to minimum standards in humanitarian settings and the Global Strategy should reinforce these, setting out priorities for women, youth and children in emergency settings, and reminding governments and others of their rights and responsibilities to meet the minimum standards of care.

- **#Adapt: Meeting the needs of #Adolescents** – Adolescents have added a vibrant and energetic voice to this consultation, raising crucial issues about the legislative, cultural, systems and bureaucratic barriers faced in getting access to appropriate services. Young people need the same access to quality services including comprehensive sexuality education and appropriately delivered services. What emerges from this consultation is that shifting norms in order to genuinely meet the needs of adolescents will require adaptation of services and approaches on a larger scale. The Strategy can help guide countries and partners to meet that challenge.

- **Systems: Health care workers still the frontline challenge** – Fundamental health systems challenges remain around attracting, training, deploying, motivating, managing and retaining skilled, enthusiastic, committed, kind and dedicated health workers. With their own needs and often loaded with carer responsibilities at home, female health workers have particular challenges themselves. Health workers are a critical driver of service quality; yet they remain the greatest challenge for health systems everywhere.
• **Financing, UHC and the Global Strategy** – The costs of saving the lives of family members creates huge financial burdens for households driving many millions into poverty every year and the numbers could increase as chronic disease burdens grow. Domestic and global financing systems, soundly and sustainably linked to universal health coverage (UHC), are vital elements to addressing and curbing this slow-motion emergency. The Global Strategy is well placed to demonstrate and promote the links between the needs of the poorest and most vulnerable people – often women and children – to the UHC agenda, drawing attention to promotive and preventative services that will have impact on well-being throughout the life course.

• **Information, monitoring and accountability** – The Strategy should be accompanied by sound proposals for a robust, integrated and aligned accountability framework that promotes streamlined and unified data collection at the country level, encourages comprehensive monitoring across the whole national health system and enables national and global commitments to women’s, adolescents’ and children’s health to be tracked and verified. Monitoring requirements (including indicators and associated targets) should strike the right balance between ensuring that country results are comparable to others at the global level, yet integral rather than additional to each country’s own health management information system and sub-national monitoring needs. As part of the overarching guidance to countries around domestication, the Strategy should provide an accompanying toolkit to support monitoring and accountability systems building and surveillance.

• **Research, evidence, knowledge and dissemination** – New evidence emerges constantly. The Global Strategy and its implementation platform can contribute to strengthening the ‘evidence – knowledge – policy – delivery’ continuum by building in concrete approaches to adjusting policy recommendations to changing knowledge and improved practices, and to support a continuous drive to keep focused on filling the health related knowledge gaps that prevent women, adolescents and children from reaching their potential.
1. INTRODUCTION

1.1 Background

The Global Strategy for Women’s and Children’s Health, launched in September 2010, aims to bring together a broad range of partners from different sectors in a global effort to improve women’s and children’s health. Since its launch, more than 400 commitments from 300 partners have been made to implement the Global Strategy, including financial commitments of USD60 billion. This report contributes to the current effort to update the Global Strategy for Women’s, Children’s and Adolescents’ Health (referred to as the Global Strategy or simply, the Strategy) for launch in September alongside the new post-2015 Sustainable Development Goals (SDGs). This updated Global Strategy will build on these gains for the post-2015 era.

This report aims to synthesise the views of more than 4,550 organisations and individuals (Appendix A) who discussed and provided input into the process, including written comments from more than 375 unique organizations and networks. In its capacity as co-lead of the advocacy workstream for the Global Strategy process, the Partnership for Maternal, Newborn & Child Health (PMNCH) has been asked by the UN Secretary-General’s Office to undertake a wide-ranging consultation to support the updating of the Global Strategy. This consultation process was carried out between January and March 2015, and draws on analysis produced during a previous round of consultations in late 2014 for the Global Financing Facility (GFF) in support of Every Woman Every Child. A further round of consultations will be undertaken by PMNCH in May 2015, once the first draft of the Global Strategy has been released.

1.2 Purpose and Approach

The principal objective of the consultation has been to canvass and synthesise views on general and specific questions about what the updated Global Strategy should include and how it should build on the strengths and limitations of its first iteration.

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2 Every Woman Every Child (2010) “Global Strategy for Women’s and Children’s Health”. Available at: http://www.everywomaneverychild.org/resources/publications


4 The report, entitled Consultations on updating the Global Strategy for Women’s, Children’s and Adolescents’ Health: Perspectives on the Global Financing Facility, was published on 15th December 2014, and is available at www.WomenChildrenPost2015.org. The Executive Summary of this report is provided in Appendix C.
(2010 – 2015) from a full range of PMNCH members and other stakeholders. The purpose was to prompt a broader discussion about priorities, challenges and essential elements to be included in the updated Strategy through enabling as many stakeholders as possible to provide their views on what is likely to form the guiding principles for the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) community over the coming decade. This synthesis report, which collates these views, will inform the first draft of the updated Strategy document, currently under development.

A Consultative Advisory Group (CAG) drawn from the PMNCH constituency groups was formed to oversee this wide-ranging consultation. Their mandate was to review and approve the synthesis report, guide and support the process of engaging PMNCH members, and to facilitate information sharing and consensus-building among the constituencies.

A web-based consultation hub was established as a platform to host a survey, share information, and support dialogue and discussion through social media about the update to the Global Strategy more generally. Views were collected in several ways, including an online consultation survey (in English, French and Spanish and also available offline), through several country-based and regional meetings, partner-hosted events, citizen hearings, direct submissions to the CAG or the PMNCH Secretariat, and PMNCH constituency-based consultations (Appendix A provides full details of all consultation events and Appendix D includes the consultation survey).

A few PMNCH partner networks, including several Youth networks, operated their own bespoke surveys and incorporated questions specifically relating to the Global Strategy or developed submissions that represented the views of many partners within their networks (for example, the International Planned Parenthood Federation). Citizen hearings were held in Indonesia, Nepal, Nigeria, Tanzania and Uganda, attracting over a thousand people. Working through these PMNCH partners, the reach of the consultative process was further increased.

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5 The seven constituencies that bring together PMNCH members are governments, donors and foundations, non-governmental organisations, healthcare professional associations, academic, research and training institutions, private sector partners, and multilaterals. The Consultative Advisory Group (CAG) was formed to support the Global Financing Facility (GFF) consultations in 2014 and has continued on from that.

6 Although the government constituency was unable to participate in the CAG given the time limitations, a wide range of countries participated in this consultation in a range of ways including through focused engagement, regional consultations (e.g. New Delhi Stakeholder Consultation and Citizens’ Hearings held across a wide range of countries. See Appendix A for full details).
1.3 Data management methodology

The feedback gathered across all channels was recorded and collated by the consultation team. Responses were deconstructed and coded by topic using qualitative research methodologies. The data processing approach was cross-checked within the consultation team members to ensure that views were sorted in a relevant and inclusive manner, to the extent possible and within the resource and time constraints of this consultative process.

1.4 Outline of the Report

This report organises the feedback into three areas: (i) Cross-cutting themes; (ii) Inputs into specific dimensions of the Global Strategy; and (iii) Conclusions and Recommendations. Throughout the report, quotations from respondents have been used where appropriate and helpful, with the constituency group provided in brackets after the quote.

PMNCH would like to convey its thanks to the thousands of participants for their thoughtful and comprehensive inputs to this consultation process. Space and time limitations notwithstanding, it is hoped that most respondents will note that some or all of their views have been reflected in this report and that, taken as a whole, the report does justice to the complex but vibrant array of remarks made.

1.5 On-going consultation process

This report has been developed to provide a timely input into the first draft of the Global Strategy. It will be submitted the Office of the Secretary General in the first week of April, 2015. It will also be sent to each of the survey respondents and posted on the consultation web-hub (www.WomenChildrenPost2015.org).

Draft Technical Working Papers, which will form the basis of the Global Strategy, have been published on the web-hub for feedback (until 15th April 2015). In May and June of 2015, PMNCH will undertake a further consultation process to offer partners and stakeholders the opportunity to provide feedback on the first draft of the updated Global Strategy, which will be published on this same web-hub on 6th May 2015.

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7 Views from country governments and country based NGOs were given the most weight. See the web hub for shared comments: www.WomenChildrenPost2015.org

8 Whilst contributions were received in English, French and Spanish, all quotations have been translated into English for ease of reading.
2. **Contextual and Strategic Issues**

This section of the report synthesises a number of issues that have surfaced from across the consultation. It highlights a range of critical contextual, strategic and cross-cutting issues that, together, speak to how the Global Strategy might achieve greater impact, wider appeal and optimal responsiveness in a rapidly changing world.

2.1 The Global Strategy and the Every Woman Every Child platform

“*A strong, unifying global voice that empowers and connects*” (International Non-Governmental Organisation (IntNGO)).

Across the consultation, participants used language about the Global Strategy (and its accompanying Every Woman Every Child advocacy platform) to elevate it above simply that of a handy reference document to something much more akin to a process that continues to evolve and adapt to changing needs. Every Woman Every Child and the 2010-2015 Global Strategy have demonstrated that they can link parliamentarians and legislators, tax and finance policymakers, businesses and social action groups, health workers, activists, technical specialists, global and local communities and individuals, and provide them with unified goals and objectives. As a platform for action, political will and accountability, respondents felt that the implementation of the updated Strategy would create the scope to focus energy for delivery, frame policy needs and harness financing. As one country said: “*As a platform for galvanizing the global commitment to improve maternal, child and adolescent health, the Global Strategy can play an important role in strengthening political will and leadership by setting up a close partnership with countries’ leaders, fostering on-going and constructive dialogue with national key stakeholders … and providing assistance in a way that may significantly complement the national government-initiated programs*” (Countries).

2.2 Propulsion beyond 2015

“*...need to continually feel the urgency*” (Health Care Professional Associations (HCPA)).

How the Strategy links into, supports, and builds on other global and national processes will, to a large extent, determine its weight in the post-2015 global policy canopy. The updated Strategy will be an important mechanism to bridge the expiring Millennium Development Goals (MDGs) and the prospective SDGs through its role in building political will but also by translating high level aspirations into meaningful and measurable actions, and defining a new vision and direction. It has the scope to be the jet fuel needed to ensure that joined-up action for women’s and children’s health does
2.3 A commitment to the most vulnerable

The Global Strategy will be a critical instrument in building commitment and delivering results to “target the most vulnerable and least reached/ most marginalized communities” (Multilateral), who may live in urban slums not just remote, rural areas. In its ability to create a firmer link between “various initiatives and the drive towards universal health coverage, [the Strategy will help to] ensure cross-sectoral action and targeting to the poorest and most vulnerable groups, countries and populations” (IntNGO), as well as to highlight how these “underpin the achievement of poverty reduction ... and the enactment of women’s and children’s rights” (Donors and Foundations, D&F). One youth leader said “…My fear is that the SDGs will tackle health and will forget people with disabilities. What gets counted matters. The issue of representation is critical” (Youth consultation event, Uganda).

2.4 Principles of the Global Strategy

“Equal value for women’s lives” (Countries).

The value of women’s, adolescents’ and children’s lives, their rights to equality, and an overriding concern and depth of feeling about equity surfaced consistently across all the consultation feedback. The consultation instruments did not specifically interrogate views about what proposed principles the Global Strategy should embrace and yet, what came through again and again was a clear demand for equity and human rights, especially at the individual and community level, to be at the heart of both the Strategy and the actions of country governments, donors, multilateral agencies, Non-Governmental Organisations (NGOs) and others. “Focus on equity – not only geographically but across class, caste, religion, gender, sexual minorities” (Delhi Consultation Event), and especially “in marginalised populations” (IntNGO).

2.5 Agency: The role of the Law, Consent, and Autonomy

“Protection is important, but empowerment is more important” (Private Sector).

Although much of what determines women’s, adolescents’ and children’s health outcomes rests on access to quality services, knowledge and education, and behaviour, culture and attitudes; access is also underpinned by legal rights - the concept of autonomy and the right of consent. While recognised as necessary but not sufficient, the idea of having the autonomy to act and the capacity to assert one’s rights peppers
the narrative on health, especially for women and girls. Adolescents talked about needing parental consent to access reproductive health services, and women talked about the decision to seek obstetric care resting in the hands of other family members or the need for male approval before they can access contraceptives. Large groups of young women, adolescent girls and girl children are subjected to female genital mutilation/cutting (FGM/C) without choice, warning or consultation. And, for all girls and women, safe abortion may be limited or denied where they live. Refugees, forced migrants, and the disabled – especially disabled young people – can feel invisible and powerless. Agency – both legally and practically – is a recurring theme and intertwined with accountability, rights, access and health service delivery.

2.6 Old drum, New beat: Health workers remain a key challenge

“...You know these people are passionate about their work, but they cannot remain positive with their [heavy] workload” (Youth consultation event, Uganda).

Health workers remain one of the thorniest and yet most central challenges to delivering high quality services to those most in need. There were several dimensions to health workers as facilitators of improved health outcomes. There are a number of health systems issues that are more or less well understood (if difficult to address), including numbers, recruitment, deployment, retention, management and training of staff. The workload of many health workers was raised a number of times, “...these are hard-working people who have their own issues” (HCPA). The need to embrace community health workers and formally integrate them into the health system was a well-articulated view: “...formalize the inclusion of community health workers ... in the health system, they need to be involved in the health planning process” (Burkina Faso consultation event).

But another dimension is that many health workers are also women, themselves mothers, wives and carers, and they can be both drivers of change and barriers to it. For example, adolescents in particular talked about the importance they place on friendly, non-judgemental health workers. Health service reforms often aim to improve retention by appointing nurses and other health workers from the surrounding community. However, these health workers are then of that community and may need additional support and on-going encouragement to be drivers of change (for example around access by young people to sexual health services), especially where social norms are deeply held.

The comments made by respondents of all constituencies across the consultation articulate the value of the Global Strategy in identifying health workers as a key
challenge (and vital element) to delivering health outcomes for women, adolescents and children.

2.7 Taking the longer view: The life course approach

“...Gaps in one life stage will develop as gaps in another life stage” (National Non-Governmental Organisation (NatNGO)).

The Strategy will likely prioritise the main causes of poverty-related preventable death in women, adolescents and children (communicable diseases like malaria, HIV/AIDS and TB as well as maternal and newborn causes). This would be expected and welcomed by respondents. Increasingly, however, the main causes of preventable death include non-communicable diseases (NCDs) (such as cancer and diabetes), environmental exposure and the ill effects of urbanisation across all age groups. Many respondents were thus keen to highlight the value of taking a life course approach. One respondent suggested that the Strategy should make “explicit linkages between continuum of care and the life course approach - not much use in targeting mothers and under-fives if at different points in their life course they encounter insurmountable barriers to receiving health care” (Academic, Research and Training Institutions (ART)).

One such point is at the end of life, whatever the age, with several respondents suggesting that, as carers, women often deliver palliative care to loved ones at home (to their own children, to a spouse or their parents). For many millions of people across the world, including women, young people and sometimes children, mental health including depressive disorders and anxiety are a major affliction. Injuries, harmful behaviours and existing or new disabilities can all curtail or limit healthy life for many young people. So, while most respondents would probably still prioritise the prevention of maternal and young child deaths (considering it, as many do, unfinished MDG business), a cross-cutting theme emerging from the consultation was a recognition of the complex and multifaceted pathologies affecting women, young people and children over the course of their lives.
3. REFLECTIONS ON THE GLOBAL STRATEGY THEMATIC AREAS

This section synthesises respondents’ views by thematic area following the structure of the questions in the consultation survey, adopted in turn from the Global Strategy Thematic Working Groups. Reports from the country and regional consultation events aligned well with these areas also. Readers may notice that occasionally, there is some overlap between two or more themes. For example, aspects of monitoring and data collection overlap with innovation; and leadership and accountability share common ground. The report organises the synthesis in line with the questions asked to ensure a clear structure and tries to minimise repetition. Ahead of the thematic syntheses, Section 3.1 below summarises views from respondents about their broad priorities for the updated Strategy and their ambition to see the updated Strategy be as comprehensive as possible.

3.1 Priorities for the updated Strategy: A significant step change

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

Respondents welcomed the opportunity to provide their thoughts on what the updated Global Strategy should prioritise and how it should mark a step change from the 2010-2015 Strategy.

During the consultation in late 2014 on the GFF, a number of questions were asked about the 2010-2015 Global Strategy together with thoughts about priorities for the next one. Thinking about priorities, many respondents expressed the hope that the updated Strategy would address a number of perceived limitations by bringing together the many policy strands needed to address RMNCAH fully. These included:

- A focus on particular health services and challenges such as sexual and reproductive health and rights (SRHR), newborns, stillbirths, quality of care in the 48 hours around child-birth, including life-saving interventions such as...

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9 This section draws on material prepared for the preliminary lessons learned paper published in January 2015 and available here: http://www.who.int/pmnch/activities/advocacy/globalstrategy/2016_2030/en/index1.html. The Executive Summary of that report, including lessons learned and priorities for the updated Strategy, is provided in Appendix B.

10 Published in December 2014 and available here: www.womenchildrenpost2015.org
emergency obstetric care, safe abortion, and family planning (FP), including for adolescents and the disabled;

- Concerns about ensuring the systems, services, financing and health workers were in place to deliver quality care, sustainably and fairly, to those most in need;

- An ambition to see more about human rights, equity and gender equality, about addressing the needs of women and children in emergency settings, and including more about meeting the needs of disabled groups; and

- Adolescents’ health more generally.

Although in this current consultation, respondents were not specifically asked about priorities, these previous views were confirmed and further amplified, and concerns about specific RMNCAH challenges surfaced throughout the material. For example, many expressed a concern that, going forward, neglected areas should remain at the heart of global and national efforts including newborns, stillbirths, SRHR, and (welcomed by many) adolescents. In addition, several respondents expressed a hope that the Global Strategy would embrace new challenges and ensure that the Strategy addressed women’s, adolescents’ and children’s health across the full range of settings. The detail of these views are captured in the rest of this section by thematic area.

3.2 Leadership

“...they need to be reminded of what they committed at the global level” (Youth meeting, Uganda).

“We... commit ourselves to eliminate preventable maternal, newborn and child deaths and to improve adolescent health...” (East Africa Community Health Ministers and Parliamentarians Forum).

Respondents offered a wide range of comments and views regarding the importance and potential of leadership at global, regional, national and local levels. From high-level views, such as to get “governments to be signatories at a UN General Assembly” meeting (IntNGO), to the detail of district and community training in monitoring, sustained engagement in and commitment to the delivery of the Global Strategy; all were seen as being “vital to success” (NatNGO) and important contributors to “strengthen political will and leadership” (Countries).
Leadership at the country level

Many respondents from across a wide range of geographies were concerned that countries should commit to the Global Strategy “above party politics” and “adapt [the Strategy] within the national reference framework” (D&F). The Strategy should include provisions for “domesticating” it (NatNGO), in order to “build national ownership” (IntNGO). Respondents also specifically suggested the development of an accompanying toolkit to “locally adapt the Global Strategy within the national reference frame” (Countries), as well as providing “guidance in translating global objectives into country specific targets” (ART).

The challenge for leaders – and parliamentarians – at the country level was to get the balance right between using the potential of the Global Strategy to “build a multi-stakeholder ‘movement’ with a strong advocacy and communication element” (D&F), but also to “clarify roles and responsibilities” (ART), and make specific commitments to clearly articulated goals and results for women, children and adolescents. At the national level, leaders should be encouraged to demonstrate “inspiring leadership” themselves (HCPA), as well as to welcome and “develop the involvement of civil society” (NatNGO). This leadership can galvanise transformation across all sectors of society and throughout the country. Specifically, respondents suggested a number of strategies that could be used “to publicise success stories and build interest and commitment” (Private Sector) including:

- “Activities with stakeholders and media, …and collaboration with Civil Society Organisations” (NatNGO);
- Encourage “simple cross sectoral results framework chaired at high level (deliverology [sic] and roadmap)” (D&F);
- “Emphasize the benefits and returns on investing in women and children” (ART);
- Good communications about best practice and examples of what has worked elsewhere; and
- “Identify national champions who can promote the Strategy” (NatNGO).

Leadership at the sub-national and community level

Respondents expressed a range of views about what would be necessary to ensure local level capacity and willingness to be accountable for sustained commitment to the health of women and children. Indeed, engaging local leadership and devolved governments, would “set a firmer foundation for long-term sustainability of [national] development policies and programs” (D&F). For many respondents, local leadership was
considered to be as important as at global and national levels, mainly because understanding local “health practices and beliefs needs to be reflected in health services to effect behavioural change” (HCPA). Three key issues were identified in order to achieve this:

- Firstly, local level decision-makers needed “authority, decentralised mandates, sub-national strategies and targets and an accountability framework [linking] all three levels” (D&F) that includes “decentralization and devolution of powers” (New Delhi cross-constituency consultation).

- Secondly, to fully embrace and support (and lead) the implementation of the Strategy, leaders need to understand it and buy into it. The Strategy should encourage “sensitising and informing local authorities” (Multilateral), to ensure that all local leaders are on board and understand the issues, goals and targets in the Strategy. A road show or tool kit at subnational level would help strengthen political commitment at this level.

- Thirdly, continued political and technical leadership at local level will rely on having good information, demonstrating progress, and building momentum. Good clear metrics and tools to track progress and verify results will be essential to holding local leaders to account and retaining public interest. Success depends on “the broad engagement of stakeholders” (NatNGOs), “definitely including faith-based organisations” (Multilaterals), and other CSOs (Civil Society Organisations) working on the ground.

Leadership at the global level

At a global level, some respondents felt that the Global Strategy helped to bridge the out-going MDGs and the next cycle of SDGs in order to “keep RMNCAH on the agenda globally for universal accountability” (IntNGO). Essential to this would be to ensure the Strategy “applies globally... to all countries, societies and people” (NatNGO).

Several approaches for the Strategy to build political support for women’s, children’s and adolescents’ health outcomes were identified:

- Demonstrate the “leadership and personal involvement of the United Nations Secretary General ... and clear commitments by stakeholders” (D&F).

- Reach for an authentic voice “by involving citizens” in the global dialogue (Private sector).
• Create the opportunity for world leaders to “sign public statements of commitment” (IntNGO) to a cross-UN framework that “outlasts individual country political cycles” (D&F).

• Publicise reports that “highlight progress made as well as challenges remaining” (Private sector).

• “Provide guidance, goals/ objectives for improving the health of women, children and adolescents” (ART).

• Engage and mobilise young people, particularly exploiting the opportunities presented by the expanding role of social media.

• Elicit regional level engagement, for example from the African Union or ECOWAS (Economic Community Of West African States) (NatNGO).

3.3 Health systems strengthening and universal health coverage

The Global Strategy is “uniquely poised to offer a powerful voice in support of women, newborns, children and adolescents within the global universal health coverage discourse. The Strategy should use this power to inform and advocate on behalf of the world’s most vulnerable people” (IntNGO).

The Global Strategy was thought to be “an important tool in the hands of policy makers to keep universal health coverage at [the] top of the agenda. This helps in convincing world leaders to rise above politics and allocate resources for the unmet needs of under-served populations” (NatNGO). Across the responses, there was near unanimous agreement that universal health coverage (UHC) was essential (74%) or important (24%) to the delivery of RMNCAH. However, looking at this another way, 26% considered UHC to be useful or important but not essential to delivering health outcomes for women and children.

In general, respondents were aligned with the WHO (World Health Organization) purpose statement of UHC, “to ensure that all people obtain the health services they need without suffering financial hardship when paying for them.” The challenge was how to operationalise this ambition in practical terms and what role the Strategy should play in this. The views of respondents can be synthesised into three main areas of discussion:

11 www.who.int/universal_health_coverage
• One set of comments focused predominantly on the close relationship of health systems strengthening (HSS) to UHC. For example, ensuring access to quality basic care through the removal of geographical and financial barriers requires both sustainable health financing systems and human resources for health policies that generate adequate numbers of trained and appropriately deployed health care providers. UHC and HSS are thus indelibly linked and one cannot be had without the other.

• A second line of discussion was around demand-side financing and its relationship to UHC. Many respondents said that UHC should not be equated with free health care. Nonetheless, respondents were vocal about the importance of adequate government budgets, and basic and life-saving care that was free at the point of use, especially for women and children. There was also a clear demand for sustainable health financing models that encompassed all citizens. One example offered was for a “global commitment to encourage states to provide health insurance to citizens” (NatNGO).

• Thirdly, the quality and coverage of care delivered is central to genuinely achieving UHC. To monitor this quality, respondents suggested the Global Strategy should include a “How to” guide or something covering the dimensions of quality, identifying the principal actions required to ensure the inclusion of the most marginalised, how to calculate costs and the challenges of measuring impact. “The Global Strategy could introduce measurable health targets for every stage of the life cycle to encourage the view that more can be done to improve health for all age groups” (IntNGO), particularly around integrating and knitting together NCD and RMNCAH issues through a life course approach.

Respondents were also asked about their views on HSS to improve outcomes for RMNCAH. Figure 1 shows the distribution of views. The majority thought that national level policy and governance was the most important element of systems strengthening, followed closely by ensuring access to services, community-based services, information systems, human resources management and quality of care.
3.4 Financing

“...position health as an investment, not as a cost” (Private Sector)

Health financing is a huge and varied challenge deeply linked to many other themes discussed in this report. Here, the priorities of respondents are briefly reviewed together with their thoughts about the critical elements of RMNCAH financing that should be included in the Global Strategy. Health financing was considered a particular challenge in settings where there was extreme poverty and low capacity. Furthermore, financing for health outcomes is about “more than financing the health sector” (D&F). In all settings, respondents were clear that transparency, openness and accountability were needed to ensure funds were used where they could have the greatest impact on women, young people and children.

Figure 2 below highlights the main concerns of respondents. The leading challenge raised by respondents was the need to broaden the range of financing partners for RMNCAH services at national and sub-national levels, including non-traditional donors such as the private sector, businesses, governments and CSOs. Another area of high priority continues to be centred on building inclusive, predictable and sustainable domestic financing systems12 that both raise more funds for health, and then distribute

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12 The GFF Consultation Report (available at www.WomenChildrenPost2015.org) also identified that domestic financing, rather than global financing for example, was a major concern.
these funds more efficiently and equitably across sub-national regions, levels of care and health priorities. Respondents also emphasised the need to engage with CSOs to help track and verify financing commitments.

**Figure 2: Priority areas for the Global Strategy to support and incentivise sustainable financing for RMNCAH services**

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobilize new/different domestic finance sources</td>
<td>5</td>
</tr>
<tr>
<td>Promote sustainable national health financing</td>
<td>4</td>
</tr>
<tr>
<td>Help CSOs advocate/monitor domestic financing</td>
<td>3</td>
</tr>
<tr>
<td>Advocate for a national roadmap process</td>
<td>2</td>
</tr>
<tr>
<td>Promote cross-subsidisation by pooled financing</td>
<td>1</td>
</tr>
<tr>
<td>Inform government decisions through research</td>
<td>0</td>
</tr>
<tr>
<td>Encourage domestic finance commitments</td>
<td>0</td>
</tr>
<tr>
<td>Set out evidence on demand side financing</td>
<td>0</td>
</tr>
<tr>
<td>Advocate for more predictable aid flows</td>
<td>0</td>
</tr>
<tr>
<td>Promote stronger public financial management</td>
<td>0</td>
</tr>
<tr>
<td>Advocate legal national fee policy enforcement</td>
<td>0</td>
</tr>
</tbody>
</table>

**Domestic financing for RMNCAH**

Respondents raised the important requirement in most countries for better national coordination of domestic, donor and private funds flowing into the health sector “*to prevent duplication and target support to neglected areas*” and ensure funds are prioritised to build health systems and UHC (Cross-constituency consultation event, Abuja). The differences between humanitarian and development donor financing sometimes cause unnecessary delays and gaps in coverage. “*Awareness among Donors is needed to sensitize them about holistic SRH services*” in order that they can “*bridge the financing gap between humanitarian and development*” modes of funding and ensure continuity of services for women, children and adolescents (IntNGO). Many respondents felt strongly that a broad range of providers (including the private sector and CSOs) should “*have an active role participating in the design, implementation and evaluation of finance strategies*” for essential services (Private Sector).

Financing for RMNCAH should be integrated into the national budget and indeed, countries should “*ensure financing goes first to a basic package of care for women and children*” (Multilaterals). Ultimately, it was recognised that financing “*is still too low*” for RMNCAH, and “*needs to be improved and focused on community needs*” (NatNGO).
Linked to this, a number of respondents raised specific concerns about the cost to patients, clients or families as a barrier to access. This was identified very clearly as a barrier to access among adolescent respondents. In particular, fees for FP commodities and services, antenatal care (ANC) and delivery, and children’s health services were all considered onerous and counter-productive. For example, financing arrangements and out of pocket costs “within the context of fragile settings where most maternal deaths occur is of particular concern” (D&F).

Unsurprisingly, there was a range of views regarding which financing system was most appropriate for RMNCAH services. Some respondents were adamant that health care should be free to the extent possible, but certainly free at the point of use (“abolish user fees”, “reduce and eliminate co-payments” (NatNGO)), and even monthly public sector insurance payments were considered too high for one respondent. On the other hand, a number of respondents felt that public-private financing partnerships could work and “partners feel more responsible as funds are raised from within” (HCPA). In addition, “the potential of [the private] sector is so huge... [and could help to] drive RMNCAH improvements” (Private Sector). Although financing for health is context specific, respondents were vocal about the need to ensure the right balance between:

- Funding long term, sustainable, good quality health services;
- Including all who needed care (not excluding the poorest); and
- Fostering a multi-dimensional approach that included the private sector.

At a global level, respondents were enthusiastic about harmonised approaches to financing RMNCAH especially in order to align financing to “the goals of the Global Strategy” (IntNGO). Many were open to exploring alternative approaches including results-based financing. Across the full range of comments, most respondents agreed that financing was a critical challenge to improving services. Every partner has a role to play. Howsoever funds were raised and distributed for essential health services, it had to be fair and transparent, and to act to reduce access barriers, build stronger partnerships and improve equity.

**The Global Financing Facility**

PMNCH has led a series of consultation processes, which began with a consultation around the development of the GFF at the end of 2014.\(^\text{13}\) Broadly, respondents to that consultation vocalised a high level of agreement with the GFF’s central aim of building

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\(^\text{13}\) The report, entitled *Consultations on updating the Global Strategy for Women’s, Children’s and Adolescents’ Health: Perspectives on the Global Financing Facility*, was published on 15th December 2014, and is available at [www.WomenChildrenPost2015.org](http://www.WomenChildrenPost2015.org). The Executive Summary of this report is provided in Appendix C
long-term domestic financing for women’s, adolescents’ and children’s health in the context of the updated Global Strategy. There was also strong agreement with the ambition to mobilise additional financing for RMNCAH and support for the GFF’s ideas of building sound national plans, backed by financing roadmaps, and better RMNCAH harmonisation. A number of concerns and issues for clarification were also identified. As part of the current consultation on updating the Global Strategy for Women’s, Children’s and Adolescents’ Health, respondents were asked whether they had enough information about the GFF development process and sufficient updates on progress about the on-going development of the GFF.

Of those who replied to this question, half felt confident that they had enough information (or would have if they looked for it) and that “the work is good” (NatNGO). However, the other half of respondents did not feel well enough informed and said they would value more information about “process, timelines and next steps” (IntNGO). Amongst those who wanted more information, national NGOs were the largest sub-group.

Respondents were also invited to provide additional comments about the GFF. These broke down into three main areas and are closely aligned with some of the headline comments emerging from the first consultation report.

- Firstly, many respondents continue to be concerned about ensuring that the GFF builds on “existing, locally developed health financing strategies and coordinating mechanisms” (D&F) and “needs more feedback from stakeholders” (NatNGO). The GFF should ensure it promotes “inclusive country leadership and meaningful participation of civil society organisations” (Countries).

- A second theme that emerged from the comments concerned “transparency around how the [funds] will be invested” (IntNGO), “less red tape”, (NatNGO) and that the “process should be open and participatory” (NatNGO), as well as the need to “ceaselessly clarify the implications for others” (Multilateral). Respondents also sought clarity about “how we will be monitoring the direction of the funds once placed into the hands of countries” (NatNGO).

- A third issue was around who would be able to access funds, especially small or “emerging organisations” (Private Sector), how the funding mechanism would strengthen national budgets and how to ensure the funds get to “those who need them most” (IntNGO).
3.5 Adolescents

“Nothing about us without us” (South Asia Regional Youth Network)

One aspect of the updated Global Strategy that marked a real step change from the first was the inclusion of adolescents. Respondents expressed appreciation for that and said it was “a major opportunity to identify the challenges and best practices” (Countries) to meet the needs of this important group. Some commented that they felt young people had not received enough attention in the past and “adolescent health and nutrition have been forgotten, as programs too often go from under-fives to adults” (IntNGO). Stakeholders from a wide range of constituencies recognised adolescence as a critical stage in the lifecycle (for health as well as other aspects of transitioning to adulthood, including skills, education and employment). In particular, the importance of adolescence as an “entry point for change, e.g. for maternal under-nutrition, reducing low birth weight, preventing stunting, reproductive health/safe motherhood and breaking negative cycles” (IntNGO) was mentioned often and was a recurring theme including services for sexual and reproductive health for boys as they become men, recognising that they can be “more active and less accountable” (NatNGO).

The consultation survey asked respondents to prioritise outcomes for young people to be included in the Global Strategy. Figure 3 below shows the range of responses.

**Figure 3: Priority outcomes for adolescents that the Global Strategy should address**

<table>
<thead>
<tr>
<th>Access to affordable, quality services</th>
<th>Access to (in-)formal health education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to education, training &amp; information</td>
<td>Protection from harmful traditional practices</td>
</tr>
<tr>
<td>Ensuring participation &amp; decision-making</td>
<td>Social norms transformation</td>
</tr>
<tr>
<td>Ensuring social &amp; financial support</td>
<td>Mental health services and counseling</td>
</tr>
<tr>
<td>Prevention of injuries &amp; harmful behaviors</td>
<td></td>
</tr>
</tbody>
</table>

The clear priority was access to affordable, quality youth friendly health services, including SRHR. The other leading priority was access to formal and informal health education, incorporating comprehensive sexuality education (universally across youth
Consultations on updating the Global Strategy: Round 1 – Priorities for the Global Strategy

consultations) for all young people, including the disabled who said they felt especially marginalised. Not surprisingly, the views expressed by youth during the wider consultation events echo this outcome. During youth-focused and led consultation meetings, the two top priorities consistently emerge as access to appropriate services and access to knowledge, information and education about health generally, and SRHR in particular, including, for some, education about pregnancy and delivery. There was also a strong interest in behaviour change communication and techniques. Respondents repeatedly mentioned the need to make reproductive health services more ‘adolescent-friendly’. Partly this was operational: opening hours, location of services, costs, or accessibility in school uniform. Partly this referred to friendly, non-judgemental, helpful health workers, something many young people raised across the consultation. But it also required an evidence-based approach to ensure the right services are delivered in the right way.

Participants in an online youth consultation hosted by Girls’ Globe expressed concern over the age of consent and patient-confidentiality barriers to accessing sexual and reproductive health services. As one respondent put it, using the language of the young, “Question of confidentiality re adolescent health, #HIV, is major challenge... Similar challenges in #Peru: Teens must go w/ parents to clinic to get #SRH services. So they don’t go... Same story globally. The question of age consent is critical” (Youth). However, several respondents warned that “stand-alone adolescent-specific services are not the preferred option” (D&F), rather that “quality services for adolescents [should be] integrated in existing clinics” (Countries).

Access by all young people to comprehensive, effective, practical, and early health education, especially education on SRHR, also received widespread support. Respondents felt that more should be done for adolescent girls in particular. For example, as one respondent suggested “menstrual hygiene management should be integrated into the Strategy as an issue of health, dignity, and equity in access to education” (IntNGO).

Youth education was also considered an important opportunity to drive long-term transformation of cultural norms, including attitudes towards contraception, abortion, delayed marriage, child-spacing, LGBTQI, and harmful cultural practices such as FGM/C. In relation to changing society, young people talked about the idea of ‘a second chance’. As one youth leader noted “when a boy impregnates, he does not have to give up school so why should a girl who gets pregnant?” (NatNGO).

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14 LGBTQI: Lesbian, gay, bi-sexual, transgender, queer, intersex
There was general acknowledgement across the responses that interventions advocated by the Global Strategy would most likely be adapted by countries to different cultures and settings. Some respondents agreed that, to be effective, adolescent health interventions “need to be tailored to country needs and what will be acceptable – it should not be one size fits all – that is a recipe for failure” (ART).

Young people want a stronger voice in policy making, and to participate more fully in the design and delivery of adolescent and young adult services “...countries should consider adolescents and young people as partners” (Women Deliver Youth Survey). Youth leaders emphasised inclusivity and diversity, capacity building, and agency in policy-making processes. They also suggested that a financial commitment to adolescent health, for example, including a budget line for adolescent health services, and to ensure that these are not “empty promises” (Youth Leaders meeting, Uganda).

3.6 Health-influencing sectors (Social and Economic Determinants of Health)

“...break away from working in silos...” (Countries)

Respondents were crystal clear that health-influencing sectors were essential to achieving health outcomes and that “cultivating cross-sector partnerships between health and non-health sectors” was vital (Countries). However, "coordination between health and other sectors is possible where health is made a development issue and not an issue requiring a clinical/medical approach only” (Multilateral). Of all the economic and social drivers of health, education was considered both the most important (resoundingly so), but also the one that offered the best opportunities for immediate inter-sectoral working to improve outcomes for RMNCAH (Figure 4 overleaf). Other important sectors were human rights, water, sanitation and hygiene (WASH), women’s economic and political participation, nutrition, gender based violence, and livelihoods. Although working across sectors was vital, it was considered “important to avoid fragmentation” while still “linking to other overarching health agendas including UHC” (Cross-constituency consultation, New Delhi).
One interesting idea raised several times, mostly by country governments, was what could be called development conundrums: challenging intersectoral problems that have serious health consequences but still insufficient evidence about how to address them in practice. Stunting was the most frequently cited example. Although nutrition is a factor in stunting, the evidence is strong that nutrition alone will not reduce stunting. The evidence is growing (but remains insufficient) that sanitation, hygiene, maternal health during pregnancy and nutrition altogether combine to promote healthy growth and limit stunting, but, for such a prevalent problem (over 200 million children in the world are stunted), it remains an outstanding challenge. Gender-based violence may be another example and there are likely others.

Regarding specific ideas about accelerating inter-sectoral working, respondents had much to share. Some thought that countries should "consider focusing cross-sector work at sub-national level, with budget allocation for coordination and implementation following a results-based, cross-sectorial programming framework" (IntNGO). Important to success would be sufficiently trained and managed community based workers who were able to work across sectors, for example in early childhood development, nutrition or sanitation. The idea of inter-sectoral working at the community level was linked to another idea of building knowledge and commitment among people and...
communities themselves through strengthening grassroots movements for development (for example, a women’s movement or reproductive rights movement).

By far the largest number and diversity of experience and practice has been between education and health. Education was the most important priority by far among respondents and offered the best opportunities for immediate collaboration including:

- Better and more age appropriate health education to all children delivered through formal and informal education services;
- Keeping girls in school through ensuring menstrual hygiene and sanitation facilities are available;
- Comprehensive reproductive and sexual health to adolescents;
- Education about lifestyle, reducing harmful behaviours;
- Age appropriate education of younger children about gender relations, rights and equality;
- Female (adult) literacy using health and development material;
- Education aimed at strengthening parenting in men and women; and
- Women’s training opportunities (for example to train as midwives, teachers, health visitors).

Box 1 below provides examples of other collaborative experiences presented throughout the consultation.

**Box 1: Examples of collaborative experiences**

<table>
<thead>
<tr>
<th>National level inter-governmental programmes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Bolivia, working in mixed commissions of health, education and social services has been tried &quot;with good results&quot; (HCPA).</td>
</tr>
<tr>
<td>Additional examples were provided from Ethiopia (maternal health); Bangladesh (WASH and nutrition); Scotland (early childhood development); and Zimbabwe (HIV/AIDS).</td>
</tr>
</tbody>
</table>

Other kinds of inter-governmental partnerships would "incentivize the stakeholders to break away from working in a silo approach" (Countries) such as:

- Inter-sectoral or cross-cutting ministry programmes (for example, Local government, Sports and Youth, Agriculture and Rural Development, Environment and Finance);
- Allocated budgets for integrated plans at State or District level (for example, the Panchayat Programme).
3.7 Humanitarian settings

“...take into consideration the lessons learned from these emergency situations, ensuring that proper SRH supplies are included in the disaster kits, like condoms and emergency contraception...” (Regional Consultation, Chile).

Ensuring the Global Strategy was relevant to humanitarian settings was considered by respondents to be crucial to success not only because “51 fragile states [vulnerable to conflict and disasters] account for 60% of maternal, 53% of under-five and 45% of newborn mortality” (New Delhi Stakeholder Consultation), but also because when an emergency happens or conflict spreads, “women and children are often the first to suffer” (NatNGO).

Many respondents thought it essential for the Strategy to embrace disaster risk reduction and emergency preparedness approaches. Respondents identified a number of priority needs for women and children in emergencies (Figure 5) including: (i) ensuring the availability of basic supplies, including family planning; (ii) specialist services for example for assault or gender-based violence; and (iii) safe access to services.

Figure 5: Priorities for women, children and adolescents in emergencies

[Table showing priorities]

Respondents raised the growing needs of communities on the move including: refugees fleeing conflict, internally displaced populations, those forced to migrate for other reasons and even those who are trafficked. Vulnerable in a range of ways, women and children in these communities require good quality, accessible and comprehensive services that require joined up working between health, social services, law enforcement, housing and food security/ livelihoods services.
Considering these needs, respondents looked to the Global Strategy to spell out strongly and clearly how important good quality services are early in a crisis, especially the full range of sexual and reproductive health services for women and adolescents. Several respondents said that the health response should be well “plugged into the cross-sectoral response” (IntNGO).

Prevention always being the best approach, respondents thought that countries should be encouraged to strengthen resilience especially at the community level, by “anchoring emergency preparedness and response services” (Countries) into HSS efforts. The Global Strategy should “be included into disaster risk reduction and emergency preparedness strategies” (IntNGO), so that risk and risk assessment for women, children, and adolescent health “should become an integral part of national health programs, with costed, targeted and better articulated plans within national disaster risk reduction and health strategies” (Cross-constituency consultation event). In specific terms, the Strategy should spell out the RMNCAH needs of women and girls in humanitarian emergencies including, as a minimum, through:

- The implementation of the Minimum Initial Service Package (MISP),\(^\text{15}\) a package of basic sexual and reproductive health services for women and girls in emergencies;
- HIV/STI (Sexually Transmitted Infection) diagnosis and treatment, contraception including emergency contraception, and access to safe abortion services;
- Access to counselling and a comprehensive package of SRHR services especially for survivors of sexual violence; and
- Dialogue with local authorities about safety and security of girls and women, including positioning water and sanitation facilities.

The very recent agreement of the global Framework for Disaster Risk Reduction at the March 2015 Conference on Disaster Risk Reduction\(^\text{16}\) already includes many (but not all) of these points and respondents hoped there would be a concrete link made between the Global Strategy and this framework.

### 3.8 Human rights

“We … pursue actively the ideal of “leaving no country behind” and “leaving no one out” especially the vulnerable including the refugees, Internally Displaced Person (IDP) and stateless people…” (Yamoussoukro Declaration).


Respondents suggested that “human rights should always be an integral part of the approach” to the Global Strategy (NatNGO). The key principles underpinning human rights, including non-discrimination, equality, participation, empowerment, accountability and transparency, should be applied to all aspects of the Strategy. It is “paramount to strive for gender equality in the eyes of the law, society and education” (Countries). Countries should all be encouraged to “sign, ratify and remove reservations to human rights instruments such as the Convention on the Elimination of Discrimination Against Women” (NatNGO).

Gender inequality was considered the leading barrier to the realisation of human rights and respondents to the survey suggested that it was vital for the Global Strategy to address it fully (Figure 6). Other barriers included the lack of knowledge and information, which rendered people unable to assert their rights, and a range of access and service delivery barriers that prevented women and adolescents especially from receiving timely services. Additionally, gender inequality was exacerbated by harmful cultural practices and social constraints.

**Figure 6: Human rights related barriers to full access of RMNCAH services**

<table>
<thead>
<tr>
<th>Gender Inequality</th>
<th>Lack of Knowledge and Information</th>
<th>Lack of Access (distance, cost, time)</th>
<th>Harmful Cultural Practices</th>
<th>Policy and Service Insufficiencies</th>
<th>Social Arrangements and Constraints</th>
<th>Financing Constraints</th>
<th>Legal Barriers</th>
<th>Lack of Choice / Range of Suitable Services</th>
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Respondents thought it important for the Global Strategy to remind partners of the “the protocols signed by member countries with reference to human rights declarations in country constitutions” (Countries), including treaties they have signed up to (for example, the Rights of a Child and the Declaration on Human Rights). Most women and children in the world today are covered – theoretically – by the human rights guarantees that their governments have agreed to be bound by. The failure to guarantee these rights, however, stems from three sources.
Firstly, legislation may actively or passively undermine rights (for example, around child marriage, child labour, access to safe abortion services, lesbian, gay, bisexual, transgender and intersex rights, and gender inequality); Secondly, the implementation and application of relevant legislation at national, sub-national and community levels, especially where legislation is ignored in favour of pervading cultural behaviours, harmful practices and patriarchal or other societal norms; and Thirdly, for various reasons, people do not or are not able to assert their rights under the law.

The range of responses to this part of the consultation reinforces this third failure: lack of knowledge, lack of access, and unequal status were seen as the main barriers for women and children. Furthermore, having the legal right of access to health care, education and other essential services was not seen to be sufficient without the political will to enforce rights and social arrangements to guarantee access to legal services to enforce rights. Countries needed to ensure they created responsible agencies with the “powers to monitor compliance with global commitments” (IntNGO). It was important to respondents to “heavily press communities and target audiences to respect the addressed human rights issues” (IntNGO).

It was also relevant to the protection of rights that demands could be made by individuals to governments that are strong enough and institutionally sound enough to understand and fulfil their obligations to their citizens, not repress them. Legal protection for RMNCAH is not enough without long-term investment in the development of the justice system in order that communities feel they have the legal backing to demand their rights, seek justice in the case of violations and hold individuals and national authorities, including health providers, accountable. “If [a country] doesn’t have localised legal aid, sometimes seeking justice can be action in futility” (NatNGO), but women’s access to legal services would better “enable them to challenge gender discrimination and inequalities” (NatNGO). Respondents were clear though, that efforts to secure rights should be around “initiatives [that] are appropriate and relevant to beneficiaries” (HCPA) and target the lowest income and most vulnerable groups (women and young girls in particular).

As with other aspects of ‘domesticating’ the Strategy, respondents agreed it was important to have flexibility about how systems are put in place so that country specific solutions could flourish. This would involve engaging entire communities and “establishing strong active partnerships between different actors of society” (Private Sector), including women and young people. However, respondents also thought that
engaging men and boys was important: "mobilize men to support women’s and adolescents’ sexual health rights" (IntNGO), as well as to challenge and shift cultural norms about male violence, especially gender-based violence.

However, respondents were divided about the role of faith leaders. Some felt it was essential to engage and involve local faith leaders to build understanding and knowledge about a human rights based approach, while others were less certain, suggesting that human rights should be guaranteed irrespective of an individual’s faith. On the other hand, some respondents suggested “human rights and gender equality need to be in the school curriculum” (Private Sector). There are far more available channels now to spread knowledge about human rights and several respondents suggest the use of technology and social media to open up access to information, especially for reproductive health among adolescents. Technology could also help countries “set up platforms to create broader awareness of the link between health and human rights” (D&F). All communities should be included and governments should make efforts to “…reach out to indigenous communities” (National Consultation, Panama).

3.9 Innovation

“…plan from the start on how to scale up successes” (Private Sector).

Respondents were asked two quite specific questions about innovation including, firstly, to suggest the RMNCAH gaps that would best benefit from innovative solutions and, secondly, to consider how countries could ensure that investment in innovation meets country priorities. As many respondents demonstrated through their contributions, innovation does not necessarily mean something technological or new. It includes new ways of applying/adapting/developing solutions or ideas at scale.

Two clear messages emerged from consultations. Firstly, innovation cannot by definition be a one-size-fits-all, but must be tailored to specific needs and contexts, sometimes even to the local rather than national or global level. Secondly, it is vital to keep the focus on articulated, recognised problems and find innovative solutions to address these, rather than the other way around. “RMNCAH innovations should be country-developed and led and should reflect the real needs of the most affected countries rather than being the ‘innovation du jour’” (NatNGO). Clearly some innovations are best developed at global level (for example, new commodities) but even these should be designed to be adaptable to different country situations.

Respondents were asked to suggest what critical gaps are most suitable for innovation and there were many ideas and views offered, summarised into Box 2 below.
Box 2: Some of the critical gaps that could best be addressed by innovation

Many examples of how innovation could solve problems were provided, including:

- Use mobile phones and other portable devices to:
  - Disseminate health messages, particularly giving girls and boys FP information
  - Enable community health workers to identify danger signs in the first week
  - Improve referral links at community level
  - Ensure follow-up appointments, such as ANC visits
  - Improve monitoring and data collection, such as birth and death registration

- Use social media and other communications platforms and apps to:
  - Change social norms amongst adolescents
  - Increase health education, particularly around menstrual hygiene, SRHR
  - Help promote accountability of health services
  - Develop security apps for women and girls

- Develop, use and review a range of specific tools such as:
  - Guidelines for active feeding practices using nutrient dense food
  - The use of the partograph in delivery
  - Parenting programmes and early childhood development
  - Better use of verbal autopsy

- Develop new and more effective commodities and equipment such as:
  - FP and STI-prevention methods, including male methods
  - New food products to address health problems in children
  - Equipment suitable for low-resource settings

- Develop innovative ways of working and processes such as:
  - How to improve and maintain health worker skills, particularly in remote areas
  - Ways to include adolescents in decision making
  - Develop, deliver and test the use of telemedicine
  - Health care payment mechanism reforms
  - Better policies to end early and forced marriages
  - Community mechanisms to count every death/ stillbirth
  - Peer education models to encourage accessing services

In the context of this consultation, there was near universal agreement that well-chosen and carefully developed innovation could address critical gaps across the whole spectrum of care in SRHR, maternal, newborn, child and adolescent health spheres. Technology, including both hardware and software, and the development of new commodities, was most often suggested. However, there were also lots of examples of innovation in systems, tools, and processes with the recognition that, “the most effective innovations are often the simplest” (HCPA), as well as a warning that “we shouldn’t innovate for the sake of innovation” (IntNGO).
How should countries decide what problems require innovation? Respondents suggested that in order to identify relevant challenges where innovation might make the difference (as opposed to delivering a known solution fully and to all in need), health sector partners need timely data and information, the means to discuss and prioritise needs, and close community and civil society links to build interest in solutions and ensure investments will meet people’s needs. Innovative solutions can therefore best be designed and achieved through “establishing strong and active partnerships between different actors of the society towards the active implementation of RMNCAH innovations” (Private Sector). A step-wise approach to piloting projects before scaling up, as well as ensuring evidence is published, would avoid wasted time and effort.

3.10 Monitoring and Accountability

Respondents were vocal about the responsibility of the Global Strategy to “promote alignment of accountability mechanisms ... and set a clear framework for a multi-stakeholder commitment to accountability, with clear, measurable results, based on country specific suggestions and country commitments” (D&F).

Respondents were first asked to agree or disagree with a range of statements aimed at testing how much the accountability arrangements currently in place should be retained, improved or replaced (Figure 7). Among respondents who were familiar with them, there was overwhelming support for both the Independent Expert Review Group (iERG) and the Commission on Information and Accountability for Women’s and Children’s Health (CoIA) processes. In accompanying comments, respondents considered these processes to have strengthened global accountability significantly, making it more objective and transparent. Over three quarters of respondents thought that Countdown had improved accountability at country level. And, although the majority of respondents considered that global tracking and monitoring influenced donors to strengthen their commitments and probably made it easier to hold country governments to account, an even greater number considered that current investments in global and country level accountability were insufficient.
Monitoring and accountability was a multifaceted area of inquiry that attracted a vibrant and highly engaged set of responses. To simplify the material, views are synthesised across five themes: (i) accountability at the country level; (ii) accountability at a global level; (iii) data collection, monitoring and information systems; (iv) capacity building; and (v) the role of people and communities in delivering accountability.

**Domestic accountability**

At a country level, discussion centred around who should be accountable, for what and how to track and verify results. A large proportion of respondents raised the need for “more emphasis on establishing or strengthening ... country accountability mechanisms, which should include wide memberships” (IntNGO), but many also suggested the all-important condition that allowed a “tailored approach to each country” (IntNGO).

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17 For the sake of simplicity, “Don’t know” responses have been left out of the graph.
However, these three elements do not have to be in opposition to one another, rather it is possible to:

- Enable individual countries to shape accountability instruments and processes to their own environments and systems; and
- Develop and agree accountability metrics that enable comparison to other countries; and
- Be transparent about tracking and monitoring these at a national and global level.

It does, though, potentially increase the scope for diluting accountability rather than strengthening it. One of the clear benefits of the MDGs raised in the Preliminary Lessons Learned consultation was around the value of simple standard metrics for all countries together with explicit standards of achievement (results targets). From an accountability perspective, the Global Strategy will have to find the right balance therefore between potentially competing aims of being directional (aspirational even) and being adaptable at country level.

Suggestions about how to build transparency and sustain political will at national level included:

- Developing a high level dashboard with traffic lights (red, amber, green) against process indicators linked to outcomes;
- Introducing country score cards, report cards, and other assessments against public commitments;
- Continuing the Countdown data, possibly expanding distribution within the country, as well as including a sub-national version with disaggregated data across provinces or districts; and
- Including civil society and citizens; educating citizens about their rights to health.

Within countries, and whatever set of metrics and process was finally agreed, respondents were vocal about the role and responsibilities of all health sector partners to support and use a common system, some going so far as to suggest partners make “formal commitments that just national indicators will be used” (Private sector).

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The behaviour and compliance of partners at country level generated a lively set of comments including:

- Transparency around financial data (by private and public sector partners, IntNGOs and CSOs, donors and multilateral agencies);
- Simplified collection requirements; “Minimum data set” (ART);
- Link to the SDG target to achieve UHC, possibly by tracking of user fees;
- Build one health management information system (HMIS) that all partners use;
- Agreed data indicators; system to be used by all stakeholders in the country (all partners);
- Disaggregated data is more useful (wealth quintile, sex, geography, age);
- Use multiple methods including focus group discussions to validate findings and deepen understanding (NatNGO); “First hand stories” (NatNGO); “evidence-based advocacy materials” (ART);
- “Ensure the inclusion of adolescent indicators” (Private sector).

Referring to the GFF, one comment identified the need to build skills in the monitoring, record keeping, and communication that would be required to undertake “the development and implementation of financing roadmaps for improvement in maternal and child care” (Countries), thus reinforcing the multiple levels and functions of national accountability and monitoring systems.

**Global accountability**

At the global level, accountability should be focused on engaging stakeholders, building commitments and shoring up political will around sustained action (and funding) for women, children and adolescent health needs. “The updated Global Strategy can play a crucial role in improving the impact of accountability mechanisms and initiatives by incentivizing country partners and key RMNCAH stakeholders to integrate accountability mechanisms into their RMNCAH programs” (Countries).

In order to build a strong accountability culture, the following issues were considered essential:

- Clear metrics: “create transparent, simple, clear metrics...” (IntNGO) and “not too detailed” and “measurable targets” (NatNGO).
- “Follow-up and measurement... so that signing up to the Strategy is not an empty action” (IntNGO).
• Country and partner commitments “should be public” and if not binding, at least tracked openly (D&F).

The Global Strategy process (as opposed to the document) should aim to “advocate with leaders to allocate [both global and domestic] resources” (Private Sector). Some respondents suggested the Strategy process needed to be accompanied by “advocacy to secure, maintain and monitor the political commitment to RMNCAH and perhaps open a “roll of honour” to recognize political leaders who show unwavering support and commitment to RMNCAH both in action and words” (IntNGO). At all levels, identify youth actors to participate in dialogue, strategy development and delivery.

**Data collection, information systems and monitoring**

“...Building a nationwide reliable system of information, data collection and management, particularly by strengthening country processes, system and capacity” (Countries).

Respondents liberally shared their views about the mechanics of collecting, processing, analysing, using and reporting results and progress. It emerged as a global and country challenge that tends to attract a lot of attention (and sometimes resources) but little harmonised working and rarely any kind of joined-up programming. National monitoring systems should be “timely, complete, relevant, specific, accurate and usable” (IntNGO) and yet, they were often a “huge waste of funds” (IntNGO). “Countries should track essential data only” and ensure those who collect the data can see the results (D&F).

Many respondents referred to the rapidly advancing opportunities offered by electronic systems suggesting countries should move quickly to optimise the potential benefits of eHealth, mHealth, mobile phone technology and other electronic media, as well as to expand access to the internet. Comments included: “Use mSystems to enter community data in real time” (Private sector); “handheld devices for community health workers” (NatNGO); and “use new technology like Global Positioning Systems, and Geographic Information Systems” (IntNGO). But there was caution too, “mHealth is not going to solve all ...problems. It is a great tool to have and use but it should be part of a diverse set of tools” (ART), especially given limited network coverage in some hard to reach places. Some of these challenges could be overcome through using “locally adapted technologies fitting the context (for example, able to continue working through power outages)” (D&F).

A strong line of thinking emerging from the consultation was the value of a single, unified system of data collection that was supported by all donors and multilateral
agencies and used by all partners (including the private sector and NGOs). This system could be multifaceted and include a variety of collection instruments (routine data, surveys, spot checks and special one-off processes). However, the critical point was that there should be just the one data collection system, used to its fullest potential by everyone. There was thought to be a lot of wasted effort at the moment as well as distractions: “Stop doing baselines, midlines, and endlines for every project rather than using existing data effectively” (IntNGOs). On the other hand, “if surveys are planned, make sure the samples are large enough to be significant and include difficult areas in the sample” (NatNGO).

Although there is broad agreement about the desirability of building one health information system, the practicalities are challenging and potentially expensive. There is always pressure to demonstrate that project results have been achieved for example, and specific data is often needed for that purpose.

**Capacity building**

Several respondents suggested that training should be stepped up, for example by including “concepts of accountability and monitoring in professional training programmes [and] continuing professional development” (HCPA). Others suggested using “national organisations to train, implement and use official tools and instruments for M&E” (Private Sector), or “training CSOs and local community leaders” (NatNGO) to ensure better understanding about data management and how to use data putting “more emphasis on building capacity to measure and record data in hard to reach areas” (IntNGO).

Respondents were vocal about the role of the health worker in data collection processes, so often given data collection duties on top of (not instead of) service delivery duties. The aim should instead be to “educate and mentor public health workers” (HCPA), ensure they are “supervised and managed” (HCPA); and are provided “training and technical support” (NatNGO). Furthermore, countries “need to ensure people collecting data can also use it locally for their own quality improvement” (D&F).

Data collection and management processes should be carefully thought through in relation to the heavy workload already borne by many health workers. “Don’t overload staff”, but rather “pay staff to do data entry – these tasks frequently are just put onto people who already have full-time jobs… otherwise it leads to errors and delays” (ART).
People and Communities: Who is data for?

“Populations who are involved in the collection of data need to be updated on aggregated data, possibly including benchmarking, making transparent how they are faring compared to others or the national average” (Countries).

Respondents had well-articulated views about the importance of ensuring that data collected were shared with people widely suggesting, “data should be public” (NatNGO) and that “reporting in plain language” (IntNGO) increased transparency and accountability. Furthermore, the management of records should “enable mothers and children to have their own records or have access to their own data” (IntNGO).

Many ideas were suggested about how to report back to communities and share data openly to “involve key affected population[s]” (IntNGO), including the use of media, schools, newspapers, and other channels to create opportunities for participation at the local level and to build public interest in health service performance. This was about the need “to invite and speak to the citizens to share experiences as they are key informants” (IntNGO) and to approach data in a way that was “less mechanism heavy…” (Multilaterals). Some respondents also thought that the ideal system would be “participatory” (HCPA) and would “include the population in data collection” (ART). In relation to participating in monitoring and accountability, “Everyone has a phone, [and can] text an answer or rating to a specific number” (Private Sector).
4. CONCLUSIONS AND RECOMMENDATIONS

“At last! Women, children and adolescents are at the center of health and development” (NatNGO).

4.1 A compass for the post 2015 world

There is a huge amount of support for the process of building an updated Global Strategy and a strong sense that this is a vital process, important to get right. This consultation has attracted inputs across every continent and constituency group, including young people. The challenge for the Strategy may be to meet the high expectations of constituents and to incorporate the considerable range of ideas, priorities and challenges identified. For many respondents, the Strategy underpins the platform for action and is synonymous with it.

4.2 Balancing unfinished business and new challenges

The Strategy will have an important role in ensuring that RMNCAH priorities continue to be at the centre of global and national health efforts in their fullest expression. Although there are new and emerging priorities, the basic needs of women and children have not yet been met and a full package of SRHR services should always be available, including safe abortion and reproductive health services for women and girls. Some previously neglected policy and outcome areas – for example, newborn health – have recently started building momentum. Stunting, gender-based violence, early childhood development and other multidimensional challenges should be included in the Strategy to ensure they are identified (and claimed) as, at least in part, a health responsibility.

4.3 Future-proofing the Strategy

Although it should continue to focus on the vital, essential services that drive preventable mortality, the Strategy should take a life course approach and think broadly about context, trajectories, emerging science and up-coming challenges. The horizon includes challenges related to setting (urban slums, hard to reach areas, people on the move), diseases (especially NCDs, mental health), service delivery challenges (aging populations, end of life and palliative care), and new multidimensional challenges with health impacts (climate change, migration, conflict). Furthermore, as knowledge grows, we understand more about the pernicious links between communicable diseases and diseases of poverty, as well as the NCDs that are responsible for a growing proportion of preventable deaths and disabilities. The links
between HPV (Human papilloma virus) and cervical cancer are clear, but emerging evidence suggests that maternal malnutrition may be linked to a child’s predisposition to cardiovascular disease as an adult. Currently, the global debate often seems to polarise the two sets of health challenges, placing diseases of poverty and NCDs in opposition to one another. The Strategy can make an important contribution to the process of bringing these two spheres together without detracting from either.

Other ways the Strategy could be future-proofed may be to consider the growing importance of global health security (emerging diseases, new forms of conflict), the complexities of health in emerging economies, including the demographic dividend many countries aim to achieve, the efforts to encourage new donors and new sources of financing, for example through innovative funding modalities, and financing in the age of austerity. Another aspect of future-proofing is through evidence and knowledge building, which is discussed further below.

4.4 Enlarge the tent: Humanitarian Situations

Women and children caught up in humanitarian situations, both rapid onset and complex emergencies, have acute needs. Depending on the emergency, there may be refugees, forced migrants, or internally displaced women and children. They may be dispersed or together in groups; on the move or stationary. With the number of conflicts currently unfolding around the world, the regular onset of natural disasters and other unforeseeable situations, the needs of these displaced communities must be integrated into plans and programming, rather than separated as a ‘special situation’. The humanitarian context should be, from a service planning point of view, an anticipated situation that some people get caught up in, some of the time: the unknowns are where, when, who exactly and for how long. Each situation may be exceptional but the fact of emergencies is far from being so. There are already clear international guidelines about addressing many of the urgent health needs of these communities and yet, for a number of reasons, services often fall short. The Global Strategy should identify clearly the importance of meeting urgent health needs in these populations (especially SRHR needs) by ‘normalising’ the fact of displacement. It should reinforce the responsibilities of governments, multilateral agencies and others to ensure the minimum standards of care that are required for displaced women and children.
4.5 #Adapt: Meeting the needs of #Adolescents

Adolescents and young people have added a vibrant and energetic voice to this consultation, raising crucial issues about the legislative, cultural, systems and bureaucratic barriers they face getting access to the services they need and to realise their rights. Adolescents’ need for comprehensive sexuality education and good quality, appropriately delivered services has come through loud and clear, as has the energy and enthusiasm of youth across many countries to get involved in transforming their own societies. What is also clear is that young people’s concerns and attitudes, their facility with social media, and their expectations about the future, suggest that meeting adolescent needs is not just a case of adding onto existing services. What emerges from this consultation is that shifting norms in order to genuinely meet the needs of adolescents will require adaptation on a larger scale. Societal norms, service delivery approaches, access standards, information services, and health worker attitudes, knowledge and communication styles are likely to need adaptation. The Strategy can help guide countries and partners to meet that challenge.

4.6 Systems: Health care workers still the frontline challenge

Although there are many facets to HSS, to financing and delivery, and to policy making and planning, the challenges around attracting, training, deploying, motivating, managing and retaining a cadre of skilled, enthusiastic, committed, kind, non-judgemental and dedicated health workers touches on every aspect of these consultations. Health workers also need constant skill refreshing, especially in light of their broadening remit. Community based health workers continue to be an important cadre in order to locate and support the hardest to reach. With their own needs and often loaded with carer responsibilities at home, female health workers have particular challenges of their own, but are vital to better outcomes for all women, adolescents and children in their communities everywhere.

4.7 Financing, UHC and the Global Strategy

Over 100 million households a year fall back into poverty as a result of health problems, often driven by the need to pay upfront for health services to save a life. With the rise of NCDs everywhere, the serious health impacts on women and men are likely to increase significantly. Domestic and global financing systems, solidly linked to countries’ UHC agendas, are vital elements to build resilient health care systems and

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address and curb this slow-motion emergency. The Global Strategy is in a good position to demonstrate and promote the links between the needs of the poorest and most vulnerable people – often women and children – to the UHC agenda.

4.8 Information, Monitoring and Accountability

The Strategy should be accompanied by sound proposals for a robust, integrated and aligned accountability framework that promotes streamlined and unified data collection at the country level, encourages comprehensive monitoring across the whole national health system and enables national and global commitments to women’s, adolescents’ and children’s health to be tracked and verified. Monitoring requirements (including indicators and associated targets) should strike the right balance between ensuring that country results are comparable to others at the global level, yet integral rather than additional to each country’s own HMIS and sub-national monitoring needs.

There is strong demand by the wider RMNCAH community for a comprehensive accountability framework that builds on recent experience, including the iERG, CoIA and Countdown. A comprehensive approach requires various instruments and processes which, together, have the capability to: fully undertake commitment tracking at global and national levels; measure, compare and explain results; identify the trajectory of critical indicators; undertake risk assessment about barriers to progress; and provide guidance and recommendations about addressing these barriers, which subsequently forms part of the on-going accountability system. The Strategy should be clear about guidance for national and global level accountability and, as part of the overarching guidance to countries around domestication of the Strategy, provide an accompanying toolkit to support monitoring and accountability systems building and surveillance.

4.9 Research, evidence, knowledge and dissemination

New evidence emerges constantly. Evidence becomes knowledge and knowledge, in turn, can drive policy, programming and service delivery. How will the Global Strategy approach this ‘evidence – knowledge – policy – delivery’ continuum? While it is vital to be alive to the constantly shifting evidence base, the way that evidence is understood in specific contexts and how it is used to optimise RMNCAH outcomes are questions that each country will need to take decisions on. Where possible, the Strategy should identify known priorities for evidence and knowledge-building. This consultation suggests a number of priorities which concern countries immediately, including
maternal mortality, early childhood development and stunting, reducing violence, especially gender-based violence, saving newborn lives and reducing stillbirths. A range of operational challenges have also been identified, for example around reaching communities with life-saving services, youth access to SRHR services, and building service delivery approaches that meet basic needs across the entire life course. But, beyond the research and evidence gaps that are already known, the Strategy and its implementation platform and partners should build in the means to anticipate and adjust to changing knowledge and improved practices and to support a relentless drive to keep focused on filling the health related knowledge gaps that prevent women, adolescents and children from reaching their potential.
APPENDIX A: LIST OF RESPONDENTS AND CONSULTATION EVENTS

A.1 Organisations

- 2015 action
- Academics Stand Against Poverty (ASAP) India
- Action Against Hunger
- Action for Health Initiatives Inc.
- Advance Family Planning (AFP) Initiative
- Advocacy Forum for Tobacco Control
- Africa Youth and Adolescents Network
- Africaid
- African Union
- African Women Leaders Network for Reproductive Health and Family Planning
- African Women’s Development Fund
- AIDS Information Center, Uganda
- Aids Law Project, Kenya
- Aisyiyah
- Aisyiyah PDA Banyumas
- Aksi 2015
- Alay Sa Bayan NS Foundation
- Aliansi Remaja Independen (Independent Young People Alliance)
- Alliance for Reproductive Health Rights
- Allied Youth Initiative - Uganda
- Aman Foundation
- Aman Health Care Services
- American Academy of Pediatrics
- Australian College of Midwives
- AMREF (formerly the African Medical and Research Foundation)
- Aotearoa Youth Leadership Institute
- APPI
- Asia Pacific Alliance for Sexual and Reproductive Health and Rights (APA)
- Asian Forum of Parliamentarians on Population and Development (AFPPD)
- Asian-Pacific Resource & Research Centre for Women (ARROW)
- Aso Radio
- Asociación Española
- Asociacion Obstetrica del Uruguay
- Associação Portuguesa dos Enfermeiros Obstetras
- Association Burundaise pour le Bien Être Familial
- Association des Jeunes Solidaires de l’Afrique AJSA/Sénégal
- Association des sages-femmes du Bénin
- Association For Reproductive & Family Health, (ARFH) Nigeria
- Association Internationale des Technologistes Biomédicaux (ASSITEB-BIORIF)
- Association of Gynaecologists and Obstetricians, Tanzania (AGOTA)
- Association of Ontario Midwives
- Association of young people living with HIV and AIDS in Malawi

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20 Members of these organisations submitted their views to the Global Strategy consultations via (i) the Global Strategy survey (online and offline); (ii) partner-held consultations; or (iii) direct submission through the Global Strategy consultation team and PMNCH Secretariat.
Consultations on updating the Global Strategy: Round 1 – Priorities for the Global Strategy

- Association Protection Environnement Evaluation Sociale
- Association Serasera Fantantenana
- Azad India Foundation
- Balance Promoción para el Desarrollo y Juventud A.C
- Banshidhar & Ila Panda Foundation
- Barbados Midwives Group
- Barcelona Institute for Global Health
- Barrie Midwives
- BBC Media Action
- Belgium Medical Students’ Association
- Beyond Beijing Committee
- Bhartiya Mahila Evam Gramin Utthan Sansthan
- Bill & Melinda Gates Foundation
- Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health
- Blessing Way Midwifery
- Bolivia Dir. General de Planificación
- Born Midwives/Association of Ontario Midwives
- Botswana YWCA (Young Women’s Christian Association)
- Busoga Linkage Foundation
- C3 India
- Canadian Association of Midwives
- Canadian Medical Association
- Cancer Africa
- CARE USA
- Caribbean Student Environmental Alliance
- Carolina Global Breastfeeding Institute, University of North Carolina
- Catholic Health Association of India (CHAI)
- Catholic Relief Services
- cBe consulting
- Center for Creative Initiatives in Health and Population
- Center for Health, Education, Training and Nutrition Awareness (CHETNA), India
- Center for Indonesian Medical Students’ Association
- Centre for Affordable Water and Sanitation Technology (CAWST)
- Centre for Family Medicine
- Centre for the Study of Adolescence
- Centre for Youth Inclusion
- Centro de investigación y Promoción para America Central de Derechos Humanos (CIPAC)
- Centro Nacional de Equidad de Género y Salud Reproductiva (CNEGSR), Mexico
- Chatham House
- Chemonics International Inc.
- CHESTRAD International (Centre for Health Sciences Training, Research and Development)
- Child in Need Institute (CINI)
- Childbirth Survival International
- Christian Spiritual Youth Ministry (CSYM), Huduma, Tanzania
- CIAM- Public Health Research and Development Centre
- Civil Society Form for Child Rights in Mozambique (ROSC)
- Civil Society Legislative Advocacy Centre (CISLAC), Nigeria
- Civil Society MDG Campaign/ Global Call to Action against Poverty (GCAP) Zambia
Consultations on updating the Global Strategy: Round 1 – Priorities for the Global Strategy

- CLAN (Caring & Living As Neighbours)
- Clinton Health Access Initiative
- Coalition for Adolescent Girls
- Coalition for Health Promotion and Social Development (HEPS-Uganda)
- Colegio de Matrones y Matronas de Chile
- Colegio De Obstetras Del Perú
- Colegio De Obstetricas De La Pcia De Buenos Aires-Argentina
- Columbia University Mailman School of Public Health
- Community Health and Research (CHR) Initiative, Nigeria
- Conseil des Volontaires en Population et Développement
- Cordaid
- Daily Trust
- Dasra Impact Foundation
- Delhi University
- Department for International Development, United Kingdom
- Department of Foreign Affairs and Trade, Australia
- Department of Health, Nassau County, New York, USA
- Development Media International
- Digni
- Dot Youth
- DSW (Deutsche Stiftung Weltbevoelkerung)
- DSW, Tanzania
- E4A
- East African Community (EAC)
- Education as a Vaccine
- EducommunicAfrik
- Ege University Medical Faculty Department of Public Health
- Egyptian Family Planning Association
- Ekjut
- Emas - USAID
- Emonyo Yefwe International
- Enfermero Gineco-Obstetra, Hospital de Obaldia, Panama
- Engenderhealth
- Episcopal Relief & Development
- Equilibres et Population, Burkina Faso
- Equitable Health Access Initiative, Akure & Lagos, Nigeria
- Espolea
- European Union
- Evangelical Lutheran Church in America
- Evidence for Action
- Executive Office of the UN Secretary General
- Faculty of Medicine, Eduardo Mondlane University
- Family Care International
- Family Larsson-Rosenquist Foundation
- Family Planning Association of India
- Federacion Latinoamericana de Obstetricia y Ginecologia (FLASOG)
- Federal Ministry for Economic Cooperation and Development
- Female Health Company
- Financing For Development Corp
- Finnish Evangelical Lutheran Mission
- Fiocruz (Fundação Oswaldo Cruz), Brasil
- Fopria Serang, Banten, Indonesia
- Forum Jeunes et OMD, Youthfim
- Health and Rights Education Programme (HREP) Malawi
- Health Partners International
- Health Poverty Action
- Health Promotion Tanzania
- Health Reform Foundation of Nigeria (HERFON)
- HealthBridge Foundation of Canada
- HealthEnabled
- HelMSIC - Hellenic medical students international committee
- Hero’s Shelter Inc.
- Hindustan Latex Family Planning Promotion Trust
- Hriday Youth Network
- Human Health Aid-Burundi
- I.M. Huechuraba, Santiago
- IAIM (International Association of Infant Massage) Australia
- ICF International
- ICS (Instituto de Cooperación Social) Integrare
- iERG (independent Expert Review Group)
- InCircle, Finnacle Capital
- Indonesian Midwives Association
- Indonesian Planned Parenthood Association (IPPA)
- Institut de Médecine Tropicale
- Intermed International
- International Association for Adolescent Health
- International Community of Women Living with HIV
- International Community of Women Living with HIV, Chile
- Forum Peduli Kesehatan Ibu dan Anak (Fopkia)
- Fountain Healthcare Ltd
- Framework Convention Alliance (FCA)
- Fransiskan Misionaris Maria (FMM)
- FXB Center for Health and Human Rights
- Gabungan Organisasi Wanita (GOW)
- GBCHealth
- Generation Development Initiative
- Geneva University Hospital
- Georgetown University Hospital
- Girl Generation
- Girl Museum, Inc.
- Girls Not Brides: The Global Partnership to End Child Marriage
- GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit)
- GLAPD - Great-Lakes in Action for Peace and the Sustainable Development
- GlaxoSmithKline Pharmaceuticals Limited
- Global Alliance to Prevent Prematurity and Stillbirth (GAPPS)
- Global Development Impact
- Global Fund to Fight AIDS, TB and Malaria
- Global Health Strategies
- Global Health Visions
- Global Public-Private Partnership for Handwashing (PPPHW)
- Global Youth Coalition on HIV/AIDS
- GLOBE
- Gram Bharati Samiti (GBS)
- Grand Challenges Canada
- Griffith University
- HACEY Health Initiative
• International Community of Women Living with HIV, Zimbabwe
• International Confederation of Midwives
• International Federation of Medical Students Associations (IFMSA)
• IFMSA, Morocco
• IFMSA, Netherlands
• IFMSA, Pakistan
• International Institute of Social Studies
• International Pediatric Association
• International Planned Parenthood Federation (IPPF)
• International Society of Ultrasound in Obstetrics and Gynecology (ISUOG)
• International Women’s Health Coalition
• International Youth Alliance for Family Planning Uganda chapter
• IntraHealth International
• Ipas
• Ipas, Pakistan
• IPE Global Private Ltd.
• Islamic Relief Worldwide
• ITES
• Jago Nari
• Japanese Organization for International Cooperation in Family Planning (JOICFP)
• Jhpiego
• Jhpiego, Kenya
• John Snow, Inc.
• Johns Hopkins Center for Communication Programs, Indonesia
• Junxion Strategy
• KASETA Development Ltd, Nigeria
• Kiala Foundation
• Kibogora Hospital
• Kigali Women’s Midwifery Care
• Kindermisionswerk
• Kindernothilfe
• Kiviwosheg Ibera Visionary Women Self Help
• Know Violence in Childhood
• Labrador Grenfell regional health services
• Laurentian Midwifery Education Program
• Let Girls Lead
• Lifespring Hospitals
• Liverpool School of Tropical Medicine
• Liya Kebede Foundation
• London School of Hygiene & Tropical Medicine
• LongRiver Infotech
• Makgaganeng
• Mama Ye
• Marie Stopes International
• Medela AG
• Medical Women Association of Tanzania (MEWATA)
• Medionix, a media company
• Medtronic Philanthropy
• Merck
• Micronutrient Initiative
• Middle East Council of Churches
• Midwifery Association of Pakistan
• Midwifery Services
• Midwives Association of British Columbia
• midwives@ethiopia
• MILES Chile
• Ministère de la Sante et de l’Action sociale, Sénégal
Ministère de la Santé, Sénégal
Ministerio de Salud, Chile
Ministerio de Salud/ Programa Nacional de Adolescentes y Jóvenes, Unknown
Ministry of Health, Bhutan
Ministry of Health, Ecuador
Ministry of Health, Kenya
Ministry of Health, Mexico
Ministry of Health, Republic of Indonesia
Ministry of Health, Samoa
Ministry of Foreign Affairs, Nepal
Ministry of Labour, Health and Social Affairs of Georgia
Ministry of Public Health, Cameroon
Ministry of Public Health, Reproductive Health Directorate, Afghanistan
Ministry of Women, Children and Social Welfare, Nepal
Ministry of Women and Child Development, India
MNCH 2
Mongolian Family Welfare Association
Morgane Richardson Doula
Mother and Child Health & Education Trust
mothers2mothers
Mouvement de Libération de la Jeunesse Centrafricaine (MLJC)
mPowering Frontline Health Workers
MS Health Pty Ltd
MSD Pharmaceuticals
Muhammadiyah
Muslim Family Counselling Services
Namibia Women Association
Naretu Girls and Women Empowerment Programme
Naripokkho
National Association of Portuguese Medical Students
National Center for Youth Issues, USA
National Council of Churches of India
National Council of Food and Nutrition / Conseil National d’Alimentation et de la Nutrition, Benin
National Foundation for Cancer Research (NFCR)
National Health Mission, Government of India
National Institute of Public Cooperation and Child Development (NIPCCD), India
National Institutes of Health (NIH)
National Reproductive Health Working Group, Nigeria
National Youth Service Corps
Nav Srishti
Nazareth College
NCD Child
NCDA (Non-Communicable Disease Alliance)
Nestle India
New Century Initiative
Newborn Foundation
Nigerian Medical Students Association
Novo Nordisk A/S
NSW Health Australia
Nyabohanse Children Rescue Centre
OFFER (Organization for Friends Energies and Resources)
Oikos
ONE
Consultations on updating the Global Strategy: Round 1 – Priorities for the Global Strategy

- One Million Community Health Workers Campaign
- Oratechsolve Inc
- Organizacion Dominicana de Estudiantes de Medicina
- OSSEDI (Organisation for Sustainable Socio-Economic Development initiative) Malawi
- Pak Arab Fertilizers Multan Pakistan
- Pan-American Health Organisation (PAHO)
- PAHO, Bolivia
- Partners in Population and Development, Africa Regional Office
- Partnership for Faith & Development
- PATH
- Pathfinder International
- PATHS2
- Pelkesi
- PERDHAKI (Persatuan Karya Dharma Kesehatan Indonesia)
- Permanent Mission of Canada to the UN
- Persagi DPC Sambas, Indonesia
- Pharmaceutical Society of Nigeria (PSN)
- Philippine NGO Council on Population health and Welfare (PNGOC)
- Philips
- Piramal Foundation
- PKBI (Perkumpulan Keluarga Berencana Indonesia)
- Plan Internacional Oficina Regional para America Latina
- Plan International Asia Region
- Plurinational State of Bolivia, Dir. General de Planificación
- Polish Midwives Association
- Population Action International
- Population Foundation Of India (PFI)
- Population Matters
- Population Reference Bureau (PRB), Nigeria
- Population Services International
- Positive Vibes, Zambia
- Pragati Development Consulting Services Ltd. (PDCSL) for UNICEF Gujarat
- PRAYAS (Initiatives in Health, Energy, Learning and Parenthood)
- Presidente Del Colegio De Obstétricas De La Provincia De Bs. As. - Argentina
- Preventing Cervical Cancer (PINCC)
- PWC (Price Waterhouse Cooper)
- Rabin Martin
- RACHA (Reproductive and Child Health Alliance), Cambodia
- Radio Nigeria
- Rahnuma - Family Planning Association of Pakistan
- RBM (Roll Back Malaria)
- Reliance Foundation
- Reproductive & Family Health Association of Fiji
- Reproductive Health Association of Cambodia
- Reproductive Health Uganda
- Réseau des ONG Béninoises de Santé (ROBS)
- Restless Development
- Results for Development Institute
- RESULTS UK
- Rotarian Fellowship for Population and Development
Consultations on updating the Global Strategy: Round 1 – Priorities for the Global Strategy

- Royal College of Obstetricians and Gynaecologists
- Royal Dutch Organisation of Midwives (KNOV)
- Rutgers WPF
- Rwanda Nutrition society
- Safe Motherhood Network Federation, Nepal
- SAHAYOG
- Sangath
- Saraswathi Shanmugam Public Charitable Trust
- Save the Children
- Save the Children, Cambodia
- Save the Children, Nigeria
- Save the Children, Norway
- Save the Children, United Kingdom
- SERAC (Socio-Economic Rural Advancement Committee) Bangladesh
- Shreya
- Sida
- Sierra Club
- Simavi
- Singapore Planned Parenthood Association
- Six Nations Birthing Centre
- Six Nations Maternal and Child Centre
- Social Development and Management Society
- Sociedad Boliviana De Pediatría
- Society for Elimination of Rural Poverty (SERP)
- Society for nutrition education and health action (SNEHA), India
- Solomon Islands Living Memorial Project
- SOS Children's Villages Indonesia
- St George’s Hospital Maternity Liaison Committee
- Support for Integrated Health Care Initiative (SIHCI)
- Surrogacy Centre India (SCI)
- Tanzania Registered Midwives’ Association (TAMA)
- Telegrahy, Nigeria
- Temitayo Erogbogbo, Nigeria
- Thurston County Progressive Network
- TREAT Asia/amfAR
- Trust for Indigenous Culture and Health (TICAH)
- Tuvalu Family Health Association
- UBINIG / Tabinaj
- Uganda Youth and Adolescents Health Forum (UYAHF)
- Unilever
- Union for International Cancer Control
- United Church of Christ, USA
- United Nations Association of Tanzania
- United Nations Children’s Fund (UNICEF)
- UNICEF, Indonesia
- United Nations Foundation
- United Nations Population Division
- United Nations Population Fund (UNFPA)
- United Nations Women
- United Nations Women, Zimbabwe
- Universal Versatile Society
- Universidad Andres Bello
- Universidad de Chile
- Universidad de Santiago de Chile
- Universidad de Valparaiso
Consultations on updating the Global Strategy: Round 1 – Priorities for the Global Strategy

- Universidad Diego Portales
- Universidad Mayor
- Universidad Privada Antenor Orrego Trujillo Peru
- Universidad San Sebastián
- Universitas Muhammadiyah Yogyakarta
- Université McGill
- University College of the North
- University of Antioquia
- University of British Columbia
- University of Dundee
- University of Maastricht, the Netherlands
- University of Melbourne
- University of Newcastle
- University of Technology Sydney
- University of Washington
- University Research Company
- UN-Women Knowledge Gateway for Women’s Economic Empowerment
- USAID
- USAID’s Maternal and Child Survival Program
- Vat Mirro, Nigeria
- Viasat 1 Television
- Vietnam Family Planning Association
- Visible Impact
- Vision for Mission Initiative-Ethiopia
- Vision spring initiatives
- Voice of Africa Zimbabwe
- Voluntary Health Association Of India
- WASH Advocates
- WaterAid
- Wellbeing Foundation Africa
- Wellspring Advisors
- White Ribbon Alliance
- White Ribbon Alliance for Safe Motherhood India (WRAI)
- White Ribbon Alliance Nigeria
- WHO (World Health Organization)
- Willows Foundation
- WomanCare midwives
- Women Acting Together for Change (WATCH)
- Women and Children First, United Kingdom
- Women Deliver
- Women4GlobalFund
- Women’s Global Network for Reproductive Rights
- World Food Programme
- World Heart Federation
- World Lung Foundation
- World Vision
- World Vision India
- World Vision Indonesia
- World Vision Senegal
- World Vision US
- YADC
- Yayasan Cipta Cara Padu Foundation, Indonesia
- Yayasan Orangtu Peduli
- YCPII
- YouAct, European Youth Network on Sexual and Reproductive Rights
- Young Health Programme
- Young Peoples Network on Sexual Reproductive Health, HIV and AIDS
- Youth Act Alliance
A.2 Networks and Organisational responses

- Advance Family Planning (AFP) initiative
- African Union
- Communiqué of the 2nd East African Community (EAC) Health Ministers’ and Parliamentarians’ Forum on Health and Symposium on RMNCAH
- Health Partners International
- International Children’s Palliative Care Network (ICPCN)
- International Community of Women Living with HIV
- Ipas
- Joint NGO submission on youth sexual and reproductive health and rights
- NCD Alliance

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21 These networks and organisations submitted responses which represented organisational, rather than individual, views.

22 Signatories of AFP’s organisational response include: African Women Leaders Network for Reproductive Health and Family Planning; African Women’s Development Fund; Equilibres et Population, Burkina Faso; Health Promotion Tanzania; International Planned Parenthood Federation (IPPF); Jhpiego Kenya; Johns Hopkins Center for Communication Programs – Indonesia; Partners in Population and Development, Africa Regional Office; Pathfinder International; Population Action International; Reproductive Health Uganda; Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health; United Nations Association of Tanzania; Yayasan Cipta Cara Padu Foundation, Indonesia


24 The EAC submitted this communiqué to reflect EAC regional positions relevant to the Global Strategy. Signatories represented the governments of Burundi; Kenya; Rwanda; Tanzania; and Uganda.

25 Endorsed by Africa Youth and Adolescents Network; Center for Creative Initiatives in Health and Population; Education as a Vaccine; Global Youth Coalition on HIV/AIDS; International Community of Women Living with HIV; International Federation of Medical Students’ Associations; International Planned Parenthood Federation; International Women’s Health Coalition; Let Girls Lead; Uganda Youth and Adolescents Health Forum; Women Deliver; Women’s Global Network for Reproductive Rights; and YouAct, European Youth Network on Sexual and Reproductive Rights.
A.3 Consultation Events

<table>
<thead>
<tr>
<th>Event</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHMiN Consultation, Abuja, Nigeria</td>
<td>22</td>
</tr>
<tr>
<td>African Union Commission 3rd Conference of Ministers Responsible for Civil Registration Expert Group Meeting, Republic of Cote d’Ivoire</td>
<td>300</td>
</tr>
<tr>
<td>AfriYAN (African Youth and Adolescents Network) Survey of National SRHR/HIV Youth Networks</td>
<td>12</td>
</tr>
<tr>
<td>Cambodia Reproductive and Child Health Alliance Consultation at Medicom Conference, Phnom Penh, Cambodia</td>
<td>30</td>
</tr>
<tr>
<td>Chilean Association of Midwives-led consultation, Santiago, Chile</td>
<td>16</td>
</tr>
<tr>
<td>Citizens’ Hearing and District Hearings, Indonesia (42 focus groups in 40 districts)</td>
<td>400</td>
</tr>
<tr>
<td>Citizens’ Hearing and District Hearings, Uganda</td>
<td>800</td>
</tr>
<tr>
<td>Citizens’ Hearing, Abuja, Nigeria</td>
<td>120</td>
</tr>
<tr>
<td>Citizens’ Hearing, Nepal</td>
<td>35</td>
</tr>
<tr>
<td>Citizens’ Hearings, Tanzania</td>
<td>861</td>
</tr>
<tr>
<td>Community of Practice Health System Planning and Budgeting, Ouagadougou, Burkina Faso</td>
<td>25</td>
</tr>
<tr>
<td>Girls’ Globe Google Hangout</td>
<td>30</td>
</tr>
<tr>
<td>Global Health Beyond 2015 CHESTRAD webinars</td>
<td>20</td>
</tr>
<tr>
<td>Global Health Beyond 2015; Commission on the Status of Women, CHESTRAD Consultation Side-Event; New York, USA</td>
<td>15</td>
</tr>
<tr>
<td>Hriday Youth Network Schools Consultation</td>
<td>191</td>
</tr>
<tr>
<td>Indonesia National Consultation</td>
<td>105</td>
</tr>
<tr>
<td>IPPF Africa regional office CSO review of the Maputo Plan of Action</td>
<td>134</td>
</tr>
<tr>
<td>Inter-Parliamentary Union (IPU) 132nd General Assembly, Consultation side-event, Hanoi, Viet Nam</td>
<td>150</td>
</tr>
<tr>
<td>IWCH Young Women’s Caucus, New York, USA</td>
<td>20</td>
</tr>
<tr>
<td>Multi-Stakeholder Dialogue for ICT/mHealth scale up in Bangladesh</td>
<td>40</td>
</tr>
<tr>
<td>NCDA tele-consultation</td>
<td>16</td>
</tr>
<tr>
<td>New Delhi Private Sector Consultation</td>
<td>40</td>
</tr>
<tr>
<td>New Delhi CSO Consultation</td>
<td>86</td>
</tr>
<tr>
<td>New Delhi Multi-Stakeholder Consultation</td>
<td>200</td>
</tr>
<tr>
<td>Mid-Process Briefing on the Global Financing Facility, Global Health Council</td>
<td>51</td>
</tr>
<tr>
<td>Panama national consultation</td>
<td>6</td>
</tr>
<tr>
<td>Philippines Multi-stakeholder forum</td>
<td>103</td>
</tr>
</tbody>
</table>
A.4 Demographics of Survey Respondents and Event Contributors

The two figures below represent the demographics of those who provided their views and inputs into this consultation process, presented by PMNCH constituency group. The first figure presents those who participated in targeted consultation events (Figure A.4.1) and the second figure presents those who completed the online and offline survey (Figure A.4.2).

**Figure A.4.1: Event and network contributors by constituency (n=4,075)**

<table>
<thead>
<tr>
<th>Event</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third UN World Conference on Disaster Risk Reduction - Sendai Japan</td>
<td>28</td>
</tr>
<tr>
<td>Uganda Youth Leader Meeting</td>
<td>15</td>
</tr>
<tr>
<td>Uganda RMNCAH Multi-stakeholder Consultation on the Global Strategy</td>
<td>100</td>
</tr>
<tr>
<td>Young Leaders Global Strategy Survey, Women Deliver</td>
<td>19</td>
</tr>
<tr>
<td>YWCA Young Women’s Caucus, New York, USA</td>
<td>40</td>
</tr>
</tbody>
</table>
Figure A.4.2: Survey respondents by constituency (n=482)

- National NGO: 29%
- International NGO: 25%
- ART: 10%
- HPA: 12%
- Youth: 7%
- Private Sector: 6%
- D&Fs: 5%
- Multilaterals: 3%
- Countries: 3%
APPENDIX B: PRELIMINARY THOUGHTS ON LESSONS LEARNED & FUTURE PRIORITIES

We provide below the executive summary of the “Preliminary thoughts on lessons learned & future priorities” report published on 16th February 2015.26 This report summarises perspectives on the last Global Strategy and early views on the updated Strategy gathered during the Global Financing Facility (GFF) consultations which took place from September to December 2014:

Executive Summary

This report aims to synthesise the views of over 1,400 organisations and individuals (Appendix A) who contributed to the first phase of an on-going and broad consultation process around the development of the new global and national commitments to women’s, children’s and adolescents’ health with their thoughts on the Millennium Development Goals (MDGs) and the Global Strategy for Women’s and Children’s Health. The first phase of the consultation was conducted between October and December 2014 and although it focused on the GFF27, three open-ended questions that probed respondents’ views about the broader policy environment for women’s and children’s health were also included. This report summarises the views expressed in these questions and builds on feedback received through the various consultation events.

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

Lessons learned

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

27 The GFF was announced at the “Every Woman Every Child” event during the 69th UN General Assembly in New York, in support of the Global Strategy for Women’s and Children’s Health to build long-term domestic and international funding commitments for women’s, children’s and adolescents’ health. The report, entitled Consultations on updating the Global Strategy for Women’s, Children’s and Adolescents’ Health: Perspectives on the Global Financing Facility, was published on 15th December 2014, and is available at www.WomenChildrenPost2015.org.
1. “Simple clear goals can drive action and lead to positive results”

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

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

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

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

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

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

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

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

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

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

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

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

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

**Priorities for the future updated Global Strategy**

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

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

- A **comprehensive approach to the continuum of care**, especially for maternal and SRHR services, in the context of sustained and serious investments in health systems strengthening and the integration of services, with particular community-level focus.

- Address the **economic and social determinants of health** (namely nutrition, education, poverty, WASH and social protection).

- **Country ownership** of the Global Strategy, including the development, priority-setting, planning and implementation processes, promoted alongside the SDGs.

- **Inclusive, bottom-up planning** (sub-national, national, regional and global), with wide stakeholder engagement feeding in to timed and costed roadmaps.

- **Flexible targets independently selected by countries** to achieve global goals.

- **National and sub-national data collection and management systems**, feeding in to a unified sustainable system that tracks progress within and between countries.

- A high quality, realistic **human resources for health plan**.

- **Bridge the gap “between Global Strategy and community activities”** ... with a systematic approach to this”.

- Include a **costing analysis, investment case, and guidelines** about what spending is required in order to achieve outcomes.

- **Private sector involvement** that includes clear contribution of commitments with do-no-harm agreements.

- **Retain the strengths of the first plan**, including clarity, evidence-based interventions, focus, accountability, and forging a common set of goals.

*Consultations on updating the Global Strategy: Round 1 – Priorities for the Global Strategy*
APPENDIX C: PERSPECTIVES ON THE GLOBAL FINANCING FACILITY

We provide below the executive summary of the “Perspectives on the Global Financing Facility” report published on 15th December 2014. This report synthesises feedback from consultations on the Global Financing Facility (GFF) which took place between September and December 2014.

Executive Summary

This report has been developed to provide a timely and constructive input to the GFF business plan development process, in the context of supporting the 2015 update to the Global Strategy for Women’s, Children’s and Adolescents’ Health. It is the first report in a consultation process that will extend through the early part of 2015 around the development of the next Global Strategy for Women’s Children’s and Adolescents’ Health under the Every Woman Every Child banner. Over 1,400 individuals and organisations contributed views on the GFF (Appendix A), in the course of the Partnership for Maternal, Newborn and Child Health (PMNCH)-hosted consultation process, which took place over five weeks, from 10 November 2014 to 12 December 2014. Comments were collected through an online survey (www.WomenChildrenPost2015.org) and a range of consultation events and meetings supported by PMNCH members. The participation in the consultation reflects the enthusiasm and interest that the GFF has generated. The report arranges comments into three sections (context and landscape, design, and implementation). The summary of findings and conclusions form the final section and are summarised below in this Executive Summary.

Summary of findings

The consultation process accumulated a rich collection of views over a short period of time. A summary of the findings includes:

1. A high level of agreement with the central aim of the GFF to build long-term domestic financing for women’s and children’s health in the context of an updated Global Strategy for Women’s, Children’s and Adolescents’ Health.

2. Strong agreement with the ambition to mobilise additional financing for reproductive, maternal, newborn, child and adolescent health (RMNCAH). The prospect of a new financing instrument was cautiously but generally welcomed.

28 Full report is available at: http://www.who.int/pmnch/gff_report.pdf
3. Strong commitment to the idea of building sound national plans, backed by broadly agreed financing roadmaps that together reflected country leadership, country priorities, and country decision-making processes.

4. Wide-ranging support in principle for more and better RMNCAH harmonisation and the need to ensure that the GFF does not lead to further fragmentation.

5. Concerns were expressed over the potential conflict between harmonisation goals and the objective aimed at increasing global funding to RMNCAH and concern about timing, transition to the GFF of existing funding commitments, the risk of gaps and lost momentum.

6. A sense that the GFF needed to become something more ambitious (more broadly owned and with wider possible beneficiaries) than a World Bank Trust Fund and that to be truly global it needed to have a critical mass of partners working together with shared ambition linked clearly to the objectives of the Global Strategy for Women’s, Children’s and Adolescent’s Health specifically and the Sustainable Development Goals (SDGs) more generally. While this may have to be achieved over time, the features of something more global than a trust fund would include:
   - Governance, decision-making, and stakeholder structure that is broader and more inclusive than a World Bank Trust Fund structure would usually entail;
   - Processes designed to build transparency and accountability in the decision-making and use of funds, monitoring and accountability; and
   - Delivering funding to stakeholders in partner countries in a range of ways not necessarily limited to current Trust Fund rules and to eligible recipients other than national governments.

7. Strong interest in clarifying how the operational model of the GFF will advance and champion a rights-based approach and in particular, how it will promote, protect and expand access to sexual and reproductive health and rights services (SRHR).

8. Near universal interest in and commitment to the importance of accountability, robust arrangements to track inputs, outputs and outcomes, inclusive decision-making, transparency and openness at every stage of the process.
Summary of Recommendations

A. Strategic recommendations

1. **Build coalitions**: To achieve its ambitious objectives, the GFF should seek to build a much broader based coalition of partners among donors, countries, and health and non-health sector stakeholders, taking the time to develop shared understanding about the ambition, scope, operational model and implications of the GFF for health financing.

2. **Develop a political advocacy strategy**: The development of such a coalition could be underpinned by a much more active and concerted political advocacy strategy with the dual aim of: (i) fostering better understanding about the GFF within and beyond the health sector (for example, among ministry of finance colleagues in both donor and partner countries, and all the donor nations who support IDA); and (ii) lifting the GFF away from being a World Bank managed Trust Fund and towards an instrument with global stature that could operate alongside GAVI and the Global Fund.

3. **Integrate the GFF into a broader vision for financing women’s, children’s and adolescents’ health**: The GFF should be developed and implemented in the context of a larger, more joined-up/ shared vision around global financing for women’s, children’s and adolescents’ health in the coming years. That vision – itself something like a global roadmap – should be developed by a critical mass of donors, partner countries, civil society organisations, and others, including or even initiated and led by GFF sponsors. The financing workstream of the process to update the Global Strategy for Women’s, Children’s and Adolescents’ Health is an excellent opportunity to take this forward, but important work towards building this vision could start immediately with the right leadership.

4. **Build a clear SRHR policy and approach**: The GFF should seek to work with representatives from the SRHR community to build clear policy addressing SRHR in its broadest sense including a range of potentially sensitive issues (for example, female genital cutting, violence against women and girls, abortion, and early marriage).

5. **Clarify the GFF’s role in civil registration and vital statistics (CRVS) efforts**: The approach to CRVS should be clarified in relation to broader data systems, record keeping systems, health information management systems especially with respect to current efforts underway in several UN agency partners, and
elsewhere in the World Bank. The GFF business plan could helpfully outline how it will contribute to bringing partners together to streamline the whole area of data and information management in the context of the updated Global Strategy and avoid being another of several initiatives.

B. Operational recommendations

6. **Agree a set of operating principles:** The GFF should develop a set of operating principles that ensure concerns are addressed and rights are protected, for example: (i) promotion of human rights; (ii) transparency and openness; (iii) promotion of multi-sectoral working; (iv) incorporation of civil society into global/ country based accountability processes; and (v) eligibility for funding should extend to all aspects of the updated Global Strategy for Women’s Children’s and Adolescent’s Health.

7. **Agree a health systems strengthening approach:** The GFF should adopt an approach to funding health systems strengthening and universal health coverage.

8. **Build on what is already working in countries:** The GFF should be explicit about building on country processes already in place and operational by creating a flexible approach to the roadmap development process to ensure the GFF adds momentum to what is on the ground already rather than creating competing or alternative processes that drain time and capacity.

9. **Develop a proactive communications strategy:** The GFF should develop and implement a proactive communication strategy in order to increase direct and open communication with the RMNCAH community. This communication strategy would provide an immediate opportunity to clarify a number of points including the: (i) meaning of front-runner country status, why they were selected and how the next countries will be selected; (ii) how information will be shared in country and who will be responsible for ensuring that in-country arrangements progress; (iii) opportunities to join/ contribute to discussions before decisions are taken; and (iv) role of civil society organisations in the GFF business planning process, in the implementation at country level and in the future.

But it would also facilitate on-going dialogue, alert partners to opportunities to contribute views, ensure the timetable for discussion and decision-making is well publicised, enable the business planning team to communicate decisions
that have been taken about design and implementation issues, test out proposed ideas and receive comments back from the community.

10. **Adopt a plain language approach (in more than just English):** The business plan should be written without jargon and with minimal use of acronyms. Words like *leverage* and *synergistic* are not well understood outside of the World Bank. The material should be available in other languages.

11. **Develop (and test) a comprehensive accountability structure:** The accountability framework should include global and country level mechanisms linked to the Global Strategy and drawing on what has worked well elsewhere.

12. **Support learning and reduce complexity:** The business plan should explain very clearly how the facility will work, including the proposed linkages between the GFF and IDA lending, which should incorporate a clear explanation of how the GFF grants will flow in conjunction with IDA lending. This would also create an opportunity to address and alleviate the many concerns raised about the danger of GFF’s undue influence on countries’ decision-making related to IDA borrowing and use of those funds.
APPENDIX D: CONSULTATION SURVEY

The online survey questions are reproduced below for ease of reference:

National leadership and operationalization

Q1. How can the updated Global Strategy encourage sustained, strong political and administrative leadership and commitment for RMNCAH?

*Drop-down list:*
- At the global level:
- At the national level:
- At the sub-national level:

*Follow-on question:*
Please mention any further comments you have about how the Global Strategy can strengthen political will and leadership.

Health systems strengthening and universal health coverage

Q2. What are the most important health systems strengthening investments for improving RMNCAH services at the country level?

Choose up to five from the list:

- Policy, planning and governance at national level
- Information systems and data collection & analysis
- Public-private mix in service delivery
- Quality of care
- Strengthening community-based services
- Human resources for health training, deployment and management
- Payroll reform and broader public service reform
- Medicines and supplies procurement and supply chain management
- Medicines and supplies access and use (prescribing, availability and effectiveness)
- Infrastructure and equipment
- Innovation and scale-up (including continuous improvement)
- Demand-side financing (e.g. user fees, conditional cash transfers and vouchers)
- Supply-side health financing (e.g. performance based financing, allocation of resources between priorities and between levels of service delivery such as between tertiary and primary levels).
- Accountability at the local level
- Decentralisation to sub-national level
- Legal entitlements to essential services, goods and information
- Targeting inequities and achieving universal coverage and resilience
- Other (Please specify)

*Follow-on questions:*
a) How important is Universal Health Coverage (UHC) to the delivery of RMNCAH?
   - Essential
   - Important
   - Useful but not essential
   - Not important

b) How should the Global Strategy specifically focus on Universal Health Coverage?

Adolescents

Q3. What are the priority outcomes for adolescents that this Strategy needs to address?

Choose up to three priorities:

- Access to affordable, quality health services including sexual and reproductive health services (including family planning and HIV and AIDS prevention, treatment and care)
- Access to formal and non-formal health education including comprehensive sexuality education
- Access to education, training and information
- Protection from harmful traditional practices and stigma and discrimination (FGM/C, child marriage)
- Social norms transformation particularly around gender and youth
- Ensuring social & financial support and protection
- Ensuring meaningful participation and decision-making
- Mental health services and counselling
- Prevention of injuries, risk reduction and counselling for the prevention of harmful behaviours
- Other (Please specify)

Follow-on question:

Please add any other comments about how the Global Strategy should embrace the needs of adolescents and how the RMNCAH community can learn from best practices and successes around adolescent health.

Health-influencing sectors (Social and Economic Determinants of Health)

Q4. Which of the following represent the most immediate opportunities to the RMNCAH community for partnerships aimed at alignment of planning, programming, advocacy and accountability to influence health determinants?

Choose up to five from the list:

- Education
- Water, Sanitation and Hygiene
- Rule of Law
- Human Rights
Consultations on updating the Global Strategy: Round 1 – Priorities for the Global Strategy

- Nutrition
- Women’s Political and Economic Participation
- Violence (particularly Gender-based violence)
- Shelter
- Infrastructure and Energy
- Food Security
- Environmental Pollution
- Skills and Livelihoods
- Access to Markets and Security of Ownership, including Land Rights
- Market Shaping and Access
- Inequities
- Protection
- Media and Communications
- Other (Please specify)

Follow-on question:

Please describe any specific country experience where interventions or policies have been successfully implemented with clear positive impacts on RMNCAH. Please also add any further ideas including the best ways – on a practical level – to build coordination between health and other sectors?

Innovation

Q5: Please identify the most critical gaps that could be best addressed through innovation.

Please choose up to three options:

- Sexual and reproductive health and rights (e.g. reproductive technologies, access to services for adolescents, services for men and boys, innovative sexuality education)
- Maternal health (e.g. ante-natal care, emergency obstetric care, postnatal depression, post-partum hemorrhage, pre-eclampsia)
- Newborn health (e.g. prematurity, prevention of mother-to-child transmission, complications during delivery, sepsis, early initiation of breastfeeding, stillbirth)
- Child health (e.g. malaria, pneumonia, vaccination, stunting, WASH, nutrition, early childhood development)
- Adolescent (e.g. early & forced marriage, FGM, violence against women & girls, menstrual hygiene, empowerment)
- Other (Please specify)

Please provide a specific example for each of your choices above.

First Choice:

Second Choice:
Third Choice:

Follow-on question:
How should RMNCAH innovations reflect the most pressing needs, priorities and demands of countries and be efficiently developed for adoption and scale-up by countries?

Human rights

Q6. What are the main human rights related barriers to full access to RMNCAH?

Please choose the three most important from the following list.

- Harmful Cultural Practices
- Social Arrangements and Constraints
- Gender Inequality
- Legal Barriers
- Lack of Access (opening hours, distance, cost)
- Lack of Knowledge and Information
- Policy and Service Insufficiencies
- Financing Constraints
- Lack of Choice or Range of Suitable Services
- Other (please specify)

Follow-on question:
How should a human rights-based approach be introduced into the updated Global Strategy in practical terms? How would countries operationalize a human-rights based approach? Please include examples of actual cases, where possible.

Humanitarian settings

Q7. What are the challenges and priorities in meeting the RMNCAH needs of women, children and adolescents during conflict-related and humanitarian emergencies?

Please choose the three most important from the following list:

- Address needs requiring specialist services, for example, gender based violence including sexual violence
- Guarantee the availability, cost and management of basic supplies (for example, family planning)
- Ensure a sufficient package of quality health services
- Ensure qualified service providers are available
- Ensure the cost of services does not exclude people
- Locate and reach populations most in need
- Ensure safe access to services by women and children
- Build demand among populations most in need
- Integration of private service providers to optimize access, quality and build demand
- Forge better global partnerships and cooperation (global health partners need to be joined up and work cooperatively to ensure maximum coverage and minimum duplication)
- Other (Please specify)

Follow-on question:

How can disaster risk reduction and emergency preparedness, response and recovery best be integrated into the updated Global Strategy?

Financing

Q8. How can the updated Global Strategy support and incentivize sustainable financing for RMNCAH services?

Please choose the top three strategies from the following list:

- Promote pooled financing flows at the national or sub-national level to provide cross-subsidization across geographic areas and income groups.
- Encourage the establishment of inclusive sustainable national health financing systems.
- Advocate for more predictable international aid flows.
- Mobilize new and different stakeholders to finance RMNCAH services at the national and sub-national level such as private sector, individuals, business, CSO, governments.
- Advocate for a national roadmap process to set out a package of services and financing plan.
- Provide an opportunity for national governments to make domestic financing commitments on an international stage, and report regularly on these.
- Finance work on best practice, planning tools, investment cases, and other related knowledge resources to support governments in their decision-making including the identification of a basic package.
- Promote national public financial management strengthening processes.
- Empower non-governmental and civil society sectors to advocate for and monitor domestic financing of RMNCAH.
- Set out evidence, best practice and specific effects of country contexts on demand side financing (conditional cash transfers, user fees, charges, exemptions, vouchers).
- Advocate for legal enforcement of national fee policies and regulatory systems
- Other (Please specify)

Follow-on question:
Are there particular domestic or global health financing issues that the Global Strategy should address?

**Monitoring and Accountability**

**Q9. How can data collection and management be improved where resources are scarce?**

Please suggest up to three ideas/methods:

- **First Suggestion:**
- **Second Suggestion:**
- **Third Suggestion:**

**Follow-on questions:**

a) Please use this space to make any further comments about information, data collection and management including priorities for building country processes, systems and capacity:

b) Considering accountability arrangements for RMNCAH during the last five years, how should accountability and monitoring be done in the next five years? Broadly, accountability and monitoring includes the Commission on Information and Accountability for Women’s and Children’s Health (COIA), Countdown to 2015, the Independent Expert Review Group (iERG) in addition to national and global reporting.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Disagree</th>
<th>Not sure</th>
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<tbody>
<tr>
<td>There was too much accountability (wasted money and time)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>There was insufficient accountability and monitoring at both global and national levels</td>
<td>☐</td>
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<tr>
<td>Accountability was sufficient at a global level but did not impact on country level processes enough</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Investment in accountability was about right</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Most donors and development partners strengthened their commitment to RMNCAH partly because their commitments were monitored and reported on annually</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Global accountability processes made practical</td>
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action at country level easier

<table>
<thead>
<tr>
<th>Accountability at the national level is improving in most places</th>
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<tbody>
<tr>
<td>Policy development improved at country level as a result of Countdown data</td>
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</tr>
<tr>
<td>We have the right systems to track the protection of human rights in the future</td>
<td>☐</td>
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<tr>
<td>The COIA is an important instrument for the Global Strategy</td>
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<tr>
<td>The iERG should be maintained in the future</td>
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*Follow-on question:*

What role can the updated Global Strategy play in improving the impact of accountability mechanisms and initiatives?

**Global Financing Facility**

**Q10. Have you had sufficient follow up information about the development of the Global Financing Facility (the GFF)?**

If you replied No, please specify how you like to be kept informed.

*Follow-on question:*

Do you have additional comments about the GFF?

*Optional:*

Please provide an overall statement about the updated Global Strategy. What priorities, essential services or challenges, for example, should the Global Strategy include?

This statement will be featured as part of a comment wall at www.WomenChildrenPost2015.org