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

The PMNCH 2013 Report

World Health Organization

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

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

* The US$ 88 billion is in addition to the estimated US$ 81 billion of other costs for scaling up to meet the health MDGs. These include the remaining half of health-systems costs, plus costs for diagnosis, information, referral and palliative care for any presenting conditions; remaining treatment costs for major infectious diseases, such as tuberculosis, HIV/AIDS and malaria; and costs associated with nutrition and health promotion.
The main objective of this year’s report is to assess the extent to which the 293 stakeholders who have made commitments to the Global Strategy since its launch in 2010 (up to June 2013) have implemented their commitments, and the extent to which implementation is contributing to reaching the goals of the Global Strategy. It is not a comprehensive stocktaking of all that is being done at national, regional and global levels to improve women’s and children’s health.

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

Financial and non-financial commitments: key findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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**Table 1: Financial commitments and disbursements, US$ billion**

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

Insufficient information to estimate X, Y, Z.

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

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

* Estimated on the basis of doubling estimates for 2013, which is approximately halfway along the Global Strategy’s timeline (September 2010 to December 2015).
Key findings from the four thematic analyses

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

Family planning

- An estimated 40% (117 out of 293) of commitments to the Global Strategy include family planning. The London Summit on Family Planning (11 July 2012) was a major driver of recent increases, generating 68 commitments.

- Low- and middle-income countries have made 46% of the family planning-specific commitments, followed by NGOs (27%). The private sector has made only 1% of the commitments in this area, but these are of high monetary value.

- Commitments focus on: improving access to and delivery of family planning services and commodities; addressing demand-side barriers; integrating family planning with other health-care services; and mobilizing political and community support.

- Several commitments use terms such as “rights” and “gender”, reflecting the recognition that programmes need to be rights based.

- Many stakeholders have made significant progress in implementing their commitments and some data are beginning to emerge concerning the Global Strategy’s goals of preventing 33 million unintended pregnancies and reaching 43 million new users in 49 countries in 2015. Progress is being bolstered by FP2020’s target to provide an additional 120 million women and girls with access to voluntary family planning services, contraception and information in 69 countries.

- To accelerate progress, political commitment at the highest level is needed to promote voluntary family planning. Countries need to continue to strengthen the training of front-line health workers in the provision of family planning services. Countries and development partners should build on and augment their financial commitments. A wide range of demand-side interventions are needed to address deep-rooted social, cultural and behavioural factors that inhibit women and girls from accessing family planning information and services.

Adolescent health

- Slightly over a quarter of total commitments to the Global Strategy (77 out of 293, or 26%) relate to adolescent health. NGOs account for 32% of the 77 adolescent health commitments, while low- and middle-income countries account for 37%; all other constituency groups, including multilateral organizations, foundations and the private sector, account for less than 10% each.

- Commitments relate to: adolescent sexual and reproductive health policies and services; reducing early, child and forced marriage; improving access to educational services; reducing violence against girls; and increasing youth empowerment.

- Commitments are broadly in line with the main gaps and priorities, but pledges to disaggregate data by age are lacking. Reducing coerced sex and unsafe abortion among adolescents receives little attention. Also there are no commitments to increase access to skilled antenatal, childbirth and postnatal care specifically for adolescent girls.

- Approximately 40% of survey respondents indicated that the implementation of their commitments to adolescent health would be completed by 2015.

- The analysis in this chapter suggests that stronger leadership and coordinated approaches; empowering and engaging with young people; and improving data, information and evidence would all help to accelerate progress in adolescent health.

Newborn health

- Approximately 25% of all commitments to the Global Strategy focus on newborn health.

- Despite increased interest in newborn health following the launches of Committing to Child Survival: A Promise Renewed and Born Too Soon in 2012 (the latter being accompanied by 30 new and expanded commitments), evidence suggests
that this has not yet been translated into proportionate increases in financial resources.

- Commitments to newborn health focus on: preterm births, preventing stillbirths, human resources for health, coverage of newborn services, postnatal care, and the registration and classification of newborn deaths. Two priority areas that are not well covered are preventing and treating neonatal infections, and tracking newborn health expenditure.

- Although the implementation of many commitments is under way, stakeholders’ views on whether commitments will be fulfilled by 2015 are mixed.

- Achieving the Global Strategy goals to prevent more than 3 million newborn deaths between 2011 and 2015 and to treat an additional 2.2 million neonatal infections in 2015 will require greater efforts in 2014 and 2015 to improve both the coverage and quality of newborn care interventions. The development of the Global Newborn Action Plan, embedded in the continuum of care, should see new commitments and action in the remainder of 2013 and through 2014. The role of the midwife in delivering newborn care, not just at the time of birth, but in the days following, needs to be strengthened.

- More and better use of domestic and external resources and increased awareness of the most effective interventions for improving newborn health are also needed to accelerate progress.

Advocacy

- The majority of survey respondents (80%, or 96 out of 120) indicated that their commitment contributes to advocacy for the goals of the Global Strategy. However, only 135 of all 293 stakeholders (46%) have made commitments that specifically include advocacy activities. This discrepancy suggests that many commitment-makers believe that the act of commitment, whatever its content, itself contributes to advancing the Global Strategy’s goals.

- Advocacy commitments are well aligned with the Global Strategy’s priorities. Advocacy for policy development and political support features more often than advocacy for accountability (71% and 56%, respectively, of survey respondents with advocacy commitments).

- All categories of advocacy are generally well represented: more than 80% of respondents indicated commitments to more than one area of advocacy, suggesting that advocacy commitment-makers tend to see advocacy goals as cross-cutting.

- Although stakeholders’ responses point to progress being made, only 45% (30 out of 66) expect that their advocacy commitments will finish being implemented by 2015.

- Almost 30% of survey respondents with advocacy commitments (19) had no or limited evidence to demonstrate that their commitments are contributing to the specific goals of the Global Strategy, suggesting a need for greater investment in and attention to monitoring and evaluation of advocacy.

- The main constraints to implementation are insufficient financial and human resources.

**Lessons learnt from producing three annual reports on commitments**

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

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

**Recommendations**

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

Improve targeting and implementation of commitments

- Take advantage of the mobilizing power of the Global Strategy to maintain high-level political support, involve additional stakeholders through multi-stakeholder action and accelerate implementation of commitments.

- Address inequities in the geographical distribution of Global Strategy commitments by providing additional support to countries currently receiving little attention that have not made progress in improving access to reproductive health services or that have high maternal and child mortality rates.

- Focus commitments more strongly on priority interventions that are receiving less attention and on the integration of nutrition, food safety, education, safe water, sanitation and hygiene with health.

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

- Raise additional funding, including from domestic sources, and allocate existing and additional resources (both those that can and cannot be readily monetized) to close the remaining geographical and intervention gaps towards achieving the Global Strategy’s goals.

- Improve value for money, not only by prioritizing cost-effective essential interventions, but also by taking action to reduce inefficiencies in resource allocation and use.

- Build on the acceleration of disbursements of financial commitment in 2012 by increasing clarity at source about how these funds can be accessed, and improve the ability of countries to receive and administer funds.

Mitigate constraints

- Continue to take action to address the critical human resources challenges and other health systems weaknesses, such as poor infrastructure and shortage of commodities.

- Consider gender and sociocultural issues when designing policies and programmes and allocating resources.

Improve accountability

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

- Promote the accountability recommendations as specifically noted in the PMNCH 2012 report.
II. Recommendation related to the four thematic analyses

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

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

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

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

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

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

**Address difficulties in monetizing many Global Strategy commitments**

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

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

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

**Summary**

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

The challenge for the next two years is to put into operation the commitments already made. This will require considerable additional investment in RMNCH financing, policy and services, as well as in technical support and human resource capacities, particularly at national and subnational levels. All stakeholders – countries and development partners – have a role to play in addressing the gaps in and challenges for implementation, and all have a responsibility to be accountable for their promises.
Chapter 1

Introduction

In September 2010, the United Nations (UN) Secretary-General Ban Ki-moon launched the Global Strategy for Women’s and Children’s Health (Global Strategy), which presents a roadmap on how to enhance financing, strengthen policy and improve service on the ground for the most vulnerable women and children. The Every Woman Every Child movement was established at the same time to mobilize and intensify the international and national action needed to advance the Global Strategy. Its objectives are to increase visibility and political support, mobilize resources and catalyse a renewed effort to accelerate progress towards the achievement of two of the eight Millennium Development Goals (MDGs): to reduce child mortality (MDG 4) and improve maternal health (MDG 5). Both are off track.

The Global Strategy’s ultimate goal is to save 16 million lives in 49 countries by 2015. These 49 countries were the poorest countries according to the World Bank’s list of economies as of April 2008. The 49 countries are included in the list of the 75 countries that account for more than 95% of global maternal and child deaths and that are therefore prioritized by Countdown to 2015 (Countdown), the Commission on Information and Accountability for Women’s and Children’s Health (CoIA) and the Lancet Commission on Investing in Health.

Between 2010 and 2015 the Global Strategy aims to:

- prevent the deaths of more than 15 million children under the age of five, including 3 million newborns;
- prevent 33 million unwanted pregnancies;
- prevent 570,000 women dying of complications relating to pregnancy or childbirth, including unsafe abortion;
- protect 88 million children under five from stunting;
- protect 120 million children from pneumonia.

To achieve these goals across the 49 countries, in 2015 there will need to be:

- 43 million new users with access to comprehensive family planning;
- 19 million more women giving birth supported by a skilled health worker, with the necessary infrastructure, drugs, equipment and regulations;
- 2.2 million additional neonatal infections being treated;
- 21.9 million more infants exclusively breastfed for the first six months of life;
- 15.2 million more children fully immunized in their first year of life;
- 117 million more children under five receiving vitamin A supplements;
• 85,000 more good-quality health facilities and up to 3.5 million more health workers available.

The direct costs and the health systems costs for programmes and services targeting women and children in the Global Strategy’s 49 countries were estimated to be US$ 88 billion for 2011–2015 (excluding costs for scaling up to meet other health MDGs).4

The Global Strategy identifies six key areas for action to enhance financing, strengthen policy and improve health services:

• country plans: country-led health plans supported by adequate investment;
• integration: integrated delivery of health services and life-saving interventions;
• delivering services: stronger health systems, with sufficient skilled health workers at their core;
• innovation: innovative approaches to financing, product development and delivery of health services;
• human rights: promoting human rights, equity and gender empowerment;
• results: improving monitoring and evaluation to ensure that all actors are accountable for results and resources.

About this report

This report is the third annual report produced by the Partnership for Maternal, Newborn & Child Health (PMNCH) analysing the commitments made by countries and development partners to the Global Strategy and Every Woman Every Child. The PMNCH 2012 report contributed to the independent Expert Review Group5 (iERG)’s first annual report to the UN Secretary-General. The iERG requested PMNCH to produce a 2013 report on the progress of the implementation of commitments to the Global Strategy.

The main objective of this year’s report is to assess the extent to which commitments have been implemented, and the extent to which implementation is contributing to reaching the goals of the Global Strategy. It is not a comprehensive stocktaking of all that is being done at national, regional and global levels to improve women’s and children’s health; the assessment does not include some major ongoing initiatives (e.g. the Campaign for Accelerated Reduction of Maternal Mortality in Africa, CARMMA, led by the African Union), because they are not commitments to the Global Strategy. This caveat has to be kept in mind throughout the report.

As in the 2011 and 2012 PMNCH reports, this report
includes a summary of the content of commitments, categorizing commitments by stakeholder group, type, geography and intervention area along the continuum of care. It also extends the analysis into new areas.

Chapter 2 provides an overview of all commitments including an assessment of which countries are benefiting most and which identified priority interventions are receiving the most attention. Chapter 3 describes new financial commitments and disbursements made under the Global Strategy in the 12 months since April 2012 and presents a new analysis of broader reproductive, maternal, newborn and child health (RMNCH) financing trends. Chapter 4 summarizes progress on the implementation of three categories of non-financial commitments: the strengthening of health systems, service provision and commodities; policy; and information and research.

While the 2012 report put the spotlight on a few selected countries and included a thematic analysis of accountability, the 2013 report delves deeper into commitments which focus on three areas of the continuum of care: family planning (Chapter 5), adolescent health (Chapter 6) and newborn health (Chapter 7). These were chosen because despite their growing prominence in some countries’ national health policies and on the global health agenda (they have been highlighted in the Global Strategy, by PMNCH and the iERG, and in reports on the post-2015 development agenda, etc.) they are still considered to be neglected.

Chapter 8 considers advocacy-specific commitments: what these are, who has made them and how are they being implemented. Advocacy was chosen as the fourth theme in the 2013 report because of the high proportion of commitments that include advocacy-related content. Chapter 9 reviews progress on improving accountability, building on the 2012 report.

Chapter 10 highlights the broader impact of Every Woman Every Child on women’s and children’s health. It also summarizes overall progress on implementation, noting the main catalysts and constraints by constituency and the accountability mechanisms being used. It describes the lessons from producing three reports on commitments and considers whether a similar report next year using the same approach will be able to achieve its objectives. The chapter concludes by making some recommendations.

Methods

The objectives, scope and methods of the report were developed through a consultative process. The multidisciplinary advisory group provided the technical review, and a number of PMNCH partners provided guidance and analytical inputs (see Acknowledgements). Two consultancy firms, CEPA and SEEK Development, were contracted to carry out data collection and analysis to inform different components of the report.

This report reflects and includes all commitments that have been made to the Global Strategy since its launch in 2010. The underlying analyses in the report are varied and complex; they are based on a range of information sources and data collection methods pertaining to the nature of the individual commitments and their implementation. These included:

- a content analysis of all commitment statements from the Every Woman Every Child website;
- an online survey, sent to 268 makers of commitments, of which 120 fully completed the survey (survey responses were used for selected sub-analyses presented in this report);
- detailed interviews based on semi-structured questionnaires with a selection of stakeholders;
- an extensive desk review of relevant literature and databases.

In certain cases, the commitment-makers did not provide information on their progress in implementing their commitments, and so secondary information was used where possible.

A comprehensive overview of the methods used in this analysis is provided in Annex 1, which also outlines the methodological challenges of this report. The methodology for the thematic analyses is described in Annex 2.
CHAPTER 2

OVERVIEW OF COMMITMENTS TO ADVANCE THE GLOBAL STRATEGY

This chapter provides an overview of the commitments made by a wide range of stakeholders to the Global Strategy. The chapter analyses to what extent the geographical distribution of commitments matches the countries identified in the Global Strategy as having the greatest needs. It also reviews commitments to specific RMNCH interventions along the continuum of care to assess whether they are focusing on interventions with low coverage in need of intensified efforts and more resources.

2.1 Overview of financial and non-financial commitments

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

Since the launch of the Global Strategy in September 2010, at which 111 stakeholders made commitments, the number of commitment-makers has steadily increased, and it is still growing. By April 2012, when data collection for the PMNCH 2012 report concluded, 220 stakeholders had made commitments. Since then, 73 stakeholders have made new commitments, so that there were 293 commitment-makers in June 2013, close to triple the number at the launch of the Global Strategy.

Stakeholders made their commitments at important events such as the London Summit on Family Planning (FP2020) and the launch of Born Too Soon: The Global Action Report on Preterm Birth, the UN Commission on Life-Saving Commodities for Women and Children, and the Committing to Child Survival: A Promise Renewed report. These have been vital for sustaining support for the Global Strategy and Every Woman Every Child (Figure 2.1). Of the 73 new stakeholders, 34 made commitments to FP2020 and 13 made commitments to Born Too Soon. Other new commitments were made outside these events.

The new commitments were made by low-income countries, middle-income countries, high-income countries, foundations, the UN and other multilateral organizations, non-governmental organizations (NGOs), the private sector, health-care professional associations, and academic and research institutions.
The increases in numbers of stakeholders and commitments to the Global Strategy differ across constituency groups and years. In 2011, implementing countries, the private sector and NGOs in particular joined the efforts to improve women’s and children’s health, with NGOs constituting the largest proportion of new stakeholders (35%). In 2012, these increases continued to be driven by NGOs and the private sector, but were joined to a greater extent than previously by global partnerships, foundations, and academic and research institutions (Figure 2.2).
Among all constituency groups, NGOs constitute the largest group of commitment-makers, accounting for 27% of all commitments made (Figure 2.3). Low- and middle-income countries make up the second largest group of commitment-makers (22%), followed by the private sector (15%).

A content analysis of the commitment text on the Every Woman Every Child website found that most commitment-makers (66%) focus on support for service delivery (including commodities i.e medicines, medical devices and health supplies) and strengthening health systems. Financial commitments to the Global Strategy, defined as those that specify an amount to be committed, have been made by 40% of stakeholders (Figure 2.4).

2.2 Geographical targeting: alignment of commitments with priority countries

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

One of the key questions to be answered by this report is whether the implementation of Global Strategy commitments benefits those countries in the greatest need. Although the Global Strategy focuses on 49 countries (as noted in Chapter 1), commitments also target other countries with high numbers of maternal and child deaths, such as India and Indonesia. Therefore, the geographical analysis refers to the 75 countries prioritized by Countdown and the CoIA, which include the Global Strategy’s 49 focus countries.

The survey data indicate that stakeholders have given more attention to some countries. The different circle sizes in Figure 2.5 represent the number of times a country was identified as a target country in the online survey. In addition, the degree of progress towards MDGs 4 and 5A is indicated by the circle colour. On-track and off-track countries are defined as follows:

- a country is considered on track for MDG 4 if the under-five mortality rate for 2011 is less than 40 deaths per 1000 live births or is 40 or more deaths per 1000 live births, with a mean annual rate of reduction of 4% or higher for 1990–2011;
- a country is considered on track for MDG 5A if the mean annual rate of reduction of the maternal mortality ratio for 1990–2010 is 5.5% or more.

It is important to note that Figure 2.5 is based on the number of times a country was identified as a focus country by survey respondents, so it does not reflect the actual scope and programme focus of their implementation activities. To complement this analysis, Chapter 3 discusses the targeting of RMNCH disbursements.

The countries in Figure 2.5 with small red circles, countries with high numbers of maternal and child deaths that only few stakeholders have focused on in implementing their commitments, are likely to require further support to make significant progress towards MDGs 4 and 5A.

The 49 countries prioritized by the Global Strategy receive a mean of 12.1 commitments (median of 10.0) while all other countries also prioritized through Countdown receive a mean of 7.4 commitments (median 7). Of the 20 countries receiving the most commitments, 18 are Global Strategy priority countries.

Nine of the ten countries most often identified by respondents in the 2013 survey were already among the countries most often selected as focus countries by stakeholders in the PMNCH 2012 report (Figure 2.6).
As discussed in Chapter 3, six of these ten countries (the United Republic of Tanzania, India, Kenya, Ethiopia, Nigeria and Uganda, listed in descending order based on the number of times they were mentioned by survey respondents) are also among the countries that received the largest share of RMNCH disbursements in 2011. Of these ten countries, three are on track to achieve MDG 4 (the United Republic of Tanzania, Ethiopia and Malawi) and Bangladesh is on track to achieve MDGs 4 and 5A (none of the other nine countries is on track for MDG 5A).

Prioritization of commitments does not seem to be correlated with progress towards MDGs 4 and 5A. The level of attention received by the seven countries that are on track for both MDGs 4 and 5A differs substantially: while three (China, the Lao People’s Democratic Republic and Egypt) were the focus of only six stakeholders, three others (Viet Nam, Nepal and Cambodia) were the focus of at least 12 stakeholders and Bangladesh was the focus of 27 stakeholders.

Stakeholders tend to focus on countries with a high number of deaths. India and Nigeria, two lower-middle-income countries that globally account for a substantial number of maternal and child deaths, are the second and sixth countries in terms of number of commitments (30 and 26 respectively). Most other countries from the list of those receiving the most attention also have large numbers of maternal and child deaths.

This focus is to the detriment of a number of smaller countries with very high mortality rates, and highlights significant inequities in the geographical targeting of stakeholders’ commitments. Of the 75 Countdown countries, 9 were specified by less than three survey respondents as focus countries, including 6 countries.
that are off track on MDGs 4 and 5A (Azerbaijan, Comoros, Gabon, the Gambia, Sao Tome and Principe, and Turkmenistan) (see Table 2.1). Other countries with similarly high maternal and child mortality rates but relatively few numbers of deaths (such as Djibouti, Mauritania and Togo) were the focus of only between three and four survey respondents (Table 2.1). As discussed in Chapter 3, these are also countries getting very little financial support. Given that a number of countries with high mortality rates receive insufficient attention (Djibouti, the Gambia, Mauritania and others were already identified in the PMNCH 2012 report), it seems clear that the selection of focus countries is not driven by need alone.

The challenges are particularly acute in countries that have experienced recent civil conflict or political instability and have very high rates of poverty and undernutrition (e.g. the Central African Republic).

### 2.3 Addressing gaps in coverage for essential RMNCH interventions

#### Findings:

- For the past two years, family planning has received the largest number of commitments, and commitments have increased since the 2012 PMNCH report, mainly driven by the London Summit on Family Planning in July 2012.
- Interventions critical to improving women’s and children’s health that are receiving less attention include postnatal care for mothers and newborns, antibiotics for pneumonia and improved access to sanitation facilities.

The Global Strategy emphasizes that the vast majority of maternal, neonatal and child deaths worldwide are preventable, since there are evidence-based, cost-effective interventions to save women’s and children’s lives.\(^{18}\)

As documented by Countdown, there are significant gaps in the coverage of these interventions.\(^{19}\) A key question is to what extent commitments to the Global Strategy help to address these.

The findings presented below are based on survey results whenever available. If no survey response was available for a certain stakeholder, the analysis drew on the respective commitment text on the Every Woman Every Child website. As in the geographical analysis, its results do not take the scope and content of the commitments into account, and may not correlate well with the financial resources that certain intervention areas receive. Details of the targeting of financial commitments are provided in Chapter 3, Section 3.4.

**Family planning** is receiving the most attention, with 116 stakeholders indicating support for family planning services. Family planning was identified in the PMNCH 2012 report as an area where progress could be expected, largely because of the London Summit on Family Planning in July 2012. As discussed in Section 3.4, there is strong evidence that key donors have increased their funding for family planning since 2008, with a substantial increase in 2010, and that this trend will continue. Commitments to family planning are discussed in more detail in Chapter 5.

**Skilled birth attendance** now ranks second, with 95 stakeholders reporting it as one of the main foci of their commitments. Given the existing limitations on financial reporting, it is unclear whether funding for skilled birth attendance also increased. It should be noted that funding for strengthening health systems, which includes expenditure for health personnel such as skilled birth attendants, has not increased substantially (see Chapter 4).

**Pneumonia** accounts for 18% of all deaths among children under the age of five. However, treating and preventing pneumonia is among the interventions receiving the least attention.\(^{20}\) This is particularly alarming given the low numbers of people seeking care and the poor coverage of treatment for pneumonia in

### Table 2.1: Geographical targeting and progress towards MDGs 4 and 5A for 74 Countdown countries*

<table>
<thead>
<tr>
<th>Number of times country identified in the survey as priority country</th>
<th>On track for both MDGs</th>
<th>On track for MDG 4 only</th>
<th>On track for MDG 5A only</th>
<th>Off track for both MDGs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>3–4</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>5–10</td>
<td>3</td>
<td>11</td>
<td>0</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td>11–20</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>More than 20</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>21</td>
<td>2</td>
<td>44</td>
<td>74</td>
</tr>
</tbody>
</table>

*South Sudan excluded due to lack of mortality data.
many of the Countdown countries where most of these child deaths occur. The launch of the Global Action Plan for Pneumonia and Diarrhoea in April 2013 and efforts by the GAVI Alliance (GAVI) to improve access to pneumococcal vaccines may help direct long overdue attention and resources to this leading killer of children.

**Postnatal care for mothers and babies** are interventions which receive little attention. This finding is worrisome given the high proportion of maternal and newborn deaths that occur within the first 48 hours of childbirth and that could be prevented through good-quality postnatal care services. Evidence shows that globally the neonatal mortality rate is falling much more slowly than the mortality rate for older children. This has resulted in a steady increase in the proportion of child deaths occurring during the neonatal period, from 36% in 1990 to 43% in 2011.21 Thus, achievement of MDG 4 will require a greater commitment to scaling up interventions proven to reduce newborn mortality, like postnatal, cord, thermal and kangaroo mother care. More attention should also be paid to preventing stillbirths and preterm births and providing effective care for the preterm baby. Commitments to newborn health are discussed in more detail in Chapter 7.

**Sanitation** interventions do not receive much attention, which is problematic as poor sanitation increases the risk of acquiring diseases such as diarrhoea, another leading cause of child mortality. Interventions to improve access to sanitation facilities have not progressed fast enough to meet MDG 7.22

Figure 2.7 presents an overview of the intervention focus of Global Strategy commitments and how they relate to median coverage levels in the 75 Countdown countries for the eight CoIA coverage indicators across the RMNCH continuum of care, plus two additional global consensus indicators related to water and sanitation and tracked by Countdown. It is based on 119 completed online questionnaires and a content analysis of the commitment text. Coverage data are from the two latest Countdown reports.23 Prevention of mother-to-child transmission (PMTCT) of the human immunodeficiency virus (HIV) is one of the CoIA recommended indicators, but coverage data are not available for all Countdown countries. Existing data show wide variations in coverage levels, with coverage in five countries reaching 75% or more of the target population and with four countries’ coverage reaching less than 25% of the target population (this relates to 19 of the 21 Countdown countries considered priority countries for PMTCT). A considerable number of stakeholders of the Global Strategy (89) focus their commitments on PMTCT, so it appears that the importance of action here is being recognized.

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**Figure 2.7:** Commitments related to the median coverage of essential RMNCH interventions in Countdown countries

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Coverage levels (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand for family planning satisfied*</td>
<td>61%</td>
</tr>
<tr>
<td>Antenatal care (4 visits or more)*</td>
<td>57%</td>
</tr>
<tr>
<td>Skilled attendant at birth*</td>
<td>62%</td>
</tr>
<tr>
<td>Postnatal care for mother*</td>
<td>26%</td>
</tr>
<tr>
<td>Postnatal care for newborn*</td>
<td>42%</td>
</tr>
<tr>
<td>Exclusive breastfeeding (&lt;6 months)*</td>
<td>44%</td>
</tr>
<tr>
<td>DTP3 vaccine coverage*</td>
<td>84%</td>
</tr>
<tr>
<td>Antibiotics for pneumonia*</td>
<td>42%</td>
</tr>
<tr>
<td>Improved sanitation facilities*</td>
<td>40%</td>
</tr>
<tr>
<td>Improved drinking water sources*</td>
<td>76%</td>
</tr>
</tbody>
</table>

**Commitments to the Global Strategy**

- Median coverage levels for the 75 Countdown to 2015 countries
- Commitments to the Global Strategy

**Note:** Figure excludes PMTCT due to lack of coverage data.

**Sources:**
- Analysis of survey results and commitment text.
Chapter 3

Financial Commitments

This chapter assesses the financial commitments to the Global Strategy and recent RMNCH financing trends. Section 3.1 provides an overview of financial commitments to the Global Strategy, including estimates of the amount of pledged funding that is subject to double-counting and the amount that is additional. Section 3.2 reports on progress on disbursements against Global Strategy commitments using the latest data on donor disbursements and country health expenditures, which were not available for inclusion in the PMNCH 2012 report. It finds that more than US$ 25 billion of commitments had been disbursed by June 2013, which is more than double the disbursements that had been made as of one year ago. Section 3.3 analyses broader RMNCH financing trends to also reflect other significant investments in women’s and children’s health that are not Global Strategy commitments. The final section projects disbursements for RMNCH until 2015, based on a trend analysis, and estimates the extent to which the financing gap for women’s and children’s health will be reduced. It also estimates what progress can be expected towards the Global Strategy outcomes for two key RMNCH areas, family planning and immunization.

3.1 Overview of financial commitments to advance the Global Strategy

Finding: As of June 2013, US$ 59.4 billion had been committed to the Global Strategy, up from US$ 57.6 billion in April 2012 (including upward adjustments of US$ 0.6 billion due to changes in commitments). The US$ 1.2 billion in new commitments since May 2012 does not include the financial commitments made at high-profile events that had already been pledged to the Global Strategy on previous occasions. Given that 25–32% (US$ 14.7–19.0 billion) of the US$ 59.4 billion is subject to double-counting, the actual value of the financial commitments to the Global Strategy is US$ 40.4–44.7 billion. These figures refer to commitments expressed in explicitly financial terms. If it were possible to monetize other commitments that also contribute to meeting the goals of the Global Strategy, the total financial value of all commitments to the Global Strategy would be significantly higher.

The 2012 PMNCH report estimated that US$ 57.6 billion had been committed to the Global Strategy by April 2012.
Over the following 14 months (May 2012 – June 2013), new financial commitments amounting to US$ 1.2 billion were made, bringing the total to US$ 59.4 billion (adjustments were made to 2012 commitment estimates, resulting in an increase of US$ 0.6 billion). This amount includes both existing and additional financial resources from stakeholders brought under the umbrella of the Global Strategy and it does not subtract funding that is double-counted. It also refers to commitments expressed in explicitly financial terms. It is beyond the scope of this report to estimate the financial value of policy, health systems and advocacy commitments not expressed in financial terms, but it is reasonable to assume that they would considerably increase the total financial value of commitments to the Global Strategy.

The number of stakeholders that had made financial commitments increased by 19%, from 98 in April 2012 to 117 in June 2013. Of these 117 stakeholders, 31 were low- and middle-income countries (26%). Annex 3 provides a breakdown of the number of financial commitments by stakeholder group.

Most of the US$ 1.2 billion in new financial commitments, since those reported in last year’s report, is linked to a number of events:

- At the London Summit on Family Planning in July 2012, US$ 2.6 billion in additional funding was committed by donors and the private sector for the period covering 2012–2020. For the purposes of this analysis, these commitments were prorated for 2012–2015 (where required) to enable comparison with other commitments, most of which had been made within the Global Strategy’s time frame. Further analysis revealed that part of this funding had been pledged to the Global Strategy in previous years, including US$ 320 million by the Bill & Melinda Gates Foundation (Gates Foundation), US$ 244 million by Germany and US$ 200 million by the UK. Total new funding to the Global Strategy for 2011-2015 committed at the Summit amounts to an estimated US$ 1.1 billion.

- Declared financial commitments covering the period until 2015 made to Born Too Soon amounted to US$ 3.2 billion. However, only the US$ 800 000 committed by the Global Alliance for Clean Cookstoves was new funding.

- US$ 50 million of new financial resources were pledged by Norway as part of the UN Commission on Life-Saving Commodities for Women and Children. Norway also pledged approximately US$ 80 million for 2013–2017 as part of the Saving Mothers, Giving Life partnership. Prorated for the period 2013–2015, this pledge amounts to US$ 50 million.

- Five stakeholders (Clinton Health Access Initiative/ IKEA foundation, McCann Health, Micronutrient Initiative, the Rockefeller Foundation and Teck Resources Ltd) made new financial commitments totalling US$ 48.5 million, which was not linked to a specific pledging event.

- No financial commitments were made at the launch of Committing to Child Survival: A Promise Renewed, which was not conceived as a financial pledging event.

Some recent financial commitments made to advance the health of women and children are not listed as Global Strategy commitments on the Every Woman Every Child website, and therefore were not counted in this analysis. This includes, for example, over US$ 4.0 billion pledged to the Global Polio Eradication Initiative at the Vaccine Summit in April 2013. In 2014, the question of whether commitments made at various nutrition-focused events in 2013 are part of Every Woman Every Child will need to be addressed.

Figure 3.1 breaks down the US$ 59.4 billion of financial commitments made to the Global Strategy by constituency group. These findings are based on an analysis of the financial commitment statements from the Every Woman Every Child website; in addition, nine stakeholders that made no reference to funding in their initial commitment statement but monetized their commitment in 2011 are included. High-income countries made the largest financial commitments, followed by global health partnerships (mostly GAVI and the Global Fund to Fight AIDS, Tuberculosis and Malaria [Global Fund]). Low-income countries also committed to providing significant funding (US$ 10.8 billion). However, some of that sum would need to come from external sources, which means that these commitments could be subject to double-counting.

![Figure 3.1: Financial commitments to the Global Strategy by constituency group](image-url)
After eliminating instances of double-counting based on results from the online survey, interviews and making assumptions due to incomplete data, double-counted funding was estimated at US$ 14.7–19.0 billion (25–32%) of the overall commitments. Double-counting refers to funding committed twice by different stakeholders: for example, a donor commitment to a global health partnership that is reported as a Global Strategy commitment by both the donor and the partnership (for details, see the financial background paper to this report27).

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

Global Strategy commitments include previously existing RMNCH financing and additional investments specifically targeting the funding gap identified in the Global Strategy.28 To determine the amount of additional funding, a conservative approach was used: funding was only counted as additional if convincing evidence was available to support the assumption. The estimate of new funding is therefore likely to be significantly underestimated. Based on this analysis at least US$ 17.7–22.0 billion can be confirmed as new and additional on top of RMNCH spending levels before the Global Strategy was initiated (see the financial background paper for more details).

Of this amount, an estimated US$ 12.4–16.5 billion is targeted at the 49 Global Strategy countries. However, it should be emphasized that this figure only refers to commitments expressed in explicitly financial terms. While commitments to the Global Strategy in its first three years have contributed to a significant reduction of the funding gap, it is clear that additional resources are needed.

### 3.2 Progress in the disbursement of financial commitments to the Global Strategy

This section tracks disbursements of financial commitments to the Global Strategy. The analysis is based on data from the Organisation for Economic Co-operation and Development (OECD) Creditor Reporting System (CRS)29 and WHO’s National Health Accounts (NHA) database.30 Both sources include expenditure data until 2011. In addition, the analysis relies on information provided by stakeholders in interviews and the online survey. Given that only a limited number of stakeholders provided data on 2012 disbursements, the estimates below are more likely to be underestimates of the amounts that were actually disbursed.

Because the CRS database and NHA data do not allow for direct tracking of RMNCH spending, the disbursement analysis and the analysis in Section 3.3 rely on the following approaches.

- The Muskoka methodology was used to calculate Official Development Assistance (ODA) for RMNCH.31 This method is based on imputed percentages to funding reported to the OECD by donors under certain purpose codes or to selected multilateral organizations. Many donors calculate their RMNCH spending in this way.
- In accordance with the assumption laid out in the financial estimates in the Global Strategy,32 government RMNCH expenditures in low- and middle-income countries were calculated assuming that they would constitute 25% of total government health expenditures. This proxy, which is based on data from NHA sub-accounts, is only a rough estimate.33

It needs to be re-emphasized that the timelines of the financial commitments of stakeholders vary, as does whether or not they comprise new and additional funds.34

**Finding:** There is growing evidence that committed funding is being disbursed. An estimated US$ 25.0 billion was disbursed between the launch of the Global Strategy and June 2013, more than double the US$ 11.6 billion reported as of September 2012.
Total disbursements by all stakeholders to their respective Global Strategy commitments are estimated at US$ 25.0 billion as of June 2013. Of this sum, US$ 14.4 billion was disbursed in 2010–2011. Preliminary data suggest that US$ 10.5 billion was disbursed in 2012 and early 2013. These disbursements include both previously existing RMNCH funding (baseline spending) and additional financial flows to RMNCH. Some of the disbursements are subject to double-counting. This applies to disbursements by GAVI and the Global Fund, and to funding expended by NGOs. The exact amount, however, is very difficult to estimate.

The US$ 25.0 billion excludes 2012 disbursements by low-income countries and several OECD countries for which data were not available. If the assumption is made that their disbursements remained at 2011 levels, the amount of disbursements increases to US$ 26.1 billion.

Disbursements by international stakeholders totalled US$ 17.7 billion to June 2013, a 73% increase over the US$ 10.2 billion estimated in the PMNCH 2012 Report. The increase is due both to improvements in available data and increased disbursements.

High-income countries disbursed US$ 9.3 billion, and GAVI and the Global Fund disbursed US$ 4.5 billion. Substantial amounts were also disbursed by NGOs (US$ 2.3 billion), foundations (US$ 1 billion, of which US$ 775 million is from the Gates Foundation) and multilateral organizations, including the World Bank (US$ 469 million). Disbursements by the private sector (US$ 35 million) and health-care professional associations (US$ 4.8 million) remained more limited.

The 27 low-income countries with financial commitments to the Global Strategy increased their government spending on RMNCH from US$ 2.2 billion in 2010 to US$ 2.7 billion in 2011. This is an increase of US$ 493 million (23%) compared with 2010. Health expenditure data are not yet available for 2012, but if the conservative assumption is made that expenditures in 2012 remained at the same level as in 2011, this would result in another US$ 0.5 billion, bringing the disbursed amount to a total of US$ 1 billion by 2012.

Three middle-income countries that committed to maintaining their RMNCH or family planning funding levels (India, Indonesia and the Philippines) increased government RMNCH spending from US$ 6.8 billion in 2010 to US$ 8.3 billion in 2011.

About 42% of overall disbursements (US$ 10.4 billion) are additional to previous spending levels. The disbursements considered additional are provided by high-income countries (US$ 5.2 billion, 50%), middle-income countries (US$ 2.8 billion, 27%), global health partnerships (US$ 1.1 billion, 10%), the Gates Foundation (US$ 775 million, 8%) and low-income countries (US$ 493 million, 5%).

Shifts in intervention focus of commitments by high-income countries and the Gates Foundation

It is possible to disaggregate the bilateral RMNCH disbursements for Global Strategy commitments of high-income countries (and the Gates Foundation) reporting to the OECD CRS. Disbursements from these stakeholders increased from US$ 6 billion in 2008 to US$ 9.3 billion in 2011. Funding for all interventions except strengthening health systems increased between 2008 and 2011 (Figure 3.2). Expenditures for nutrition, reproductive health and family planning showed the steepest growths, of at least 100%. However, in absolute terms funding for nutrition remains small, though this has been addressed at several events in 2013, which are outside the scope of this report. Funding for HIV rose in absolute terms and continues to account for the largest share of RMNCH funding by this group of donors. Funding for other infectious diseases, including malaria, also increased. Overall, large parts of RMNCH financing therefore contribute to MDG 6, especially to HIV/AIDS.
3.3 Analysis of overall RMNCH financing trends

Finding: ODA to the 49 Global Strategy countries and the 75 Countdown countries peaked in 2010, decreasing slightly in 2011 as a result of the financial crisis that affected donor flows to RMNCH. However, it should be noted that already in 2009, RMNCH disbursements grew much less than in all previous years since 2006.

This section analyses the broader RMNCH financing trends by international donors: significant other investments to improve women’s and children’s health are not reflected in the commitments to the Global Strategy. Disbursement data come from the CRS database. Given the limitations of the database in capturing RMNCH funding, the Muskoka methodology was used to estimate donor disbursements to RMNCH (see Section 3.2). Private sources, such as insurance and out-of-pocket expenditures, are excluded because there are limited data available on the RMNCH portion.
of these funding flows. If these amounts could have been included, total expenditure on RMNCH would be considerably higher.

According to the analysis based on the Muskoka methodology, RMNCH ODA to the Countdown countries by all stakeholders reporting to the CRS increased from US$ 3.5 billion in 2006 to US$ 6.0 billion in 2011; disbursements to the 49 countries of the Global Strategy grew from US$ 2.5 billion to US$ 4.5 billion (Figure 3.3). However, RMNCH ODA decreased slightly from 2010 to 2011, by 1.1% for the 75 Countdown countries and 1.5% for the 49 Global Strategy countries. This is in line with recent evidence indicating the impact of the global financial crisis. After a decade of growth, the Institute for Health Metrics and Evaluation (IHME) found that development assistance for health peaked at US$ 28.2 billion in 2010, but has levelled off since then at US$ 27.4 billion in 2011 and US$ 28.0 billion in 2012. However, there are indications that disbursement of Global Strategy commitments might have risen in 2012: five main development partners (Australia, Canada, Japan, Sweden and the United Kingdom) have reported combined increased RMNCH expenditures of almost US$ 0.5 billion compared with 2011.

It should be noted that the Muskoka methodology tends to underestimate the RMNCH ODA provided to the Countdown countries. Countdown estimates donor disbursements to maternal, newborn and child health (MNCH), using project level data in its analyses, which generates more robust results, and the data are available for 2003–2010. In 2013, Countdown published an analysis on disbursements for reproductive health in 2009 and 2010. The combined results allow global RMNCH expenditures to be calculated, which can be compared with estimates calculated based on the Muskoka methodology.

Thus, according to Countdown, US$ 7.5 billion and US$ 7.8 billion were disbursed by donors to RMNCH in 2009 and 2010 respectively. When converted to constant 2005 US dollars, the RMNCH ODA according to the Countdown analysis amounted to US$ 6.5 billion in 2009 and US$ 6.8 billion in 2010, which is on average 13.3% higher than the estimates based on the Muskoka methodology (US$ 5.7 billion in 2009 and US$ 6.0 billion in 2010).

Given that the global financial crisis has put development finance under considerable pressure, it may be considered a success that funding remained at a level similar to 2009, when the crisis started to affect donors’ spending.

A second consideration is the time lag between commitments to the Global Strategy and the disbursements of those commitments. With the long planning cycles of most donors, a linear increase starting in 2011 is not necessarily expected.

**FINDING:** The launch of the Global Strategy did not alter the geographical targeting of RMNCH ODA. The top 10 recipient countries were the same in 2011 as in 2008. They included India and nine countries in sub-Saharan Africa. Eight of the 10 countries that received the least RMNCH ODA in 2008 were also among the bottom 10 recipients in 2011.
A review of 2011 RMNCH ODA recipients (based on CRS data and the Muskoka methodology) shows that the countries receiving the lowest amounts of disbursements, both absolute and per capita, include several countries with high under-five mortality rates and/or a high maternal mortality ratio. As shown in Table 3.1, among the most striking rates of maternal and child deaths are those in the Central African Republic and Mauritania. RMNCH ODA for the Central African Republic decreased by an annual mean of 6% between 2008 and 2011, and for Mauritania by 11%. Both countries are in the bottom third of the 75 Countdown countries in terms of RMNCH ODA received per capita.

The top recipients of RMNCH funding (absolute amounts) are shown in Figure 3.4. A comparison between 2008 and 2011 reveals that the top 10 recipients remained the same. Eight of the 10 countries which received the least RMNCH ODA in 2008 are also among the bottom 10 recipients in 2011 (Figure 3.4; compare Table 3.1).

A review of RMNCH ODA on a per capita basis shows a similar picture: there was no substantial change between 2008 and 2011, and the same 14 countries were among the top 10 recipients each year. Of the 15 countries that received the highest disbursements for RMNCH per capita in 2011, only six had a population larger than 10 million (Haiti, Kenya, Malawi, Mozambique, Rwanda and Zambia). The top three recipients per capita are very small countries: Sao Tome and Principe, Solomon Islands and Swaziland (see Annex 4 for data on per capita RMNCH disbursements).

**Finding:** The Global Strategy appears to be having some impact on how disbursements for RMNCH are used. While the overall focus of RMNCH by funding area changed little between 2008 and 2011, funding for reproductive health and family planning increased.

**Figure 3.4:** Top 10 and bottom 10 Countdown country recipients of RMNCH ODA, 2008 and 2011

Source: OECD Creditor Reporting System.
### Table 3.1: Countries receiving the highest and the lowest amounts of RMNCH-related disbursements (including mortality data), 2011

<table>
<thead>
<tr>
<th>Country</th>
<th>Under-5 mortality rate (deaths per 1000 live births), 2011</th>
<th>Number of under-5 deaths ('000), 2011</th>
<th>Maternal mortality ratio (deaths per 100 000 live births), 2010</th>
<th>Number of maternal deaths, 2010</th>
<th>Disbursements received in 2011 (current US$ million)</th>
<th>Mean annual change in constant prices, 2008–2011 (%)</th>
<th>% of total disbursements to 75 Countdown countries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Countries receiving the highest amounts of disbursements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>61</td>
<td>1 655</td>
<td>200</td>
<td>56 000</td>
<td>547</td>
<td>11%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>77</td>
<td>194</td>
<td>350</td>
<td>9 000</td>
<td>451</td>
<td>19%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>124</td>
<td>756</td>
<td>630</td>
<td>40 000</td>
<td>435</td>
<td>17%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Tanzania, United Rep.</td>
<td>68</td>
<td>122</td>
<td>460</td>
<td>8 500</td>
<td>396</td>
<td>5%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Kenya</td>
<td>73</td>
<td>107</td>
<td>360</td>
<td>5 500</td>
<td>391</td>
<td>17%</td>
<td>5.4%</td>
</tr>
<tr>
<td>South Africa</td>
<td>47</td>
<td>47</td>
<td>300</td>
<td>3 200</td>
<td>300</td>
<td>11%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>103</td>
<td>86</td>
<td>490</td>
<td>4 300</td>
<td>272</td>
<td>7%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Congo, Dem. Rep.</td>
<td>168</td>
<td>465</td>
<td>540</td>
<td>15 000</td>
<td>257</td>
<td>12%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Uganda</td>
<td>90</td>
<td>131</td>
<td>310</td>
<td>4 700</td>
<td>249</td>
<td>12%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Zambia</td>
<td>83</td>
<td>46</td>
<td>440</td>
<td>2 600</td>
<td>239</td>
<td>7%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>101</td>
<td>128</td>
<td>460</td>
<td>6 400</td>
<td>232</td>
<td>22%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>46</td>
<td>134</td>
<td>240</td>
<td>7 200</td>
<td>192</td>
<td>12%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Malawi</td>
<td>83</td>
<td>52</td>
<td>460</td>
<td>3 000</td>
<td>192</td>
<td>8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>54</td>
<td>23</td>
<td>340</td>
<td>1 500</td>
<td>172</td>
<td>6%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>22</td>
<td>32</td>
<td>59</td>
<td>860</td>
<td>156</td>
<td>11%</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Countries receiving the lowest amounts of disbursements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>45</td>
<td>8</td>
<td>43</td>
<td>79</td>
<td>15</td>
<td>25%</td>
<td>0.21%</td>
</tr>
<tr>
<td>Central African Rep.</td>
<td>164</td>
<td>25</td>
<td>890</td>
<td>1 400</td>
<td>13</td>
<td>-6%</td>
<td>0.18%</td>
</tr>
<tr>
<td>Eritrea</td>
<td>68</td>
<td>13</td>
<td>240</td>
<td>460</td>
<td>13</td>
<td>25%</td>
<td>0.18%</td>
</tr>
<tr>
<td>Gambia</td>
<td>101</td>
<td>6</td>
<td>360</td>
<td>230</td>
<td>13</td>
<td>13%</td>
<td>0.18%</td>
</tr>
<tr>
<td>Iraq</td>
<td>38</td>
<td>42</td>
<td>63</td>
<td>710</td>
<td>12</td>
<td>-22%</td>
<td>0.17%</td>
</tr>
<tr>
<td>Mauritania</td>
<td>112</td>
<td>13</td>
<td>510</td>
<td>590</td>
<td>11</td>
<td>-11%</td>
<td>0.16%</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>161</td>
<td>9</td>
<td>790</td>
<td>460</td>
<td>11</td>
<td>13%</td>
<td>0.15%</td>
</tr>
<tr>
<td>Korea, Dem. Rep.</td>
<td>33</td>
<td>12</td>
<td>81</td>
<td>280</td>
<td>10</td>
<td>79%</td>
<td>0.14%</td>
</tr>
<tr>
<td>Mexico</td>
<td>16</td>
<td>34</td>
<td>50</td>
<td>1 100</td>
<td>8</td>
<td>7%</td>
<td>0.12%</td>
</tr>
<tr>
<td>Equatorial Guinea</td>
<td>118</td>
<td>3</td>
<td>240</td>
<td>61</td>
<td>8</td>
<td>-10%</td>
<td>0.11%</td>
</tr>
<tr>
<td>Djibouti</td>
<td>90</td>
<td>2</td>
<td>200</td>
<td>51</td>
<td>6</td>
<td>-11%</td>
<td>0.09%</td>
</tr>
<tr>
<td>Sao Tome and Principe</td>
<td>89</td>
<td>70</td>
<td>4</td>
<td>6</td>
<td>28%</td>
<td>0.08%</td>
<td></td>
</tr>
<tr>
<td>Gabon</td>
<td>66</td>
<td>3</td>
<td>230</td>
<td>94</td>
<td>5</td>
<td>20%</td>
<td>0.07%</td>
</tr>
<tr>
<td>Comoros</td>
<td>79</td>
<td>2</td>
<td>280</td>
<td>78</td>
<td>4</td>
<td>61%</td>
<td>0.06%</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>53</td>
<td>5</td>
<td>67</td>
<td>73</td>
<td>2</td>
<td>7%</td>
<td>0.03%</td>
</tr>
</tbody>
</table>

Source: OECD CRS.
An analysis of overall financing trends shows that there was little variation in the breakdown of RMNCH funding by area over the period 2008–2011 (Figure 3.5). Reproductive health (excluding family planning) is the only area which constantly increased in absolute and relative terms in this period (albeit modestly). Compared with 2008, funding for family planning increased substantially (see discussion below). Funding to all other areas fluctuated or decreased modestly.

Funding for reproductive health (excluding HIV prevention and treatment) and family planning increased over the four-year period 2008–2011. However, while funding for reproductive health continued to grow, funding for family planning decreased in absolute terms between 2009 and 2010, though in 2011 it started to grow again, albeit slowly (Figure 3.6).

Government RMNCH funding trends in low- and middle-income countries

**Finding:** Despite the global financial crisis, RMNCH government expenditures in low- and middle-income countries continue to grow. However, there are substantial disparities among countries, both in absolute numbers and per capita. Some countries with very low expenditures also receive little ODA for RMNCH.

Total government funding for RMNCH in the 75 Countdown countries (excluding funding from external resources) increased to a total of US$ 45 billion in 2011. This is an increase of 38% compared with 2008 and 10% compared with 2010. Three large middle-income
countries (Brazil, China and Mexico) accounted for 72% of the total funding in 2008 and 75% in 2011. Discounting the RMNCH expenditure of these three countries, overall spending would only have increased by 22%, from US$ 9.3 billion in 2008 to US$ 11.4 billion in 2011.

Total government funding for RMNCH in the 49 Global Strategy countries (also excluding funding from external resources) increased from US$ 2.2 billion in 2008 to US$ 2.6 billion in 2011, an increase of 18% compared with 2008 and 12% compared with 2010 (Figure 3.7). Mean RMNCH spending per capita in these countries increased by 33% between 2008 and 2011, from US$ 2.1 to US$ 2.7.

Mean RMNCH spending per capita (excluding funding from external resources) in the 75 Countdown countries increased by 26% between 2008 and 2011, from US$ 6.1 to US$ 7.6. A review of RMNCH spending per capita shows that among the top 10 of the 75 Countdown countries in 2011, there was no low-income country.

The group of countries with the lowest per capita expenditures on RMNCH remained largely unchanged between 2008 and 2011 (six countries figure among the bottom 10 countries in both 2008 and 2011). The per capita expenditure on RMNCH of the bottom 10 countries is substantially below the mean of the 49 Global Strategy focus countries. Some of the countries in this group (Bangladesh, Myanmar and Pakistan) are among those which received the least ODA for RMNCH per capita in 2008 and/or 2011 (see per capita disbursements in Annex 4).

3.4 Projection of RMNCH disbursements until 2015

**Finding:** An analysis of projected disbursements based on spending trends in 2008–2011 indicates that US$ 14.5 billion in additional funding for RMNCH would be available in the 49 focus countries in the period 2011–2015, covering 16.4% of the financing gap. If commitments that are not expressed in explicitly financial terms were monetized, they would contribute considerably to reducing the financing gap.
This section projects disbursements for RMNCH based on spending trends from 2008 to 2011, and presents a rather optimistic view (see Annex 5 for an alternative more pessimistic projection, including years more deeply affected by the global financial crisis). However, if the RMNCH spending trend remains similar to the change observed between 2010 and 2011 then both scenarios might prove too optimistic.

Projections based on the changes in RMNCH expenditures between 2008 and 2011 indicate an increase in RMNCH expenditures by the 49 Global Strategy countries to US$ 3.2 billion by 2015 (in constant 2005 prices and excluding external resources). This means that between 2011 and 2015 the 49 countries would spend US$ 3.6 billion from their own resources in additional RMNCH funding over the 2008 baseline (Figure 3.8).

RMNCH ODA was calculated using the mean of the disbursement estimates calculated based on the Muskoka methodology and the estimates calculated by Countdown. Based on the trend in RMNCH disbursements from 2008 to 2011, RMNCH ODA to the 49 countries would increase to US$ 7.0 billion by 2015 (in constant 2005 prices). This would result in US$ 10.9 billion in additional RMNCH ODA to these countries over the 2008 baseline.

Combined spending (expenditures by the 49 countries and RMNCH ODA) would therefore reach US$ 10.3 billion by 2015, resulting in US$ 14.5 billion of additional funding for RMNCH in the period 2011–2015 over the 2008 baseline. This would cover 16.4% of the financing gap identified by the Global Strategy.

Estimating progress towards two goals of the Global Strategy: family planning and immunization

Estimates were made of the extent to which the financing gaps for family planning and immunization, two of the Global Strategy’s goals, would be closed if disbursements continued as reported.

A projection based on funding trends between 2008 and 2011 indicates that combined expenditures for family planning (ODA and government expenditures in low- and middle-income countries) would increase by a total of US$ 1.9 billion between 2011 and 2015 (over 2008 levels in constant 2005 prices). This would close 40% of the US$ 4.9 billion financing gap for family planning identified in the Global Strategy and provide an estimated 17.1 million new users with access to family planning in 2015.

GAVI reported that it expects to immunize a total of 243 million additional children in all its approved vaccine programmes between 2011 and 2015. Given that there are also new pledges for polio vaccination, and assuming that funding for basic immunization will be provided from other sources, the financing extended by GAVI alone suggests that a much larger number of children will be fully immunized than the target of 15.2 million in the Global Strategy.

Annex 5 has more information on progress towards these two goals. Due to lack of data, it is not possible to make any statements about the other goals and targets of the Global Strategy.
Stakeholders have made significant commitments to the delivery of services, commodities and health systems strengthening (53%), advocacy (21%), policy (17%) and research (9%) (Figure 4.1). The implementation of these commitments also requires financial resources. They are only non-financial in the sense that they are not expressed in explicit financial terms, and it was beyond the scope of this report to estimate their overall value. If these commitments were valued, it would obviously change the financial picture considerably. This chapter discusses these commitments, with the exception of commitments to advocacy, which are discussed in Chapter 8.

4.1 Delivering services and commodities, and strengthening health systems

With respect to commitments to service delivery and strengthening health systems, stakeholders focus strongly on human resources, and also on educating and empowering the public, which are both important for creating demand for RMNCH services. Other commitment areas receiving a similarly high level of attention are the establishment or improvement of existing health-care facilities, and measures to ensure
Expanding the health workforce

**Finding:** Responses to the survey indicate that Global Strategy commitments have resulted in over 870,000 additional health workers being trained. This is an important step in closing the estimated shortage of health workers worldwide of between 2.5 million and 3.5 million.

Human resources are the backbone of any health system, but they are often also its weakest link. The Global Strategy estimates that to achieve its various outcome targets up to 3.5 million additional health workers will need to be available in the 49 countries by 2015. This includes community health workers, skilled birth attendants, nurses, midwives, doctors, obstetricians, other health workers with midwifery competencies and administrative personnel.

Many stakeholders focus on increasing the numbers and improving the skills of health workers in general, and skilled birth attendants and midwives in particular. Of the 220 stakeholders that made commitments to strengthening health systems, service delivery and commodities, 122 (55%) committed to strengthen the health workforce (see Figure 4.2 above). Of these 122 stakeholders, some specified their commitment further: 36 (30%) indicated they are focusing on improving the skills of existing health workers, while 46 (38%) aim to increase the number of health workers and 4 (3%) stakeholders employ a combined approach (and 36, or 29%, did not specify their commitment to strengthen the health workforce).

Some stakeholders set out specific quantified targets in their commitments to train or recruit health workers by 2015. The combined outcome of these commitments amounts to almost 1.5 million health workers by 2015. A significant number of stakeholders also indicated their intention to strengthen the health workforce, though without specifying figures. One example is Novo Nordisk’s Changing Diabetes in Pregnancy programme, in which 2,700 health-care professionals have been trained in nine African and Asian countries to better diagnose, treat and educate children and their families about type 1 diabetes.

There appears to be strong progress in this commitment field. As shown in Table 4.1, 29 stakeholders reported in the survey that they have directly contributed to training and/or recruiting 765,000 midwives, skilled birth attendants and other health workers. In addition, they reported having contributed to the training of about 108,000 new community health workers. A large part of this progress is due to the achievements reported by implementing countries and NGOs.

Improvements in the quality and quantity of the health workforce are being enhanced by capacity building and establishing or improving training facilities. In this context it should be noted that the response rate to the online survey was 45%. This means that an even higher number of health workers might have been trained or recruited, as more than half of the commitment-makers did not respond to the survey.

---

**Figure 4.2:** Focus of health systems strengthening and service delivery commitments

<table>
<thead>
<tr>
<th>Focus of Commitment</th>
<th>N=220</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit and/or train skilled birth attendants and other health workers</td>
<td>122</td>
<td>(55%)</td>
</tr>
<tr>
<td>Educate and empower the public and build demand for RMNCH commodities and services</td>
<td>108</td>
<td>(49%)</td>
</tr>
<tr>
<td>Support commodity availability/supply systems</td>
<td>99</td>
<td>(45%)</td>
</tr>
<tr>
<td>Establish new/improve existing facilities and other infrastructure essential to deliver services</td>
<td>99</td>
<td>(45%)</td>
</tr>
<tr>
<td>Reinforce community systems</td>
<td>86</td>
<td>(39%)</td>
</tr>
<tr>
<td>Improve health monitoring/evaluation and information systems</td>
<td>78</td>
<td>(35%)</td>
</tr>
<tr>
<td>Support activities with relevance for RMNCH in other sectors (e.g. agriculture, transportation)</td>
<td>48</td>
<td>(22%)</td>
</tr>
<tr>
<td>Other</td>
<td>46</td>
<td>(21%)</td>
</tr>
</tbody>
</table>

Note: Stakeholders may refer to multiple commitment areas in their commitment.

Source: Analysis of survey results and commitment text.
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Additional health workers trained or recruited (according to survey responses)</th>
<th>Community health workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>Midwives</td>
<td>926</td>
</tr>
<tr>
<td>Guyana</td>
<td>Nurses</td>
<td>300</td>
</tr>
<tr>
<td>Haiti</td>
<td>Specialists, nurses and midwives</td>
<td>50</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Doctors, specialists and midwives</td>
<td>36 804</td>
</tr>
<tr>
<td>Kenya</td>
<td>Nurses, public health officers and public health technicians</td>
<td>5 137, 2 093</td>
</tr>
<tr>
<td>Liberia</td>
<td>Skilled clinical staff</td>
<td>1 128</td>
</tr>
<tr>
<td>Madagascar</td>
<td>Additional health workers trained or recruited</td>
<td>900</td>
</tr>
<tr>
<td>Malawi</td>
<td>Nurses</td>
<td>25</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Doctors, midwives, nurses</td>
<td>26 406, 646</td>
</tr>
<tr>
<td>Niger</td>
<td>Additional health workers trained or recruited</td>
<td>1 158</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Additional health workers trained or recruited</td>
<td>2 500</td>
</tr>
<tr>
<td>Senegal</td>
<td>Additional health workers trained or recruited</td>
<td>1 000</td>
</tr>
<tr>
<td>Sudan</td>
<td>Midwives</td>
<td>3 487</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>Additional health workers trained or recruited</td>
<td>25 800</td>
</tr>
<tr>
<td>Aman Foundation</td>
<td>Medical emergency persons</td>
<td>2 178, 50</td>
</tr>
<tr>
<td>American Academy of Pediatrics</td>
<td>Additional health workers trained or recruited</td>
<td>110 000</td>
</tr>
<tr>
<td>Australia</td>
<td>Doctors, nurses, midwives and community health workers trained in Papua New Guinea</td>
<td>246, 20</td>
</tr>
<tr>
<td>Bangladesh Rehabilitation Assistance Committee (BRAC)</td>
<td>Community skilled birth attendants, community health workers</td>
<td>700, 100 000</td>
</tr>
<tr>
<td>DKT International</td>
<td>Additional health workers trained or recruited</td>
<td>70 000</td>
</tr>
<tr>
<td>EngenderHealth</td>
<td>Additional health workers trained to provide high-quality family planning, maternal health and HIV/AIDS services</td>
<td>60 000</td>
</tr>
<tr>
<td>Every Mother Counts</td>
<td>Midwives</td>
<td>15</td>
</tr>
<tr>
<td>International Planned Parenthood Federation</td>
<td>Additional community-based distributors</td>
<td>5 113</td>
</tr>
<tr>
<td>Johnson &amp; Johnson</td>
<td>Additional front-line health workers trained in collaboration with partners</td>
<td>140 000</td>
</tr>
<tr>
<td>LifeSpring Hospitals of India</td>
<td>Additional health workers trained or recruited</td>
<td>250</td>
</tr>
<tr>
<td>Pathfinder International</td>
<td>Community-based family planning agents</td>
<td>19</td>
</tr>
<tr>
<td>Rotarian Action Group for Population and Sustainable Development</td>
<td>Additional health workers and family planning providers</td>
<td>30</td>
</tr>
<tr>
<td>Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)</td>
<td>Additional health workers trained or recruited</td>
<td>330</td>
</tr>
<tr>
<td>Save the Children International</td>
<td>Additional health workers trained or recruited</td>
<td>274 962</td>
</tr>
<tr>
<td>Saving Mothers Giving Life</td>
<td>Providers trained and hired</td>
<td>586</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>764 918, 107 941</strong></td>
</tr>
</tbody>
</table>

Note: Excluding stakeholders who reported unspecified increases in numbers of health workers.

Source: Analysis of survey results.
Given the large regional disparities in shortages of health workers, it is important to assess the distribution of newly trained and recruited health workers by region. The health worker gap was identified to be most critical for sub-Saharan Africa, where 36 countries fall below the desired threshold of a coverage of 80% of the population. Unfortunately, for 658 000 of the 765 000 health workers trained, data on their specific locations are unavailable. Of 107 000 health workers who can be ascribed to a specific geographical region, about 91 000 are in South-East Asia and the Western Pacific, while only 16 000 are in sub-Saharan Africa. The location of new community health workers is clearer for 103 100 out of 108 000, and shows a similar picture: only 2100 are in sub-Saharan Africa, while 101 000 are in South-East Asia and the Western Pacific.

Certain stakeholders committed to help to improve the quality of service delivery in facilities. The Rotarian Action Group for Population and Sustainable Development committed to improve quality assurance in 10 general hospitals in two states of Nigeria (Kano and Kaduna). Evaluations have generated evidence on the success of these programs. They show that quality assurance in obstetrics led to a reduction of 60% in maternal mortality rate and 15% in fetal mortality in the 10 hospitals in three years. The project has now been expanded to two other Nigerian states.

### Table 4.2: Progress in increasing the number of health-care facilities by 85 000 by 2015

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Additional health-care facilities created (according to survey responses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>New health posts, health centres and referral hospitals 33</td>
</tr>
<tr>
<td>Haiti</td>
<td>Newly built or reinforced health centres 10</td>
</tr>
<tr>
<td>Indonesia</td>
<td>New health centres, provincial and district hospitals 572</td>
</tr>
<tr>
<td>Kenya</td>
<td>New health centres 201</td>
</tr>
<tr>
<td>Liberia</td>
<td>New health facilities 134</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Rural health centres and hospitals 231</td>
</tr>
<tr>
<td>Niger</td>
<td>New health centres, focusing on maternal and child health and new district hospitals 84</td>
</tr>
<tr>
<td>Sudan</td>
<td>New health facilities 150</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>New health centres and dispensaries 500</td>
</tr>
<tr>
<td>Australia</td>
<td>New STI clinics in Papua New Guinea 14</td>
</tr>
<tr>
<td>Bristol-Myers Squibb Foundation</td>
<td>New paediatric outpatient health facility in Tanzania and paediatric satellite facilities in Lesotho 5</td>
</tr>
<tr>
<td>International Planned Parenthood Federation</td>
<td>New service delivery points and static clinics 2 326</td>
</tr>
<tr>
<td>LifeSpring Hospitals of India</td>
<td>New health facilities 12</td>
</tr>
<tr>
<td>Novo Nordisk A/S</td>
<td>New diabetes clinics 77</td>
</tr>
<tr>
<td>Saving Mothers Giving Life</td>
<td>Facilities offering basic and comprehensive emergency obstetric and newborn care and maternity waiting shelters 101</td>
</tr>
</tbody>
</table>

**TOTAL 4 450**

Excluding stakeholders that reported unspecified increases in numbers of health facilities. Source: Analysis of survey results.
hospitals from 45 to 49 and that of district hospitals from 445 to 508 since 2010. Liberia reported an increase in its public and private health facilities from 551 in 2010 to 657 in 2012.

These findings suggest that more needs to be done to reach the Global Strategy’s target of 85 000 additional good-quality health facilities available by 2015. Also, more evidence is required to assess progress in this regard, such as data on hospital beds per 1000 people, patient numbers and the quality of care being provided.

Commodity availability and supply systems

**Finding:** Stakeholders are supporting efforts to improve commodity availability and supply systems, including previously neglected commodities such as oral rehydration salts, zinc, contraceptive implants and female condoms.

Commodity availability and supply systems were noted by 99 stakeholders (45%) as a specific focus of their commitment. A number of global initiatives were also launched to improve commodity availability. The UN Commission on Life-Saving Commodities for Women and Children, launched in March 2012, aims to increase access to medicines and health supplies by addressing barriers that obstruct access to 13 essential health commodities. Since its report was published in September 2012, significant implementation efforts have already begun. Eight countries (Democratic Republic of the Congo, Ethiopia, Malawi, Nigeria, Senegal, Sierra Leone, Uganda and the United Republic of Tanzania) have committed to speeding up access to and use of 13 life-saving commodities to all women and children in their countries by 2015. One example of country-led implementation of the Commission’s recommendations is Nigeria’s Saving One Million Lives initiative. Based on an analysis of national needs and priorities, this initiative aims to save 1 million lives by 2015 through an ambitious and comprehensive scale-up of access to essential primary health services and commodities for women and children. The Family Planning 2020 Summit also catalysed the pledging of many new commitments to increase access to a range of family planning methods.

Progress has also been made in securing and implementing new commitments for areas that are still receiving insufficient attention, such as the prevention and treatment of diarrhoea. For example, in October 2012, the Coalition for Childhood Essential Medicines was launched in Nigeria, following which non-profit and private-sector organizations are working on improving the availability of oral rehydration solutions and zinc, including developing innovative products and training providers and health workers to contribute to creating demand.

Increasing access to immunization is crucial to achieve the ambitious goals of the Global Strategy. Nearly 200 countries endorsed a shared vision, known as the Decade of Vaccines, to extend the benefits of vaccines to every person by 2020 and thereby save more than 20 million lives (Box 4.1).

**Box 4.1: Decade of Vaccines**

Acknowledging the need for increased access to immunization, in 2010 the global health community initiated the Decade of Vaccines (2011–2020). Its mission is to extend by 2020 and beyond the full benefit of immunization to all people.

As part of this initiative, the Global Vaccine Action Plan (GVAP), a roadmap aimed at providing universal access to immunization, was developed by many stakeholders involved in immunization and was endorsed by the World Health Assembly in May 2012. The development of the GVAP was coordinated by the Decade of Vaccines Collaboration guided by a leadership council representing WHO, UNICEF, the Gates Foundation, the GAVI Alliance and the US National Institute of Allergy and Infectious Diseases.

The GVAP is aimed at strengthening routine immunization to meet vaccination coverage targets, accelerating the control of vaccine-preventable diseases with polio eradication as the first milestone, and stimulating research and development for new vaccines and technologies. If the GVAP is translated into action, 24.6–25.8 million deaths could be averted by the end of the decade. The GVAP Monitoring & Evaluation and Accountability Framework monitors the implementation its goals and objectives and evaluates progress towards achieving the vision of the Decade of Vaccines. The Global Vaccine and Immunization Research Forum will track progress and stimulate debate on the research agenda of the action plan. The first forum will be held in early 2014.
Progress has been reported on the introduction of vaccines in low- and middle-income countries. By the end of 2012 GAVI had contributed to the prevention of more than 5.5 million future deaths by supporting the immunization of more than 370 million children. GAVI’s 2011–2015 strategy prioritizes the delivery of new and underused vaccines with the greatest impact on improving women’s and children’s health. Since the launch of the Global Strategy, GAVI has helped to increase the uptake of the pneumococcal vaccine from three to over 25 countries, and of the rotavirus vaccine from 4 to 14 countries, with 22 expected to have introduced it within the next two years. GAVI also supported the first measles-rubella campaign in Rwanda, which helped to vaccinate over 5 million children in March 2013. The combined vaccine is expected to be introduced in five additional countries by the end of 2013.

An example of strengthening supply chains is in Senegal, where IntraHealth International reports progress in preventing stock-outs of contraceptive methods at service delivery points. Also in Senegal, the Gates Foundation reports that the Urban Reproductive Health Initiative is reducing stock-outs of contraceptives to zero and dramatically improving the uptake of family planning.

Investing in education and creating demand

**Finding:** Public education and demand creation are a focus of almost half of Global Strategy commitments.

Almost half of all stakeholders (108, or 49% of the total, who made commitments to service delivery and health systems strengthening) indicated that their commitment supports public education and demand creation for RMNCH commodities and services. A large part of these commitments relates to FP2020 and also concerns gender equality and involvement of men.

The UK, as part of its Strategic Vision for Girls and Women, supports demand-side initiatives through interventions such as communications, working with local religious and political leaders, and outreach with young people. In its efforts to improve adolescent reproductive health, the United Kingdom is implementing programmes in Rwanda and Zambia, aiming to empower adolescent girls through mentoring, peer groups, sexuality and relationship education, and skills training.

In Uganda, the Saving Mothers, Giving Life initiative started a voucher programme for private-sector providers which has been taken over by the government. Also in Uganda, the Every Mother Counts programme supported transport vouchers for 13 500 women, allowing them to deliver their babies in a health facility.

**Finding:** Commitments have not adequately focused on determinants of health outside the health sector, such as safe drinking water, sanitation and hygiene, education, nutrition and food security.

As reported in the PMNCH 2012 report, and similar to the education and empowerment of the public to build demand for RMNCH commodities and services, stakeholders paid little attention to other RMNCH-relevant sectors, such as safe drinking water, sanitation and hygiene, education, nutrition and food security, and transportation. Only 48 stakeholders (22%) out of 220 who made commitments to service delivery and health systems strengthening indicated that they supported activities in these sectors. Most of these stakeholders are NGOs or private-sector organizations. One example is Wateraid, an international NGO: in implementing its commitment, it provided 1.6–1.9 million people with safe water and sanitation services in the past year.

Although the survey results indicate an insufficient focus on the determinants of health, important global initiatives for education and nutrition have been launched. In order to reinvigorate global education efforts, the UN Secretary-General Ban Ki-moon has launched the Global Education First Initiative to put every child in school, improve the quality of learning and foster global citizenship. Education First aims to raise the political profile of education, strengthen the global movement to achieve good-quality education and generate additional and sufficient funding through sustained advocacy efforts.

At the UK’s Nutrition for Growth event, held in London in June 2013 just a week before the G8 Summit, important commitments to improving nutrition were made. Donors pledged new commitments of up to US$ 4.15 billion to tackle undernutrition up to 2020. At the summit, the Global Nutrition for Growth Compact, a global agreement aimed at reducing undernutrition by 2020, was signed by governments, foundations and international partners, including PMNCH, civil society organizations and corporations. Signatories committed to improving nutrition for 500 million pregnant women and young children, reducing stunting, promoting breastfeeding and providing better treatment for severe and acute malnutrition.

Innovative service delivery approaches

**Finding:** Stakeholders, particularly the private sector and non-profit organizations, have committed to developing innovative service delivery solutions and tools.

A clear focus of innovative service delivery approaches is the effective use of mobile telephone technology. For example, expectant and new mothers in Bangladesh, China, India, Mexico, Nigeria and South Africa are sent free mobile telephone messages on prenatal health, reminders of clinic appointments and calls from health mentors by Johnson & Johnson.

In Kenya, Safaricom, the largest Kenyan mobile phone provider, formed a partnership called the Kenya Integrated Mobile Maternal Newborn and Child Health Information Platform (KimMNCHip) which has been
rebranded “Jamii Smart”, Swahili for a smart family. It brings together partners from the Ministry of Health and civil society, with the aim of helping accelerate the attainment of MDGs 4 and 5. The purpose is to support the Ministry of Health in managing the health of pregnant women from conception until the child is 5 years old, by collecting maternal and child health data on an android app through community health workers and health facility staff, and aggregating the data on the government’s cloud-based information system. The service also sends alerts, reminders and tips to mothers and community health workers on clinic appointments, healthy expectancy, safe delivery, immunization and other related requirements. The second phase includes mFinancial Services including “Linda Jamii” a medical micro-insurance product by Safaricom and partners, and mVouchers to facilitate transportation to health facilities. Jamii Smart is currently running in three counties and a nationwide roll-out is anticipated with more support from the Kenyan government.

Another innovative service delivery approach is being supported by the United Nations Foundation (UNF), whose mHealth Alliance seeks to provide a more solid evidence base, linking mHealth to positive impacts in areas such as health systems strengthening, and technology integration and interoperability.

Novartis and the Novartis Foundation for Sustainable Development supported WHO in the development of ICATT (IMCI Computerized Adaptation and Training Tool), an innovative e-learning software program for Integrated Management of Childhood Illness.

Merck for Mothers is addressing two leading causes of maternal mortality (postpartum haemorrhage and pre-eclampsia) and is also focusing on partnerships to develop country capacity in family planning as part its effort to reduce maternal mortality. Merck and PATH have collaborated to develop and implement a novel assessment tool to identify technologies that can save women’s lives in resource-poor settings and to help the global health community make informed decisions about where to invest limited resources. The technology assessment tool and individual technology descriptions are now available online via PATH’s website.

The assessment identified five technologies potentially worthy of further investment: blood pressure measurement devices, improved proteinuria detection, simplified dosing for magnesium sulfate, affordable uterine balloon tamponades and improved oxytocin products.
4.2 Policy commitments

Sound national RMNCH policy frameworks are at the core of implementing the Global Strategy. Stakeholders across constituency groups have made commitments to support government policies concerned with improving women’s and children’s health. This section examines the types of policy targeted by the commitments, as well as the progress in implementation.

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

The spread of supported areas is broad, with many receiving similar levels of attention. However, most attention is being paid to three areas: RMNCH financing, service delivery and technical guidelines, and health workforce policies (Figure 4.3). Support for policies was signalled in the commitments of 51 implementing countries and 85 stakeholders from other constituency groups. However, the priorities allocated to different policy areas differ between implementing countries and other stakeholders.

RMNCH financing policies are supported by 73% of implementing countries that included support for policies in their commitments, compared with only 35% of all other stakeholders. These policies include a range of different measures, such as the development and strengthening of social health insurance schemes, the removal of user fees, incentive schemes for service delivery, the creation of specific budget lines (e.g. for reproductive health policies) and demand-side incentives. One example is the Government of Kenya, which has set up a pilot voucher scheme for reproductive health services covering some parts of the country (free maternity care is already offered in all public facilities). Sierra Leone also is piloting a voucher scheme which should enable the poorest to get access to health services, and in Myanmar a maternal and child health voucher scheme has been created.

Health workforce policies are less strongly prioritized by implementing countries (37%) than by other stakeholder groups (52%). Policies for service delivery receive attention from implementing countries and other stakeholders, at 45% and 58% respectively.

Commitments to information and accountability policies, however, have received much less attention from stakeholders: only 27% of implementing countries and 33% of other stakeholders have committed to introducing them. Nonetheless, there are examples of successful initiatives. The Inter-Parliamentary Union (IPU), which in April 2012 called on 120 parliaments to intensify efforts towards achieving MDGs 4 and 5 by 2015, reported the development of an accountability mechanism to track progress in implementing this resolution. A survey conducted by the IPU showed increased political will for women’s health and significant parliamentary support for maternal and child health, particularly for the determinants of health, gender equality and health workforce strengthening.51

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**Figure 4.3:** Focus of policy commitments to the Global Strategy

Legend:
- Implementing countries that made commitments (N=51)
- Other stakeholders that made commitments (N=85)

Source: Analysis of survey results and commitment text.
Participating parliaments were mostly drawn from Africa where maternal and child death rates are highest, but also from other regions, including two high-income countries. The initiative was highlighted by stakeholders as an opportunity to improve the monitoring of national health budgets and the accountability of governments with regard to CoIA recommendations.

A large share of policies (43–61% across all areas) are implemented at a subnational or national level, particularly for policies on information and accountability, governance and health system reform, and service delivery. The rate of implementation of the other policies is similar at regional, international and organizational or corporate levels, especially for policies relating to the social determinants of health and access to essential medicines.

**Finding:** Stakeholders are making some progress in implementing their policy commitments. For example, about three quarters (76%) of survey respondents indicated that their RMNCH financing policies have been formally approved, have been operationalized, or are being implemented and monitored. Policies in other areas (for example, human rights, gender equity, governance and health system reforms) are still at early stages of development or have yet to be implemented.

Survey results suggest that Global Strategy stakeholders are making progress in implementing their policy commitments. In all seven policy areas, more than half the stakeholders have at least approved or adopted policies. In four this share exceeds 60%: RMNCH financing (76%), information and accountability (68%), access to essential medicines (63%) and health workforce (61%) (as illustrated in Figure 4.4 by the green sections on the right). However, most stakeholders have not yet started to fully implement and monitor policies, as is shown by the proportion of those who have done so, between 18% and 41%.

Progress in implementing financing policies is critical to ensure that those who are least able to pay have access to health services without risking financial hardship. One example of progress is Indonesia, where the number of people covered by health insurance increased from 153.3 million in 2011 to 163.5 million in 2012.

Progress has also been made in implementing service delivery commitments, including technical guidelines. Marie Stopes International has highlighted legislative and regulatory reforms to improve service delivery in Afghanistan, where close cooperation with the Ministry of Health resulted in the development and approval of post-abortion care guidelines in August 2012. In Nigeria, the mHealth Alliance is working with the Federal Ministry of Health to build the enabling environment for mHealth innovation to help strengthen the health system. In Niger, reforms in governance and the health system are about to take effect at the district level.

Survey responses indicate that the implementation of commitments in two policy areas has not advanced as much as expected. Policies for governance and health system reform (37%) and social determinants (38%) have not yet started or are still in the preparatory phase. One possible reason is the complexity inherent in these policies.

One organization that addresses social determinants is Together for Girls, a global partnership dedicated to
eliminating sexual violence against children, with a particular focus on girls. Together for Girls reports that it has supported five countries in completing a Violence Against Children Survey (Haiti, Kenya, Swaziland, the United Republic of Tanzania and Zimbabwe) and these countries are now implementing national response plans (see Box 6.1 in Chapter 6 for more details). The Tanzanian Government has also developed a policy on gender-based violence and medical management guidelines on violence against children, including a training package with specific protocols for children.

4.3 Commitments to research and innovation

**Finding:** Research commitments focus strongly on operations and policy. Research on the impact of interventions receives little attention, even though it is essential to inform RMNCH policies and service delivery.

Research and innovation are vitally important to inform and advance policy and service delivery for RMNCH, in order to achieve maximum impact. Forty-one stakeholders made a commitment to research. Of these, 20 (49%) focus on operational research, such as effective programme practices or identifying facilitating factors and challenges to the implementation of programmes and interventions, for example sociocultural influences (Figure 4.5). Another 16 (36%) committed to promote the links between research and policy development and to advance research on policy implementation and how policies may act as either barriers or enablers for improving RMNCH, for example the impact of laws on the introduction of new policies. Slightly fewer stakeholders (13, or 30%) focus on pharmaceutical and biomedical research, including basic research and product innovations. Research on the impact of health interventions, including efficacy, is being targeted by only five stakeholders, even though this is essential to inform RMNCH policies and service delivery.

One example of progress is the Malaria in Pregnancy Preventive Alternative Drugs (MiPPAD) project being coordinated by the Barcelona Institute for Global Health. It aims to contribute to the development of new clinical interventions to fight malaria in pregnant women by evaluating different antimalarial drug alternatives in the context of insecticide-treated nets. Clinical trials involving over 5800 pregnant women have compared the safety and efficacy of the currently recommended drug for intermittent preventive treatment in pregnancy (IPTp), sulfadoxine-pyrimethamine, with mefloquine. Trials have included HIV-infected pregnant women to provide a better understanding of the interactions between antimalarial and HIV treatments. Results will be published in the second half of 2013. The project also includes capacity strengthening and promoting networking and coordination between European and African partners.

Another example of progress in advancing impact research is the Global Health Workforce Alliance, which commissioned an analysis, based on a global systematic review and several country case studies in low- and middle-income countries, to investigate the experiences of mid-level health workers in terms of their impact on the health-related MDGs (with a significant focus on RMNCH) and other priority health services. The aim is to better understand the effectiveness of mid-level health workers and how they can be appropriately integrated into national health systems. They found that they play an important role in the delivery of maternal and child health services, antiretroviral therapy, health promotion, and the prevention of and care for noncommunicable diseases. The quality of care they delivered was not significantly less than that of physicians, and was even better in a few outcome measures.

Stakeholders focus more or less equally on conducting research and disseminating findings across all research areas for which commitments were made. Progress reported by stakeholders in the implementation of their commitments relates predominantly to these.

Analysis of survey results shows that in all research areas capacity building and financing for research receive less attention. For all research areas a stable share of 14–21% of stakeholders indicated that their commitment was focused on financing and capacity building, compared with 28–37% for conducting and disseminating research. Unless more attention is paid to these important foundations for conducting research, this trend could limit the quality and quantity of research results and thus the long-term progress towards improving women’s and children’s health. Very few stakeholders reported progress in this regard. The Barcelona Institute for Global Health with their MiPPAD project and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) are implementing projects that seek to strengthen the research capacity of frontline workers. RANZCOG also works with individuals to build local research capacity through associated partnerships and mentorship support.
5.1 Introduction

Contraception and family planning are human rights. All couples and individuals have the right to decide freely and responsibly whether and when to have children, along with their right to attain the highest standard of sexual and reproductive health, and to make decisions free from discrimination, coercion and violence. These choices help empower women and girls, supporting their full and equal participation in society. Family planning services can also save women’s lives by reducing unintended and high-risk pregnancies and unsafe abortions. These services can also help improve the survival rates of newborns and children by lengthening intervals between pregnancies.

Continued high fertility rates and huge unmet needs for family planning in many Countdown countries, especially in sub-Saharan Africa, highlight how important it is to broaden access to contraception. The median coverage of the CoIA indicator “demand for family planning satisfied” for the 37 Countdown countries with recent data is 61%, ranging from 15% (Chad) to 95% (Viet Nam). The need for family planning among adolescent girls (aged 15–19 years) is greater than among 30–34-year-old women in low- and middle-income countries. These figures indicate that significant additional investment in family planning services, including targeting adolescents, is urgent.

Figure 5.1 shows the acceleration of family planning initiatives in recent years.

Figure 5.1: Timeline of key events for family planning, 1987–2012

Launch of the Safe Motherhood Initiative
Beijing Platform for Action
World Health Report 2005 – Make Every Mother and Child Count
Recognition and inclusion of “access to reproductive health” in the Millennium Development Goals (as 5B)
Launch of the Global Strategy and the Commission on Information and Accountability for Women’s and Children’s Health
Launch of the HANDtoHAND Campaign by Reproductive Health Supplies Coalition
UN Commission on Life-Saving Commodities
London Summit on Family Planning and launch of Family Planning 2020
International Conference on Population and Development Programme of Action

Adding it up: The costs and benefits of investing in family planning and maternal and newborn health (Guttmacher Inst and UNFPA)
Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health
Lancet Series on Family Planning
Comprehensive family planning services and safe abortion services are two of the five vital interventions listed in the Global Strategy. Also explicitly recognized is the importance of MDG 3 (to promote gender equality and empower women) in achieving MDGs 4 and 5. A rights-based approach to women’s and children’s health, wider social change, shifts in gender norms, and freedom from gender-based violence and discrimination are all relevant to women’s ability to make decisions on their reproductive health and seek family planning services. The Global Strategy’s two target outcomes for family planning are:

2. In 2015 alone, 43 million new users gain access to family planning.

One of the CoIA’s recommended 11 core indicators for monitoring progress on RMNCH is “met need for contraception”, or demand for family planning satisfied.58

A 2012 review by PMNCH, WHO and the Aga Khan University identified a set of essential interventions, commodities and guidelines for RMNCH, highlighting voluntary family planning as an important intervention during adolescence, pre-pregnancy and in the postnatal period.59 The methods recommended include: barrier methods, short-acting methods (such as oral contraceptives), emergency contraceptives and hormonal injections, long-acting reversible contraceptives (such as implants or intrauterine devices) and surgical contraception in specific circumstances. Counselling on family planning is recommended as part of an antenatal care package.

Box 5.1: FP2020 and the London Summit on Family Planning

The London Summit on Family Planning on 11 July 2012 was organized under the auspices of the UN Secretary-General and co-hosted by the UK Government and the Gates Foundation in partnership with the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID). The summit aimed to:

- revitalize global commitments to voluntary family planning and access to contraceptives as a cost-effective and transformational development priority;
- improve the access to and distribution of contraceptive supplies;
- ensure girls’ and women’s rights are respected and enhanced;
- remove and reduce barriers to family planning.

Over 50 countries and development partners participated in the summit and to date, 68 commitments have been made.61 Some commitments had been included in previous Global Strategy commitments, others were partially included and yet others were new. Around US$ 2.6 billion was pledged at the summit by donors and the private sector; of this, new funding committed to the Global Strategy to 2015 totalled an estimated US$ 1.1 billion.62

FP2020 builds on the summit by enabling country ownership and fostering innovative partnerships. Its goal is to provide an additional 120 million women and girls with access to voluntary family planning services, contraception and information in the 69 countries with a 2010 per capita gross national income of US$ 2500 or less.63

The key objectives of the FP2020 movement are to:

- track progress of the commitments made at the summit, in line with the accountability mechanisms prescribed under the Every Woman Every Child initiative;
- monitor and report on global as well as countries’ progress towards the summit’s goals;
- identify barriers to achieving the summit’s goals;
- promote voluntary family planning and the prevention of coercion and discrimination in line with fundamental human rights;
- ensure data availability to support these objectives;
- publish annual reports to update the global community on progress and challenges.64

FP2020 has established a global governance framework to ensure accountability. It is led by an 18-member Reference Group, guided technically by four Working Groups, and operated by a Task Team on a day-to-day basis. FP2020 is hosted by the UNF.

The report from the UN Commission on Life-Saving Commodities for Women and Children identifies three contraceptive products as essential but under-supplied: female condoms, contraceptive implants and emergency contraception.

5.2 Overview of commitments and trends

Findings:

- An estimated 40% (117) of commitments to the Global Strategy include family planning. The London Summit on Family Planning (11 July 2012) was a major driver of recent increases, generating 68 commitments.
- Low- and middle-income countries have made 46% of the family planning-specific commitments, followed by NGOs (27%). The private sector has made only 1% of the commitments in this area, but these are of high monetary value.

Overall, 117 stakeholders (over 40%) indicated support for family planning, more than any other area on the continuum of reproductive, maternal, newborn and child care.

The number of family planning commitments has increased from 82, as reported in the PMNCH 2012 Report, to 117. This is largely due to the London Summit on Family Planning in July 2012, where FP2020 was launched (Box 5.1).60
Low- and middle-income countries have made a significant proportion of the commitments to family planning (46%), more than their share of the overall commitments (22%). NGOs have made 27% of the commitments. Commitments by private-sector stakeholders to family planning are particularly few (1%) compared with other constituencies and with overall private-sector commitments to the Global Strategy (15%).

Half of these commitments relate to sub-Saharan Africa. This focus is particularly significant: of the 39 Countdown countries with a fertility rate of four or more children per woman, 35 are in sub-Saharan Africa.

The countries subject to the largest number of family planning commitments are also in sub-Saharan Africa, as well as in Bangladesh and India. Table 5.1 presents the countries with the highest number of commitments, the Countdown indicator for the demand for family planning satisfied, and the contraceptive prevalence rate in these countries.

There are considerable differences in the number of commitments for family planning by country. As Table 5.1 illustrates, there is no clear link between the number of commitments and key family planning indicators. Eight of the 75 countries have no family planning commitments (Azerbaijan, Democratic People’s Republic of Korea, Equatorial Guinea, Guinea-Bissau, Gambia, Iraq, Sao Tome and Principe, and Turkmenistan). Guinea-Bissau is an example of a country with no family planning commitments despite low satisfaction of demand for family planning (29%).

![Figure 5.2: Family planning commitments by constituency](source: Analysis of survey results and commitment text.)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of commitments</th>
<th>Demand for family planning satisfied (2007–2012), %</th>
<th>Contraceptive prevalence rate (2007–2012), %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Most commitments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>12</td>
<td>58</td>
<td>34</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>12</td>
<td>53</td>
<td>29</td>
</tr>
<tr>
<td>Nigeria</td>
<td>11</td>
<td>43</td>
<td>15</td>
</tr>
<tr>
<td>India</td>
<td>12</td>
<td>73</td>
<td>55</td>
</tr>
<tr>
<td>Ghana</td>
<td>10</td>
<td>40</td>
<td>34</td>
</tr>
<tr>
<td>Uganda</td>
<td>10</td>
<td>47</td>
<td>30</td>
</tr>
<tr>
<td>Kenya</td>
<td>10</td>
<td>64</td>
<td>46</td>
</tr>
<tr>
<td><strong>No commitments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
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</tbody>
</table>

N/A: not available
**Box 5.2: Impact of the FALAH programme in Pakistan**

Family Advancement for Life and Health (FALAH) was a five-year programme (2007–2012) in 20 districts in Pakistan, funded by USAID and led by the Population Council, in partnership with the government. Its objective was to increase demand for family planning by changing people’s perception of birth spacing through improving knowledge and access to family planning and birth spacing services.

Evidence suggests that FALAH’s awareness-raising campaigns increased contraception uptake (by 8.5%), met needs for family planning (by 9%) and helped avert early pregnancies and marriages at a young age. A third-party evaluation by Gallup International also found that at least 50 million people (66% of the population over 18 years of age), mostly in rural areas, viewed FALAH’s advertisements at least once, agreed with their messages and would advise others on this. The programme also: developed training packages for public service providers (and trained around 24 450 providers), improved coordination between departments of health and population welfare, revised the National Standards for Family Planning, and operationalized a contraceptive logistic system. In addition, the quality of family planning services in the private sector was improved by providing training and developing geographical information system software.

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**Nature and focus of commitments**

**Findings:**

- Commitments focus on: improving access to and delivery of family planning services and commodities; addressing demand-side barriers; integrating family planning with other health-care services; and mobilizing political and community support.
- Several commitments use terms such as “rights” and “gender”, reflecting the recognition that programmes need to be rights based.

This section provides several examples of family planning commitments, organized by focus area.

**Improving delivery of family planning services:** The health workforce crisis affects all aspects of the health system, including family planning services. Countries such as Nigeria and Sierra Leone have made training front-line health workers in family planning services, including new and underused methods, an explicit action under their commitments. Some NGOs are also working in this area. For example, EngenderHealth has committed to train providers to counsel clients seeking family planning services and to promote a wide range of good-quality family planning methods.

**Addressing demand-side barriers:** Creating awareness is an important aspect of generating demand for family planning services. The Family Advancement for Life and Health (FALAH) programme in Pakistan has shown that young couples can see the benefits of birth spacing and delayed pregnancies (see Box 5.2). Awareness campaigns are also critical for tackling the cultural and societal barriers that were identified in the survey as one of the main constraints to using family planning services. Awareness initiatives inform women of their right to make reproductive and sexual choices. Liberia and Niger have committed to mainstream gender issues and address domestic violence. Empowering women is a key element of family planning.

**Tackling commodity security issues:** Supply-side interventions, such as reducing the cost of contraceptives and ensuring access in isolated areas, can have a significant impact. Ensuring commodity security and reducing stock-outs to zero have been identified as important goals by a number of commitment-makers. For example, Haiti, Madagascar, Mongolia and Senegal have pledged to achieve commodity security. Burkina Faso has explicitly pledged to reduce the cost of contraceptives. The Reproductive Health Supplies Coalition (RHSC) committed to getting 100 million new users of modern contraceptives through the launch of the HANDoHAND campaign (mentioned in Figure 5.1), mobilizing resources, providing supplies and scaling up services. Pledges were made by organizations and companies such as APROFAM (the largest non-governmental family planning provider in Guatemala), Bayer Pharmaceuticals, the UK Department for International Development, Merck MSD, Pathfinder International, UNF, UNFPA and USAID. The pledges include: increasing the supply of contraceptives by at least 2% per year in over 45 countries, ensuring greater access to affordable commodities through reducing prices, and providing over US$ 215 million in new financing for reproductive health. The Population Council, as part of its commitment to support the London Summit on Family Planning, committed to engage pharmaceutical companies to license, register and manufacture technologies it has developed so as to expand people’s choices in low- and middle-income countries.

**Improving service integration:** Some commitments are aimed at better integrating family planning with other health services, such as HIV programmes. For instance, Indonesia pledged to include family planning in its universal health coverage programme in 2014; and Niger committed to integrating family planning with school health curricula. IntraHealth International committed to foster a greater integration of family planning with HIV/AIDS services. WHO committed to working with countries to integrate the WHO Medical Eligibility Criteria Family Planning wheel and related guidelines into health systems so as to improve the access to and quality of family planning services.

**Mobilizing political and community support:** Political support in some countries, such as Kenya and Malawi, has taken the shape of commitments to help create dedicated budget lines for family planning. Local champions have also been identified as important. For instance, Burkina Faso has committed to take action, through policy, funding and programming, to improve outcomes for family planning under the leadership and advocacy of its First Lady. Engaging with community and religious leaders can be vitally important, depending on the social and cultural contexts of countries. For instance, Indonesia and Senegal list harnessing the support of community and religious leaders as an important field of action.
These examples are representative of the majority of family planning commitments, which focus on the provision of information, services and commodities and are consistent with the recommendations of the Global Strategy, Essential Interventions, Commodities and Guidelines for RMNCH and the UN Commission on Life-Saving Commodities for Women and Children.

However, some gaps have not been addressed by the commitments. Ensuring the involvement of men in family planning programmes in particular and RMNCH initiatives in general is recommended in the PMNCH 2012 report. However, the words “men” and “male” are only mentioned in 16% of the family planning commitments. One example is the Ghanaian government’s advocacy and communications to improve male involvement, such as its “Real Man” campaign. Also lacking are interventions aimed at the most important underused methods identified by the UN Commission on Life-Saving Commodities for Women and Children. For instance, emergency contraception was only mentioned in 3% of family planning commitments, and implants and female condom in less than 1% of them.

5.3 Implementation

**Finding:** Many stakeholders have made significant progress in implementing their commitments and some data are beginning to emerge concerning the Global Strategy’s goals of preventing 33 million unintended pregnancies and reaching 43 million new users in 49 countries in 2015. Progress is being bolstered by FP2020’s target to provide an additional 120 million women and girls with access to voluntary family planning services, contraception and information in 69 countries.

Consistently with the overall response of commitment-makers, half of the respondents committing to provide family planning services indicated that implementation would be completed by 2015. Almost a quarter of the respondents indicated that there was not enough evidence to decide on this; some noted that they had commitments with implementation horizons beyond 2015.

Examples of progress reported by some commitment-makers are as follows.

As part of Cambodia’s commitment to increase the proportion of couples using modern contraception methods, the number of health centres providing intrauterine device insertion services rose from 648 in 2010 to 922 in 2012. Indonesia committed to provide long-acting contraceptive methods (intrauterine devices and implants) free of cost nationwide and every family planning method in 7 of 33 provinces; free contraceptives are being provided to all poor families, comprising 46% of total family planning needs.

Liberia reported that the number of couples protected against unintended pregnancies increased from 38 342 in 2010 to 51 816 in 2012 (see Box 5.3). In Senegal an estimated 8% increase in the contraceptive prevalence

**Box 5.3: Liberia’s strategy for family planning**

In 2010, Liberia committed to increase health spending from 4% to 10% of the national budget, and to double the number of midwives trained and deployed, both by 2015. In terms of interventions for family planning, Liberia has committed to:

- providing free universal access to health services, including family planning, and increase the proportion of clinics providing emergency obstetric care services from 33% to 50%;
- addressing the social determinants of ill health through improving girls’ education and mainstreaming gender issues in national development.

Reported achievements:

- In 2012, 8.4% of the national budget went to health.
- Family planning awareness and education is part of the adolescent health programme.
- In 2012, 232 132 women of reproductive age (15–49 years) were provided with family planning services, excluding those who chose condoms.
- Oral pills and injectables (Depo) were widely distributed; 89 477 new users (41 726 for oral pills and 47 751 for Depo) were provided with them.
- Intrauterine contraceptive devices (426 women) and implants (6852 women) had a limited distribution among females, partly due to deficient service provision and inadequate access to family planning information.
- The number of couples protected against unintended pregnancies increased from 38 342 in 2010 to 51 816 in 2012.
rate in one district in a period of only 10 months shows its progress towards achieving a contraceptive prevalence rate of 27% by 2015.

The President of the Philippines has signed legislation concerning responsible parenthood and reproductive health, and put in place an administrative order to ensure contraceptive self-reliance by everyone. Kenya has enshrined individuals’ rights to good-quality reproductive health care, including family planning information, services and supplies in its constitution.

Development partners have reported progress in implementing family planning commitments. For example, the Gates Foundation concluded an agreement with Bayer HealthCare for a volume guarantee for the Jadelle contraceptive, a long-acting, reversible contraceptive implant, making it available to more than 27 million women in low-income countries at a more than 50% reduced price for the next six years. In May 2013, the Gates Foundation and Merck announced a six-year agreement to improve access to Merck’s long-acting contraceptive Implanon. As part of the agreement, Merck agreed to reduce the price of Implanon by 50% in the countries identified as priorities during the London Summit on Family Planning (see Box 5.1 above).

The International Planned Parenthood Federation (IPPF) is making progress towards its commitments, made under the Reproductive Health Supplies Coalition (RHSC’s) HANDtoHAND Campaign which seeks to enable an additional 100 million women to have access to contraception by 2015. IPPF committed to increase the number of new users of IPPF contraceptive services by at least 50%, at least doubling the number of unintended pregnancies averted, and delivering 80% of its services to the poorest, most marginalized, socially excluded and underserved women and young people. Its reported achievements are highlighted in Box 5.4.

Women and Children First reported an increase in the use of modern temporary contraceptives from 19% to 40% in a 15-month period in the urban slums of Dharavi in Mumbai, India, where the organization is targeting 2258 married women of reproductive age (15–49 years).

The Aman Foundation committed to undertake research to improve the quality and effectiveness of family planning programmes and services in targeted areas of Pakistan. To achieve this, it piloted a community programme with 50 female health workers, and provided telephone family planning counselling.

As part of the BBC Media Action’s commitment to scale up its work in Africa and Asia using media and communications to improve health, it broadcast public service announcements to support birth spacing in the Indian states of Bihar, Madhya Pradesh and Orissa.

5.4 Accelerating progress: opportunities and challenges

**Finding:** To accelerate progress, political commitment at the highest level is needed to promote voluntary family planning. Countries need to continue to strengthen the training of front-line health workers in the provision of family planning services. Countries and development partners should build on and augment their financial commitments. A wide range of demand-side interventions are needed to address deep-rooted social, cultural and behavioural factors that inhibit women and girls from accessing family planning information and services.

Political commitment at the highest level is necessary to promote voluntary family planning in the broader context of health and economic development and to integrate it with relevant programmes, for example for gender, women’s empowerment, rural development and improved education.

In family planning, front-line health workers need to be trained in the provision of services and sensitized to the needs of people demanding these services, especially women. Task shifting (for example, training community health workers to provide specific contraception services such as oral contraceptives, injectables and condoms) offers a significant opportunity to increase access to family planning information and services, especially in under-resourced areas.

Both countries and development partners need to commit more financial resources to family planning. India, Indonesia and the Philippines are among the countries that have increased their funding commitment to family planning over the past few years; more countries need to follow their example. Overall ODA

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**Box 5.4: IPPF’s implementation progress**

- The number of contraceptive services provided increased by over 20%, from 43.8 million in 2010 to 52.7 million in 2012. There were 7.3 million new users of contraceptive services in 2012, compared with 6.0 million in 2010.
- The number of unintended pregnancies averted increased by more than one third between 2010 (3.7 million) and 2012 (4.9 million).
- The numbers of unsafe abortions averted were 550 000 in 2012.
- In 2010, 31 million sexual and reproductive health services were provided to young people. This increased to 37 million in 2011 and 45 million in 2012 – increases of 19% and 45% respectively from the 2010 baseline.
- A national advocacy model was piloted in six countries to improve family planning policy and the regulatory environment. This resulted in governments increasing resource allocation, adding contraceptives to the approved list, and enacting commodity security policies in these countries.
- Supported the Merck Implanon Access Initiative and the Bayer HealthCare AG Jadelle Access Programme in its capacity as a member of the RHSC.
disbursements for family planning in Countdown countries increased by around two thirds from 2008 to 2011, despite falling from 2009 to 2010. Donor funding for contraceptives has remained more or less constant since 2001: when rising demand is accounted for, donors are satisfying a smaller proportion of people’s needs for contraceptives every year. A projection of combined family planning ODA and domestic expenditures for 2011–2015 estimates that a further 40% of the financing gap for family planning identified in the Global Strategy would be closed.

As with other aspects of sexual and reproductive health and rights, a wide range of demand-side interventions are needed to address deep-rooted social, cultural and behavioural factors that inhibit women and girls from accessing family planning information and services. Fear of punishment, including violence from partners and/or families, stigma and inequitable access to education are just a few examples.

Finally, a clear message from the family planning thematic analysis is that advocacy and partnership are vital to accelerating progress. As the London Summit on Family Planning demonstrated, global and regional forums can be extremely effective in mobilizing opinion and stimulating significant financial and policy commitments. Strategic partnerships can build political support and encourage leaders to champion family planning. At a local level, partnerships with community-based organizations and leaders help increase the reach and awareness of the services being offered.

However, more private-sector participation is needed. The UN Commission on Life-Saving Commodities for Women and Children and the family planning community have recognized the role of the private sector, not only in health-care provision and commodities, but also in sectors like consumer goods and the media and in other global health initiatives. Countries such as Burkina Faso, Indonesia, Malawi and Nigeria have also stressed the potential benefits of partnerships with private-sector actors in their commitments. Notable examples exist of successful private-sector commitments and progress (e.g. the Female Health Company, Merck and Bayer) but innovative ways to engage with the private sector are still required.
Adolescent health

6.1 Introduction

It is widely recognized that improving reproductive, maternal and child health will require concerted effort to improve the health of adolescents, particularly because of the rising number of young people globally. In 2013 there were 1.2 billion adolescents aged 10–19 years, which is expected to exceed 1.3 billion by 2030. Every year 16 million girls aged 15–19 get pregnant. Births to adolescent mothers account for 11% of all births worldwide, but these mothers carry a disproportionate burden of ill health due to pregnancy and childbirth (23%). Complications from pregnancy and childbirth are a leading cause of death for girls aged 15–19 in low- and middle-income countries. Children born to mothers aged 12–17 are significantly more likely to die during their first year of life than those born to mothers in other age groups. Pregnant adolescents have a greater risk of preterm labour and delivery than older women; the younger the age, the higher the risk. The risk of low birth weight among infants born to adolescent mothers is also high. In addition, around 2.2 million adolescents are living with HIV, of which 60% are girls.

Since 2007 the worldwide focus on adolescent health has sharpened, as detailed in global reports, initiatives, resolutions and peer-reviewed journals (Figure 6.1).
The Global Strategy, which identifies adolescents as a vulnerable group and an area where action is needed, appears to have catalysed a range of initiatives on adolescent health.

The Global Strategy notes several important challenges connected to adolescent girls’ health: unintended pregnancy; pregnancy-related mortality and morbidity in adolescent girls; and lack of gender parity in education. However, its targets and outcomes include no specific reference to adolescents.

Although the CoIA did not identify specific priorities for adolescents, its recommendation to disaggregate health indicators is highly relevant to adolescents, since data disaggregation by age is essential for the assessment of adolescent health.

The Essential Interventions, Commodities and Guidelines for RMNCH groups together essential interventions for adolescence and pre-pregnancy, in particular family planning. Other focus areas for adolescence are the prevention and management of sexually transmitted infections (STIs) and folic acid fortification (supplements) to prevent neural tube defects in offspring (though this is not specifically beneficial to adolescents’ health).

### 6.2 Overview of commitments and trends

**Finding:** Slightly over a quarter of total commitments to the Global Strategy (77 out of 293, or 26%) relate to adolescent health. NGOs account for 32% of the 77 adolescent health commitments, while low- and middle-income countries account for 37%; all other constituency groups, including multilateral organizations, foundations and the private sector, account for less than 10% each.

Approximately 26% (77 out of 293) of commitments to the Global Strategy are specifically related to adolescent health. As shown in Figure 6.2, 32% of these commitments have been made by NGOs, 25% by low-income countries and 12% by middle-income countries, with very few commitments from high-income countries, foundations and health-care professional associations, and no commitments from multilateral organizations. This suggests that the drive to address and prioritize needs in adolescent health is largely led by governments and NGOs. There may be a greater need for advocacy to the

<table>
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<tr>
<th>Country</th>
<th>Number of commitments</th>
<th>Population of adolescents aged 10–19 years (’000), and as % of total population (2010)</th>
<th>Adolescent birth rate per 1000 females aged 15–19 years (2000–2010)</th>
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<tr>
<td>United Republic of Tanzania</td>
<td>11</td>
<td>10 198 (23%)</td>
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<td>8 063 (24%)</td>
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<td>242 991 (20%)</td>
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<td>35 326 (22%)</td>
<td>123</td>
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<td>Kenya</td>
<td>9</td>
<td>9 135 (23%)</td>
<td>106</td>
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<td>31 514 (21%)</td>
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<td>Congo</td>
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<td>888 (22%)</td>
<td>132</td>
</tr>
</tbody>
</table>

Source: Analysis of survey responses.
global community to raise awareness of adolescent health needs and for strengthening and renewing specific commitments to adolescent health.

In total, commitments with adolescent health components were made to 69 countries, mostly in sub-Saharan Africa, East Asia and the Pacific region. Countries with the highest and lowest number of adolescent health commitments are detailed in Table 6.1. In general, countries receiving the most commitments have bigger populations of adolescents and/or high adolescent fertility rates. However, other countries with similar adolescent fertility rates and size of adolescent populations received no commitments (e.g. Iraq, which has a similar adolescent population to Uganda, with 10 commitments, and the Congo and Gabon have adolescent fertility rates similar to Bangladesh and Uganda).

Although adolescents and young people did not figure prominently in the MDGs, they are becoming increasingly visible in global health at all levels, and starting to have an influence on decision-making. The clear trend has been evident in the ongoing consultations and debates on the post-2015 development agenda.97 Another example is the increased attention to family planning in 2012, which has benefited adolescents: 20 of 68 commitments made at the London Summit on Family Planning related to adolescent health (see Chapter 5).

Nature and focus of commitments

**Findings:**

- Commitments relate to: adolescent sexual and reproductive health policies and services; reducing early, child and forced marriage; improving access to educational services; reducing violence against girls; and increasing youth empowerment.
- Commitments are broadly in line with the main gaps and priorities, but pledges to disaggregate data by age are lacking. Reducing coerced sex and unsafe abortion among adolescents receives little attention. Also there are no commitments to increase access to skilled antenatal, childbirth and postnatal care specifically for adolescent girls.

Most commitments to adolescent health refer to specific target groups (e.g. girls, young people) as opposed to specific issues (e.g. violence, early marriage). The main focus areas and selected examples illustrating the diversity of commitments follow.98

**Sexual and reproductive health policies aimed at adolescents:** Benin committed to developing adolescent sexual health policies; Malawi to developing a comprehensive sexual and reproductive health programme to meet the needs of young people; and Mali to implementing a national strategic plan for improving the reproductive health of adolescents.

**Health services tailored to adolescents:** Bangladesh, Ethiopia, Kyrgyzstan, Madagascar and Tajikistan committed to providing youth-friendly services and facilities. Save the Children committed to strengthening the capacity of 143 600 front-line providers to deliver adolescent-friendly sexual and reproductive health and family planning services.

**Early and forced marriage:** Bangladesh and Niger committed to implementing a minimum legal age for marriage; Burkina Faso to enforce the laws against early and forced marriage; and Sudan to advocate for the elimination of early marriage.

**Access to educational services:** Liberia committed to expanding girls’ education; the Women’s Health and Education Centre to creating health-promoting schools; and the Akaa Project in Ghana to making efforts to offer more academic and job opportunities to adolescent females.

**Violence against girls:** Burkina Faso committed to enforce laws against female genital mutilation; and Sudan to advocate for its elimination.99 The Body Shop committed over US$ 2.5 million to their Stop the Sex Trafficking of Children and Young People initiative.

**Youth empowerment:** The University of Aberdeen’s IMMPACT unit committed to work with PMNCH in spearheading the Y@U campaign to engage university students in the North and South in mobilizing support and promoting accountability for keeping mothers and babies alive and well. The Ford Foundation committed to supporting individuals and organizations working to ensure that young people are empowered to gain access to sexual and reproductive information and services.

As these examples show, commitments to adolescents generally address gaps and priorities identified in the Global Strategy and other key initiatives (Figure 6.1 above), including reducing the practice of marriage before the age of 18 and pregnancy before age 20, as well as increasing the use of contraception by adolescents at risk of unintended pregnancy. However, commitments to disaggregate data by age are lacking, as are commitments in the following three main intervention areas identified in the WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries.100

1. Reduction in coerced sex among adolescents: a number of commitments relate to reducing violence (e.g. gender-based, sexual and domestic violence). However, coercion is actually mentioned only in the UK Department for International Development’s commitment to work with partners to ensure there are safeguards against it.

2. Reduction in unsafe abortion among adolescents: although some commitments to adolescents mention abortion, this is usually related only to post-abortion care. The exceptions are Zambia (committed to reducing abortion) and the Youth Coalition for Sexual and Reproductive Rights (improving access to safe abortion).

3. Better and more skilled antenatal, childbirth and postnatal care and reduction in pregnancy-related mortality and morbidity in adolescent girls: although
the increased use of skilled care was noted in several commitments to women’s health, it was not mentioned in any commitments to adolescent health.

### 6.3 Implementation

**Finding:** Approximately 40% of survey respondents indicated that the implementation of their commitments to adolescent health would be completed by 2015.

Approximately 40% (13) of the 33 survey respondents who had made a commitment to adolescent health and also answered the question indicated that the implementation of their commitment would be completed by 2015, with 30% indicating otherwise, and a further 30% unsure. These results are largely consistent with overall survey responses in terms of the proportion of respondents indicating that the implementation of their commitments would be completed by 2015.

Highlights of progress reported by some stakeholders on implementing their adolescent health commitments are presented below.

India is making progress in integrating adolescent health into its efforts to improve women’s and children’s health (Box 6.1).

**Senegal** committed to creating a national directorate for maternal, newborn and child health (MNCH), reinstating the national committee in charge of implementing the multisectoral roadmap for the reduction of maternal and child mortality. This includes a bureau dedicated to adolescents. A strategic plan for adolescents is being developed. Senegal also committed to generating demand for family planning through mass media communication and community mobilization with targeted messages to increase the involvement of young people. It is promoting information and communication technology (ICT) to reach adolescents, and has established youth counselling centres in each region.

**GAVI** committed to increasing access to the human papilloma virus (HPV) vaccine against cervical cancer in the world’s poorest countries. Countries will be required to test ways of delivering the HPV vaccine with other interventions that benefit the health and well-being of girls. In 2013, the first 10 countries were approved for HPV demonstration programmes: Ghana, Kenya, Lao People’s Democratic Republic, Madagascar, Malawi, Niger, Sierra Leone, United Republic of Tanzania, Mozambique and Zimbabwe. GAVI will procure 270 000, 735 000 and 410 000 doses of vaccine in 2013, 2014 and 2015, respectively. The goal is to vaccinate 30 million girls in over 40 countries by 2020.

**Together for Girls**, an NGO, committed to eliminate sexual violence against children, particularly girls. Its approach has three pillars: conducting and supporting national surveys on the magnitude and impact of

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**Box 6.1: India’s progress in implementing its adolescent health commitments**


The new strategy targets adolescents at their natural places of congregation such as schools, vocational training centres, teen clubs and the community. Services will be provided through teachers, peer educators and community-based service providers. Interventions have been designed to provide information, commodities and services at the community level with referral linkages through the three-tier public health system in six core areas: sexual and reproductive health, nutrition, substance misuse, violence (including gender-based violence), NCDs and mental health.

Achievements as of July 2013 include:

- a school health programme involving universal screening, focusing on disease, deficiency and disability among 270 million children and adolescents, deploying 17 466 mobile teams;
- weekly iron-folic acid supplements for 130 million adolescents, both in and out of school;
- 5 680 adolescent-friendly health clinics are providing services, commodities and information on reproductive and sexual health;
- 851 adolescent reproductive and sexual health counsellors and 83 360 peer educators are increasing outreach;
- 10 million girls are being provided with sanitary napkins under the Menstrual Hygiene Promotion Scheme;
- in 2012-2013 alone, 7343 medical officers and 21 143 auxiliary nurse midwives/Anganwadi workers/multipurpose health workers have been trained across the country under the Adolescent Reproductive and Sexual Programme.

The Government of India is also working to ensure free and compulsory education up to age 14 through the Right to Education legislation.

Source: Survey responses and interviews.
violence against children, particularly sexual violence against girls; supporting coordinated programmes and actions in response to the data; and leading global advocacy and public awareness efforts to draw attention to the problem and promote evidence-based solutions. Working with governments and civil society, the NGO builds on existing programmes and platforms wherever possible to integrate the issue of sexual violence into social welfare, health, education and justice programmes. Progress in implementing its commitments is outlined in Box 6.2.

The World Association of Girl Guides and Girl Scouts (WAGGGS) is the world’s largest voluntary movement dedicated to girls and young women, with more than 10 million members in 145 countries. Its objective is to support girls and young women in developing their full potential as responsible global citizens by focusing on education and empowerment. As part of its commitment to the Global Strategy, WAGGGS pledged to deliver educational programmes, implement community action projects and advocate for change at national and community levels. Box 6.3 below highlights the significant progress already made.

Box 6.2: Together for Girls’ progress in implementing its commitments

- Haiti, Kenya, Swaziland, the United Republic of Tanzania and Zimbabwe have completed national household violence against children surveys (VACS) and are implementing national response plans, developed and led by national government multisector task forces, to address the surveys’ findings. Many of these countries need funding to effectively implement their violence prevention and response programmes.

- The Tanzanian Ministry of Health and Social Welfare has developed gender-based medical management guidelines on violence and violence against children, with a corresponding training package including specific protocols for children.

- The results of the surveys, and ensuing communications and advocacy efforts globally, led to Swaziland drafting legislation on child welfare and protection and on domestic violence, enacted in 2012. The US President’s Emergency Plan for Aids Relief (PEPFAR) committed US$ 5 million in 2012 to Together for Girls, in order to translate VACS findings into programme and policy responses.

- Together for Girls is working with girls in Kenya and the United Republic of Tanzania through peer-supported and peer-led girls’ clubs and radio clubs to establish safe spaces and provide education and life skills training on gender-based violence and reproductive health, including HIV prevention.

- Many countries wish to complete VACS as a critical step in their work to protect children and prevent violence, but lack the funds to pay local researchers who would undertake the surveys.

Source: Survey responses and interviews.

Box 6.3: The World Association of Girl Guides and Girl Scouts’ progress in implementing its commitments to adolescent health

- World Thinking Day, an annual celebration day for WAGGGS, was celebrated on 22 February 2013, focusing on MDGs 4 and 5.

- An informal educational programme was launched in February 2013 across its 145 member countries. Non-member countries also participated: 176 countries downloaded the activity packs. The main aim was to educate girls and young women on MDGs 4 and 5. An estimated 900 000 children and young people took part in the activities.

- The Take Action Backpack, an MDG 4 and 5 toolkit to encourage advocacy and provide opportunities for young women to speak out and influence decision-makers, is planned to be launched in 2013. WAGGGS estimates that around 500 000 girls will use this toolkit to take action (e.g. campaigning and advocacy in local schools and communities).

- A “train the trainers” event was held in April 2013 to train project leaders in using photography as a tool for change. Around 25–30 project leaders attended from 15 countries. Each project leader was provided with equipment, and will train 10–20 girls in their respective countries. The resulting photographs will be used to inspire social change through national exhibitions.

- Building on World Thinking Day 2013, the Take Action Backpack and the photo workshops, a film for young women to speak out and influence decision-makers, is planned to be launched in 2013.

Source: Survey responses and interviews.

6.4 Accelerating progress: opportunities and challenges

Finding: The analysis in this chapter drawing on survey responses, a literature review, and interviews with adolescent health experts and commitment-makers suggests that stronger leadership and coordinated approaches; empowering and engaging with young people; and improving data, information and evidence would all help to accelerate progress in adolescent health.

Stronger leadership and coordinated approaches to addressing adolescent health: Focus on adolescent health has increased over recent years, but stronger leadership and an overarching global strategy to improve adolescent health would accelerate progress and position adolescent health firmly on the broader RMNCH agenda. Although a number of organizations play important roles, there is no single institution or campaign focusing particularly on young people and adolescents. National governments lacking a strategy for adolescents should consider its benefits. Among other things it would facilitate better coordinated policies and programmes.
(e.g. HIV and education programmes) and support efforts to understand the social determinants of adolescent health concerns and the links between them. Ensuring that adolescents are considered in the design of broad interventions is a key facilitator of progress.

Survey respondents noted that increased funding is needed to effectively implement adolescent health strategies, programmes and commitments.

**Empowering and engaging with young people:** A number of the commitments include youth empowerment as a focus; and some commitment-makers include young people in their governance structures and initiatives. For example:

- IPPF requires 20% of governing board members to be under the age of 25;
- the United Nations Children’s Fund (UNICEF) engages young people to monitor the operation of the Convention on the Rights of the Child and train workers;
- the Joint United Nations Programme on HIV/AIDS (UNAIDS) mobilized young people to develop Crowd Out AIDS, the first ever crowdsourced strategy in the UN system;
- Youth Coalition, an international organization promoting adolescent and youth sexual and reproductive rights at national, regional and international levels, is led by young people (aged 18–29);
- adolescents are participating in work on *Health for the World’s Adolescents*, a WHO report to be published in 2014.

Young people are now growing up in the middle of rapid urbanization, globalization, and access to information through the internet and social media. These last are a powerful and effective channel to target adolescents, and are used by young people both to access information and to engage with one another.

**Improving data, information and evidence:**

Disaggregated data are essential to inform decisions about policies, interventions and programmes to improve adolescent health. However, few countries are tracking adolescents aged 10–15. The lack of health-related data disaggregated by age at national and subnational levels in most of the Global Strategy’s 49 countries makes it difficult to set appropriate priorities. A global consensus on indicators for adolescent health would greatly improve the comparability of data. More relevant data, information and evidence are needed to strengthen global policies and programmes for adolescents and to guide and monitor the implementation of commitments to adolescent health. In 2012 *The Lancet* series on adolescent health recommended that every country produce a regular report on the health of its adolescents.  

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*Figure: A young girl from Mali is one of many adolescents participating in the implementation of commitments to adolescent health.*
7.1 Introduction

Newborn health is an increasing global health concern. Since 2000, progress in improving newborn survival has been 40% slower than for children under five who survived the newborn period, and 30% slower than for maternal mortality.\textsuperscript{106} Newborn deaths in 2010 were only 17% lower than in 2000, with no statistically significant change has been observed for sub-Saharan Africa over the past decade.\textsuperscript{107, 108, 109} Newborn deaths as a proportion of all under-five deaths continue to rise: current estimates suggest the global average is 43\%,\textsuperscript{110, 111} and in 12 countries it is 50\% or higher.\textsuperscript{112}

This is despite the fact that the majority of newborn deaths result from three preventable and treatable conditions: prematurity, complications during birth and infections.\textsuperscript{113} A number of initiatives have helped to increase the attention being paid to newborn health (which was more or less absent from the global health agenda before 2000), and to build the evidence base for and consensus on the essential interventions for newborn health. As Figure 7.1 illustrates, most of these initiatives were launched following the publication of *The Lancet* neonatal survival series, which included a menu of evidence-based interventions that could reduce neonatal deaths by two thirds.\textsuperscript{114} The launch of the Global Strategy in 2010 also appears to have catalysed a range of initiatives on newborn health, particularly Born Too Soon and Every Newborn (the Global Newborn Action Plan), to be launched in 2014.\textsuperscript{115, 116}

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**Figure 7.1:** Timeline of key events for newborn health, 2000–2013

- **2000**: Launch of Saving Newborn Lives initiative and Healthy Newborn Partnership
- **2006**: Lancet Neonatal Survival Series
- **2007**: Opportunities for Africa’s Newborns
- **2009**: Lancet Stillbirths Series
- **2010**: Launch of the Global Strategy and the Commission on Information and Accountability for Women’s and Children’s Health
- **2012**: Essential Interventions, Commodities and Guidelines for RMNCH
- **2013**: A Decade of Change for Newborn Survival
- **2014**: Global Newborn Action Plan

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Gaps and priorities in newborn health, identified by the major initiatives, are summarized as follows.

- The Global Strategy highlights the vital need to improve newborn health. It aims to prevent over 3 million newborn deaths between 2011 and 2015, and to ensure that by 2015 an additional 2.2 million neonatal infections are treated each year.

- The Essential Interventions, Commodities and Guidelines for RMNCH present 12 proven and cost-effective interventions that can reduce newborn deaths. These reduce the need for intensive care and can largely be delivered through antenatal care, skilled birth attendance and postnatal care visits.

- The CoIA refers to newborn health in a number of its recommendations, including: tracking and reporting RMNCH health expenditure by financing source per capita; reviewing RMNCH health expenditure relative to commitments, human rights, gender, and other equity goals and results; and improving the reporting of RMNCH health spending through the OECD CRS.

A draft of the Global Newborn Action Plan discussed at the 2013 Global Newborn Health Conference, reveals a number of emerging themes: prioritizing action during labour, the day of birth and first days after birth; integrating maternal and newborn interventions; scaling up key interventions in order to reduce the main causes of death; focusing on quality of care as much as coverage; strengthening health systems; and empowering women, families and communities.

7.2 Overview of commitments and trends

**Findings:**

- Approximately 25% (75) of all commitments to the Global Strategy focus on newborn health.

- Despite increased interest in newborn health following the launches of Committing to Child Survival: A Promise Renewed and Born Too Soon in 2012 (the latter being accompanied by 30 new and expanded commitments), evidence suggests that this has not yet been translated into proportionate increases in financial resources.

Figure 7.2 shows that 20% of the 75 commitments to newborn health have been made by NGOs, 19% by low-income countries and 12% by middle-income countries. However, only 4% of commitments have been made by foundations and 3% by multilateral organizations. In addition, while the private sector makes up 15% of commitments to the Global Strategy, they comprise just 4% of commitments to newborn health.

The highest numbers of commitments are targeted at sub-Saharan Africa (55%) and East Asia and the Pacific (36%).

There are considerable differences in the number of commitments for newborn health by country. For example, while seven countries have no commitments,121
three countries have 10 commitments or more (Bangladesh, and Uganda, and the United Republic of Tanzania). However, as shown in Table 7.1, the number of commitments for a country does not necessarily relate to its newborn death rate. For example, in Iraq where no commitments were made or received, the percentage of under-five deaths in the neonatal period was 54%, higher than many countries with the most commitments. However, this statistic should not be assessed in isolation; it is important to note that the number of under-five deaths per 1000 live births in Iraq (38) is low compared with countries with the most commitments.

Trends in commitments, 2010–2013

Evidence suggests that the global community’s interest in newborn health increased following the launches of the Committing to Child Survival: A Promise Renewed and Born Too Soon campaigns in 2012. However, financial resources for newborn health have not significantly increased. For example, in 2012 the Born Too Soon campaign received new and expanded commitments from 30 organizations, including seven from academic and research organizations, six from NGOs, five from high-income countries and four from global partnerships, but only US$ 0.8 million in new financial commitments once double-counting was accounted for.

Nature and focus of commitments for newborn health

**Findings:**
- Commitments to newborn health focus on: preterm births, preventing stillbirths, human resources for health, coverage of newborn services, postnatal care, and the registration and classification of newborn deaths.
- Two priority areas that are not well covered are preventing and treating neonatal infections, and tracking newborn health expenditure.

**Table 7.1: Countries with most and fewest commitments to newborn health**

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of commitments*</th>
<th>Under-five mortality rate</th>
<th>% of under-five deaths occurring in neonatal period (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Deaths per 1000 live births (2011)</td>
<td>Average annual rate of reduction (2000–2011) (%)</td>
</tr>
<tr>
<td>Most commitments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>11</td>
<td>68</td>
<td>5.7</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>10</td>
<td>46</td>
<td>5.5</td>
</tr>
<tr>
<td>Uganda</td>
<td>10</td>
<td>90</td>
<td>4.1</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>9</td>
<td>77</td>
<td>5.3</td>
</tr>
<tr>
<td>India</td>
<td>9</td>
<td>61</td>
<td>3.3</td>
</tr>
<tr>
<td>Kenya</td>
<td>9</td>
<td>73</td>
<td>4.0</td>
</tr>
<tr>
<td>No commitments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>0</td>
<td>45</td>
<td>3.9</td>
</tr>
<tr>
<td>Congo</td>
<td>0</td>
<td>99</td>
<td>0.9</td>
</tr>
<tr>
<td>Equatorial Guinea</td>
<td>0</td>
<td>118</td>
<td>2.3</td>
</tr>
<tr>
<td>Gabon</td>
<td>0</td>
<td>66</td>
<td>2.1</td>
</tr>
<tr>
<td>Iraq</td>
<td>0</td>
<td>38</td>
<td>1.1</td>
</tr>
<tr>
<td>Morocco</td>
<td>0</td>
<td>33</td>
<td>4.3</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>0</td>
<td>53</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Note: *From survey responses.
of International Neonatal Nurses committed to support the education of nurses caring for newborns.

Coverage: A number of commitments, including those made by Malawi, Uganda, Helping Babies Breathe, the Health Care Professionals Associations of PMNCH, the Gates Foundation and UNICEF, refer to scaling up coverage and access to good-quality newborn care.

Postnatal care: Australia, Cambodia, Guinea-Bissau, Sudan, Novartis and Pathfinder committed to increasing the coverage of postnatal visits and improving the quality of postnatal care provided to mothers and newborns.

Classification of newborn deaths: An interagency technical working group convened by Saving Newborn Lives committed to advocate for civil registration and vital statistics systems, while Madagascar and Zimbabwe committed to institute or improve mortality audit systems to so as to help classify newborn deaths.

Stillbirths: Saving Lives at Birth and the Global Alliance to Prevent Prematurity and Stillbirths committed to support the reduction of stillbirths. GAVI’s commitment will help to prevent stillbirths caused by rubella infection.

In general, many of these commitments relate directly to the identified gaps and priorities for newborn health. Some refer to specific interventions cited in the Essential Interventions, Commodities and Guidelines for RMNCH. For example, the commitment made by Helping Babies Breathe focuses on neonatal resuscitation with a bag and mask, administered by a skilled birth attendant.

However, not all of the gaps and priorities are adequately addressed. Despite neonatal infections featuring as a target outcome of the Global Strategy, only four commitments focus specifically on this. The term “infection” appears in only 11% of the commitments on newborn health. Another area not specifically addressed by any commitment relates to the CoIA recommendation to track, report (including through OECD CRS) and review total reproductive, maternal, newborn and child health expenditure.

7.3 Implementation

**Finding:** Although the implementation of many commitments is under way, stakeholders’ views on whether commitments will be fulfilled by 2015 are mixed.

Responses to the survey indicate that stakeholders are at various stages in implementing their commitments to improve newborn health. While 41% (15) of the 37 survey respondents who answered the question either “strongly agree” or “agree” that their Global Strategy commitments will be completed by 2015, 38% either “disagree” or “strongly disagree” with this statement.

Progress is being made in some countries. For example, as part of Guyana’s commitment to increase emergency obstetric and newborn care (EmONC) coverage to 100%, neonatal intensive care units have been established, where the prevention of neonatal infections is given particular attention.

Some countries are implementing system-wide approaches to improve newborn health. The experiences of Malawi and Uganda are summarized in boxes 7.1 and 7.2.

Commitment-makers from other constituency groups are supporting countries in their efforts to improve newborn health. For example, Health Alliance International is working with ministries of health to train and follow up on the support of midwives to provide essential newborn care. The Council of International Neonatal Nurses and Saving Newborn Lives has established an International Neonatal Nursing Excellence Award to highlight good practice and recognize the commitment of nurses working in newborn care in low- and middle-income countries.

**Box 7.1: Malawi’s steps to prevent newborn deaths**

Despite a high fertility rate, a high HIV prevalence and low density of health workers, Malawi is one of only two low-income sub-Saharan African countries on track to meet MDG 4 on child survival. (Newborn survival is becoming increasingly important for achieving MDG 4.) However, while Malawi reduced neonatal mortality by 3.5% per year between 2000 and 2010 (above the regional average of 1.5% per year), neonatal deaths account for a growing proportion of all under-five child deaths.

Malawi’s 2010 commitment to the Global Strategy includes:

- strengthening human resources for health, including accelerating training and recruitment of health professionals to fill all available positions in the health sector;
- expanding the infrastructure for maternal, newborn and child health;
- improving basic EmONC coverage to WHO standards;
- providing free care for mothers and children through partnerships with private institutions.

In response to the survey administered as part of this report, Malawi indicated that implementation is well under way. A few examples are as follows.

- Guidelines have been developed on care for pregnant women, including on the use of corticosteroids and antibiotics in premature labour.
- A clean and safe delivery environment is being encouraged in health facilities.
- Use of clean gloves is encouraged during delivery and when the umbilical cord is being cut.
- Kangaroo mother care is encouraged in facilities, including in communities.
- At the community level, health surveillance assistants manage sepsis in neonates with antibiotics as part of pre-referral treatment.
Box 7.2: Uganda’s efforts to improve newborn health

An estimated 141,000 Ugandan children die before their fifth birthday each year, and 26% (36 660) of these are newborn deaths. However, despite high fertility rates, a severe shortage of human resources for health and civil unrest, Uganda reduced neonatal mortality by 2.2% per year between 2000 and 2010.127, 128

This is greater than the average reduction for sub-Saharan Africa, but less than the national reductions in maternal mortality and under-five mortality after the neonatal period.

Uganda commitments to the Global Strategy in 2011 include:

- increasing comprehensive EmONC services in hospitals from 70% to 100%, and in health centres from 17% to 50%;
- ensuring that basic EmONC services are available in all health centres;
- ensuring the availability of skilled EmONC providers in areas that are hard to reach and therefore hard to serve.

In 2012, as part of the Born Too Soon initiative, Uganda committed to increasing the pace of scaling up high-impact interventions to reduce deaths due to prematurity, especially by:

- preventing preterm births (e.g. through early, prompt treatment of febrile illnesses, antenatal care visits, antenatal care packages and effective childbirth care);
- managing preterm labour (e.g. through antenatal corticosteroids, antibiotics for premature rupture of membranes);
- caring for preterm babies via high-quality newborn care, neonatal resuscitation, kangaroo mother care and management of complications.

Some progress on implementation has been observed. For instance, health centres are being upgraded to increase the coverage of basic and comprehensive EmONC services and a workplan is being developed to provide basic commodities for newborn care. An important obstacle to implementation is a health workforce that is often demotivated due to poor pay and housing problems.

Uganda tracks progress towards its Global Strategy commitments through health management information systems and national health sub-accounts for reproductive and child health, and annual surveys. However, the contribution of its commitments to achieving the overall outcomes of the Global Strategy for newborn health is not being tracked.

A number of commitments to newborn health involve research and building the evidence base to inform policy decisions on newborn care. For example:

- Family Care International and the Aga Khan University undertook a systematic review to assess the impact of potential interventions on maternal and newborn outcomes, with an emphasis on links between the two and the objective of promoting investment in and implementation of evidence-based interventions found to be beneficial to both women and newborns.
- The Novartis Foundation for Sustainable Development and WHO are collaborating with the Swiss Tropical and Public Health Institute in developing IMPACT (Integrated Management of Pregnancy and Childbirth training tool) which includes training modules in pregnancy care, childbirth, newborn care and postnatal care. The first module on Essential Newborn Care has been finalized and tested in the Philippines and the United Republic of Tanzania.
- The Institute for Tropical Medicine, Antwerp achieved its commitment to create the Woman and Child Health Research Centre to focus on evidence-based interventions for reducing the morbidity and mortality of women and children, and on maternal and child health policy evaluation research.
- The University of Aberdeen is implementing its commitment to generate new evidence to improve and ensure the quality of care at birth received by mothers and babies through research activities focused on infection prevention and control. These activities have helped strengthen the evidence base on interventions and their implementation, including preventive hygiene at birth.

Although most respondents to the survey say it is too early to measure the specific contribution of commitments to the outcomes and goal of the Global Strategy, some commitment-makers are able to demonstrate progress, as follows.

Women and Children First (UK) committed to work with partners in Africa and Asia and mobilize communities to reduce maternal and newborn mortality rates through cost-effective and scalable community-based interventions. A meta-analysis of seven trials (involving Women and Children First (UK) partners) showed that women getting exposure to women’s groups practising participatory learning and action to improve maternal and newborn health was associated with a 23% reduction in neonatal mortality. The study also found that the reduction in neonatal mortality increases where the groups consist of a greater proportion of pregnant women. For example, where at least 30% of pregnant women participated in groups a 33% reduction in neonatal mortality was possible.130

The Nigerian private sector, led by the WellBeing Foundation, in partnership with the Nigerian National Primary Health Care Development Agency’s Midwives Service Scheme,131 has scaled up access to a safe delivery kit (called the Mama Kit) and as a result neonatal infections have been reduced. Clean birthing kits have been provided in those states where newborn morbidity and mortality are highest.
7.4 Accelerating progress: opportunities and challenges

**Findings:**
- Achieving the Global Strategy goals to prevent more than 3 million newborn deaths between 2011 and 2015 and to treat an additional 2.2 million neonatal infections in 2015 will require greater efforts in 2014 and 2015 to improve both the coverage and quality of newborn care interventions. The development of the Global Newborn Action Plan, embedded in the continuum of care, should see new commitments and action in the remainder of 2013 and through 2014. The role of the midwife in delivering newborn care, not just at the time of birth, but in the days following, needs to be strengthened.
- More and better use of domestic and external resources and increased awareness of the most effective interventions for improving newborn health are also needed to accelerate progress.

Achieving the goals of the Global Strategy specific to newborns will require greater efforts in 2014 and 2015 to address two main gaps identified in the 2013 survey.

**Coverage of newborn care:** Many countries that have significantly reduced newborn mortality have done so through increasing the coverage of essential interventions. However, the most recent country estimates monitored by Countdown show that the median coverage of postnatal care for babies within two days of birth is just 26%, albeit ranging from 5% to 77% (based on the latest available data between 2007 and 2012). This is the lowest median coverage of all interventions monitored across the continuum of care. There is a need for both increased domestic and external resources. Funding remains a huge constraint to coverage and access. An analysis of the OECD CRS and Countdown databases found that while donors’ attention to newborn survival in terms of the value and proportion of aid disbursements mentioning newborns and newborn interventions has increased over time, funding is not commensurate with the high number of newborn deaths each year.

**Quality of newborn care:** High quality care helps to prevent complications and permits the early recognition and management of problems, promoting better outcomes. There are many reasons for poor quality care, including deficient training and supervision of health workers, inadequate infrastructure and weak supply of commodities. More and better trained health workers are needed. Countries should better plan for, authorize and support health personnel to deliver essential newborn (and other) health interventions. The role of the midwife in delivering newborn care, not just at the time of birth, but in the days following, also needs to be strengthened.

While efforts in recent years have increased awareness of the most effective interventions for improving newborn health, there is still a gap in knowledge of what to implement, particularly at the community level. An emerging theme of the Global Newborn Action Plan is the promotion of education and information to empower women, families and communities to persistently demand good-quality care.

The contextual factors identified in the PMNCH 2012 report remain a key constraint to reducing newborn mortality. In some countries these factors include women preferring to give birth at home, reluctance not only to attend even one antenatal visit but also to seek skilled care during childbirth. In countries where husbands make decisions on when to seek care, warning signs of life-threatening complications may be overlooked, thus missing the chance to take appropriate action.
Chapter 8

Advocacy

8.1 Introduction

Finding: The majority of survey respondents (80%, or 96 out of 120) indicated that their commitment contributes to advocacy for the goals of the Global Strategy. However, only 135 of all 293 stakeholders (46%) have made commitments that specifically include advocacy activities. This discrepancy suggests that many commitment-makers believe that the act of commitment, whatever its content, itself contributes to advancing the Global Strategy’s goals.

The Global Strategy can be seen as an advocacy drive: at the highest levels all commitments to the Global Strategy relate to advocacy. To this extent, the increase in commitment-makers over the past three years has been significant, nearly tripling from 111 at its launch in September 2010 to 293 in June 2013 (see Chapter 2). While campaigns tend generally to lose impetus over time, the expanding nature of Every Woman Every Child demonstrates strong continuing attention to and support for MDGs 4 and 5.

Based on survey responses, the 2012 PMNCH report found that 73% of commitments indicated support for advocacy. This figure is higher for 2013, with 80% of survey respondents (96 out of 120) indicating support for advocacy. However, triangulated analysis of the 2013 survey responses and the commitments texts indicates that 135 of all 293 commitment-makers (46%) and only 66 of 120 survey respondents (55%) are directly engaged in activities connected to advocacy action (e.g. conducting campaigns, media and parliamentary advocacy, and influencing other commitment-makers). This suggests that commitment-makers tend to regard almost any commitment as having advocacy value in itself, even without specifying advocacy activities.

Advocacy commitments have increased and strengthened other types of commitments to the Global Strategy. These include: funding (e.g. commitments to increase finances for newborn care); health service delivery (e.g. commitments to advocate for more family planning counsellors); policy (e.g. for legislation to eliminate early marriage) and research (e.g. for catalysing funding to promote post-birth research).

In addition, campaigns on specific concerns (e.g. preterm birth and child survival, commodities and family planning) have led to many new commitments and reinforced and furthered the advocacy impact of the Global Strategy (see Chapter 10). This chapter focuses on the subset of commitments and survey responses directly related to advocacy action.
8.2 Overview of commitments and trends

**Finding:** Advocacy commitments are well aligned with the Global Strategy’s priorities. Advocacy for policy development and political support features more often than advocacy for accountability (71% and 56%, respectively, of survey respondents with advocacy-related commitments).

Figure 8.1 shows the proportion of the survey respondents with advocacy commitments indicating support for different advocacy focus areas in the 2013 survey. Advocacy for policy development/political support and service delivery are the two most common focus areas in the 2013 survey, featuring in 71% and 67% of the advocacy-related commitments respectively. Some service delivery commitments echo the Global Strategy’s call to increase the quality and number of health workers. For example, IntraHealth International is advocating for and expanding access to an increased number of skilled front-line health workers delivering quality family planning services in West Africa, as part of its commitment to FP2020.

The proportion of commitments relating to advocacy for RMNCH financing and advocacy for social determinant, human rights and equity policies in 2013 is 59%. Although US$ 1.1 billion of new and additional money was committed to the Global Strategy during 2012 (mainly from pledges made at the London Summit on Family Planning), the need for greater advocacy efforts in financing is clear: there is still a financing gap (see Chapter 3) and almost the same percentage of respondents in the 2012 and 2013 surveys cited financial constraints as one of the most significant barriers to implementation (see Chapter 10).

Advocacy for accountability features in 56% of advocacy commitments, lower than commitments prioritizing advocacy for policy or service delivery. There is a role for greater advocacy for accountability, particularly given the slow progress in establishing effective accountability mechanisms in many countries (see Chapter 9) and the need to strengthen monitoring and governance to inform evidence-based action.

An example of advocacy for accountability is provided by the Guttmacher Institute. At the London Summit on Family Planning in 2012, Guttmacher committed to develop and implement a monitoring framework and to continue evidence-based advocacy in the US and globally by updating and publishing 2012 estimates of the number of women in all low- and middle-income countries in need of family planning and the benefits of meeting the contraceptive needs of current and potential users.
**Finding:** All categories of advocacy are generally well represented: more than 80% of respondents indicated commitments to more than one area of advocacy, suggesting that advocacy commitment-makers tend to see advocacy goals as cross-cutting.

The interdependencies between the different priority areas listed in Figure 8.1 are reflected in the number of commitments (83%) that include more than one element. One third of survey responses indicated that advocacy commitments relate to all five advocacy focus areas included in the 2013 survey (see Figure 8.2). There is a strong degree of integration of issues in advocacy commitments, suggesting that the Global Strategy has been successful in encouraging advocates to address RMNCH issues in a holistic fashion, not as separate disconnected issues.

Supporting this, some commitments aim explicitly to harmonize advocacy-related activities. For example, the Africa MNCH Coalition committed to innovative and targeted advocacy for: improved domestic resources, budgeting and policy; political commitments, monitoring and accountability; and innovative partnerships. This is in line with the August 2011 Africa Integrated MNCH Advocacy Strategy, which the coalition helped to facilitate in partnership with the African Union Commission and a cross-section of partners. The Strategy integrates cross-cutting MNCH issues, aligning African MNCH frameworks with the Global Strategy to facilitate more effective and integrated implementation at both continental and country levels.

Other examples of partner collaboration include the commitment of the WellBeing Foundation to develop MNCH efforts in Nigeria for grant-making, securing new financial, advocacy and corporate social responsibility commitments from Nigerian business and philanthropic leaders. It has adopted an MDG-related communication policy in order to harmonize messaging and coordinate advocacy efforts on MNCH across regions.

**Figure 8.2:** Proportion of commitments by number of advocacy focus areas

<table>
<thead>
<tr>
<th>Number of focus areas</th>
<th>Proportion of commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>17%</td>
</tr>
<tr>
<td>2</td>
<td>23%</td>
</tr>
<tr>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>4</td>
<td>13%</td>
</tr>
<tr>
<td>5</td>
<td>33%</td>
</tr>
</tbody>
</table>

Source: Analysis of survey results.

The H4+ (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank) has committed to advocate for equity-focused approaches that include universal access to an integrated essential package of health services for women and children.

**Who carries out the advocacy?**

Unsurprisingly, NGOs have made the largest number of advocacy-related commitments (41%, or 56 out of 135). More surprising has been the large disparity between constituencies in making explicit advocacy commitments. For instance, multilaterals account for just 3% of the commitment-makers, and foundations account for 10% and the private sector for 12%.

This low response does not necessarily indicate a lack of support for advocacy objectives (since 82% of all commitment-makers indicate support). However, the support has not translated into funding or programme support for advocacy activities. This underscores the general finding that the implementation of advocacy commitments is most frequently hindered by financial and staff constraints.

High-, middle- and low-income countries together comprise 11% of advocacy commitment-makers (15 survey respondents). For example, Senegal committed to prioritize family planning and ensure that women have equal access to high-quality, affordable MNCH services. Its action plan consists of initiatives such as leveraging networks of religious leaders and national and local champions to advocate for family planning. As part of the Saving Mothers, Giving Life partnership Norway will provide co-leadership globally and mobilize international support through partnerships with African leaders and other donor governments.

The private sector accounts for 15% of Global Strategy commitments, but contributes to only 12% of overall advocacy commitments (16 survey respondents).
Health-care professional associations account for only 4% of commitments related to service delivery, despite the Global Strategy’s recommendation that they should be more involved in advocating for the training, deployment and retention of health workers. This suggests that there are untapped opportunities for collaborating with the private sector and health-care professional associations on advocacy, and that these constituencies could play a greater role.

Nearly all Countdown countries (70 out of 75) have received one or more commitments, but the density is highly variable. For example, although sub-Saharan Africa accounts for the largest proportion of advocacy commitments, the number of commitments received by countries within this region varies.

8.3 Implementation

Finding: Although stakeholders’ responses point to progress being made, only 45% (30 out of 66) expect that their advocacy commitments will finish being implemented by 2015.

Analysis of progress in the main advocacy focus areas (Figure 8.4) suggests that more than half of the commitments for RMNCH financing advocacy (56%), service delivery advocacy (53%) and advocacy for accountability (53%) are likely to be implemented by 2015. Progress is also being made in implementing advocacy for policy development and political support commitments (48%). However, the implementation of social determinants, human rights and equity policies commitments is off track, with only 37% of commitments likely to be completed by 2015.

The survey responses point to stakeholders’ progress in meeting their objectives across the different focus areas. Examples include the following.

Advocacy for service delivery: Saving Mothers, Giving Life (whose founding partners include, among others, Merck for Mothers, Norway and the United States) aims to quickly and dramatically reduce maternal mortality in sub-Saharan Africa. After one year, early results in the target districts in Uganda and Zambia are promising. Through its commitment to the Pink Ribbon Red Ribbon initiative, Merck is working with Susan G. Komen for the Cure Global Health Alliance to raise awareness of the burden of breast and cervical cancers, mobilize additional partners and work towards increasing access to cervical cancer screening, treatment for women and HPV vaccination of girls in sub-Saharan Africa. Examples of progress by countries include Haiti’s advocacy efforts which have led to 10 health centres being built or renovated to provide good-quality reproductive health and training of more health workers.

Advocacy for investment: A Gates Foundation grantee, the German Foundation for World Population’s Euroleverage project, has obtained European funds for reproductive health and family planning in targeted low-income countries, and helped countries to access funds. In addition, following its commitment to develop a global advocacy campaign and catalyse funding, the Global Alliance to Prevent Prematurity and Stillbirth has established a group with the Gates Foundation, the March of Dimes and the National Institute of Child Health and Human Development to support greater research on and policy attention to the causes and mechanisms of preterm birth.

Advocacy for policy: Together for Girls (see Box 6.2 in Chapter 6) is one example of advocacy for policy. Another is the William and Flora Hewlett Foundation’s new strategy for international family planning and reproductive health,

---

**Figure 8.4:** Implementation of commitments by 2015, disaggregated by advocacy focus area

<table>
<thead>
<tr>
<th>Advocacy Focus Area</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy for service delivery</td>
<td>15%</td>
<td>15%</td>
<td>18%</td>
<td>28%</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy for accountability systems to track commitments and progress in reaching the Global Strategy goals</td>
<td>11%</td>
<td>17%</td>
<td>17%</td>
<td>28%</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy for RMNCH financing</td>
<td>11%</td>
<td>17%</td>
<td>17%</td>
<td>28%</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy to address social determinants, human rights and equity policies</td>
<td>21%</td>
<td>18%</td>
<td>24%</td>
<td>21%</td>
<td>16%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocacy for policy development/political support</td>
<td>19%</td>
<td>14%</td>
<td>19%</td>
<td>29%</td>
<td>19%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td>17%</td>
<td>17%</td>
<td>17%</td>
<td>17%</td>
<td>33%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Analysis of survey results.
which will prioritize building advocacy capacity to promote better policies for related health services and increased financing to support these programmes.

**Advocacy for accountability:** The International Budget Partnership (IBP) collaborates with civil society around the world to analyze and influence public budgets in order to reduce poverty and improve the quality of governance. It undertakes international advocacy to enhance the transparency and accountability of RMNCH public resources, including resources in the Global Strategy framework. IBP participated in several regional and international meetings and spaces, including the Women Deliver regional consultations, and has also provided inputs on budget transparency and accountability to the Technical Guidance Note on a Human Rights Approach to Maternal Mortality and Morbidity developed by the Office of the High Commissioner for Human Rights.

**Advocacy for improved coordination among stakeholders:** At the global level, Family Care International (FCI) has advocated for improved coordination and civil society participation. At the country level, it has helped to establish and strengthen civil society advocacy coalitions for RMNCH in Burkina Faso and Kenya, working as part of a PMNCH-supported programme to create civil society RMNCH coalitions in 10 countries to support accountability and strengthen joint advocacy. Other national coalitions raise awareness of commitments and ensure that knowledge is disseminated to stakeholders. Box 8.1 illustrates how a coalition has supported advocacy at the country level in Indonesia.

### Box 8.1: Advocacy coalitions in Indonesia

As part of a collaborative national movement to accelerate the achievement of MDGs 1, 4 and 5 in Indonesia, the Strengthening National Advocacy Coalition for Improved Women’s and Children’s Health was established in 2010, with support from the Ministry of Health, the Ministry of People’s Welfare, WHO and UNICEF. Following the concept of the continuum of care, this coalition has brought together civil society organizations and networks in a jointly funded platform which plans and acts together in shaping the RMNCH dialogue in Indonesia. Working at both the national and provincial levels, it has been involved in joint advocacy planning and implementation, drafting government regulations, and drafting the Country Accountability Framework and Roadmap to implement the recommendations of the CoIA.

In 2012 the Indonesian Family Planning Association (PKBI) and World Vision Indonesia used seed funding provided by PMNCH to expand and strengthen the coalition. The funding was in response to the CoIA’s recommendation to strengthen national civil society alliances for RMNCH advocacy in various countries. National coalitions were encouraged to align priorities and activities with existing national plans and processes.

Since 2012 the coalition has conducted a capacity-building exercise on RMNCH indicators, and engaged in policy analysis, resource tracking and local advocacy. Its activities have also included research into the awareness of national breastfeeding legislation among health professionals, a workshop on adolescent health, and a series of media briefings on the status of RMNCH in Indonesia and the work of the coalition.

Creating voluntary contribution schemes to cover the cost of coalition activities and strengthening the role of Indonesia’s media in accountability are two examples of innovative approaches implemented by the coalition.

In 2013 the coalition aims to: mobilize and build awareness of all RMNCH stakeholders to take action on government commitments to the Global Strategy; mobilize parliaments, media and civil society to promote the implementation of the Country Accountability Framework; improve the implementation of national regulation on exclusive breastfeeding; and advocate for better-quality EmONC services in hospitals and health centres.

Despite a supportive policy environment, implementation has been constrained by a number of challenges, including: the unequal distribution of human resources: a lack of equipment and supplies: a lack of effective all-round health spending; and limited capacity at district level.

Source: PMNCH. Building advocacy coalitions for greater action and accountability – Note for discussion.

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**8.4 Accelerating progress: opportunities and challenges**

**Findings:**

- Almost 30% of survey respondents with advocacy commitments (19) had no or limited evidence to demonstrate that their commitments are contributing to the specific goals of the Global Strategy, suggesting a need for greater investment in and attention to monitoring and evaluation of advocacy.
- The main constraints to implementation are insufficient financial and human resources.

Stakeholders’ responses point to a number of factors accelerating the implementation of their advocacy commitments.

**Advocacy initiatives and events:** A growing number of global advocacy efforts have been developed since 2010 in association with the Global Strategy. Many are described in other chapters of this report. A few illustrative examples follow.

1. The London Summit on Family Planning in July 2012 successfully mobilized a number of financial and policy commitments in this area (as described in Chapter 3 and Box 5.1 in Chapter 5).
2. The publication of the *Born Too Soon* report in May 2012 focused greater attention on prematurity as the leading global cause of newborn deaths, and catalysed the development of Every Newborn, a global action plan to reduce preventable deaths of women and children.

3. Committing to Child Survival – A Promise Renewed initiative. In June 2012 the Governments of Ethiopia, India and the United States of America, collaborating with UNICEF, convened a meeting of more than 700 participants to renew global commitment to child survival. Since then more than 170 countries have committed to the goals of A Promise Renewed.

**Innovative media:** Online and social media are an increasingly significant way to reach wider audiences and raise awareness.

1. Television, radio and online reports tied to World Prematurity Day in 2012, coordinated by PMNCH in support of the Global Strategy, reached an estimated audience of 1.4 billion people. This generated nearly 30 million Twitter impressions and more than 50,000 Facebook “likes” for the World Prematurity Day site. Meanwhile, events were held in more than 45 countries, drawing attention to the link between prematurity and the slow decline of newborn mortality.

2. The Women’s Health and Education Centre reports that its e-learning educational programme, Women’s Health and Health Development, is available in 225 countries and is increasingly popular.

3. Intel hosted a free online Healthcare Innovation Virtual Summit and webcast on “21st Century Healthcare to Developing Countries via Partnerships” for 90 days. The initiative highlighted how ICT can help partnerships to improve women’s and children’s health.

**Parliamentary initiatives** have improved the effectiveness of advocacy efforts through first-hand local knowledge and the power to initiate actions, such as for budget allocations. Parliamentarians have played a pivotal role in influencing policy-making, for example, debating and legislating on socio-economic policies and laws. The IPU, an international organization of national parliaments, committed to mobilizing support for the Global Strategy in the world parliamentary community. In 2012, it unanimously passed a resolution on the role of parliaments in addressing key challenges to secure the health of women and children, calling on parliamentarians to undertake all possible measures to generate and sustain political will, build partnerships and closely monitor domestic policies in this area. The resolution points to the role of parliamentarians in fostering accountability by reviewing government spending and comparing it with budget allocations and commitments. As part of the Bern Initiative for Global Parliamentary Action on Maternal and Child Health, women speakers of parliament have made several advocacy commitments, for example to develop or strengthen gender-equitable national health action plans.

The three main constraints to implementing advocacy commitments identified by survey respondents were: a shortage of skilled professionals, a lack of financial resources and insufficient private-sector participation. Another major challenge is finding better ways to measure the outcomes and impact of advocacy actions.

**More resources for advocacy are needed:** Consistent with the overall 2013 survey findings, human resource shortages and financial constraints are still the most commonly encountered hindrances to implementing advocacy commitments. Three quarters of stakeholders with advocacy commitments reported barriers related
to human resources. Partner organizations are often understaffed, with limited capacity for advocacy due to poor staff training and reluctance by some donors to fund advocacy posts. Financial constraints pose a challenge for 68% of survey respondents with advocacy commitments.

As highlighted in the findings of the 2012 report, the weak economic climate and financial instability continue to limit the ability of partners to conduct advocacy activities over a period. In these circumstances it is particularly difficult to advocate for increased or even sustained funding for maternal and child health or to ensure accountability over the long term. For example, the White Ribbon Alliance found that a lack of funding for existing government commitments can also limit the scope of its advocacy to push governments to fulfil their commitments. To some extent, the funding and human resource shortfalls may be interdependent and thus mutually reinforcing. In such an environment, limited resources may be directed to service delivery while critical enabling activities such as advocacy become a lower priority. This highlights the need to increase both human and financial resources for advocacy.

**Private-sector skills and resources needed for advocacy:**

While the private sector (e.g. media and public relations companies) has contributed to advocacy initiatives in various ways, their skills and competencies in this area have not been fully utilized, including for national behavioural change campaigns (e.g. for newborn survival under the Every Newborn banner), where their skills and resources would be a significant help. In future, public stakeholders and civil society organizations could collaborate more closely with the private sector to further enhance the effectiveness and reach of advocacy initiatives and leverage private-sector resources. The main areas for private sector contributions include: monitoring and evaluation, market segmentation, celebrity endorsements and creative development of advocacy campaigns.

**Better methods for measuring outcomes and impact:**

25% of survey respondents with advocacy commitments (17 out of 66) did not know or had limited evidence to demonstrate that their commitment is improving the health of women and children. Almost 30% (19 out of 66) did not know or had limited evidence to demonstrate that their implementation was contributing to the specific goals of the Global Strategy. However, even those respondents reporting evidence of impact provided few concrete examples. Interviews with stakeholders suggest that there is general uncertainty about how to demonstrate progress in advocacy and substantiate the validity of evidence. The nature of advocacy makes it difficult to measure both outcomes and impact: both are subjective and difficult to interpret.

UNF and its partners committed US$ 400 million to help the UN address key global health priorities, including childhood immunization, through campaigns and partnerships. Broadly, UNF found that the timing of its Global Strategy commitment coincided with positive outcomes in its focus areas. For example, the 10% decline in child mortality since 2010 can be largely attributed to increases in vaccine and bed net coverage, two key focus areas of UNF advocacy efforts. In addition, UNF reports that its advocacy in the United States of America has contributed to sustaining funding for maternal and child health programmes, despite shrinking global health programmes due to restricted finance, and has also contributed to positive policy outcomes in international reproductive health and family planning.

Other stakeholders cite evidence of the positive impact of their commitments in areas such as mobilizing financial and non-financial commitments to women’s and children’s health, as well as in policy-related areas such as policy changes and implementation of policies to support women’s and children’s health. For example, in Cameroon, following new evidence of increased maternal mortality, and building on the Global Health Workforce Alliance’s advocacy and support, the midwifery school was reopened after 15 years through increased government investment in health workforce education and training. The Gates Foundation’s support for Save the Children’s advocacy in Nigeria, together with WHO, the Partnership for Transforming Health Systems Phase II (PATHS2), Capacity Plus and other partners, contributed to the Ministry of Health committing to renew the expired 2008-2012 human resources for health implementation plan, and to develop a clear and costed plan in 2013.
CHAPTER 9

ACCOUNTABILITY FOR GLOBAL STRATEGY COMMITMENTS

9.1 Introduction

The Global Strategy emphasizes the need for effective accountability mechanisms at national and global levels, and for all stakeholders to be accountable for the commitments they make. The CoIA’s accountability framework has attracted interest from other initiatives and has influenced the global discourse, not only in health but also in other development sectors. Accountability is a prominent issue in the ongoing discussions about the post-2015 agenda.

In 2011, Canada, Norway and the United Kingdom pledged US$ 40 million to help countries implement the CoIA’s recommended national accountability framework. At the end of 2012, US$ 32 million of this funding had been disbursed; the remainder will be disbursed during 2013 and 2014. The Global Fund and GAVI are providing funding for monitoring and evaluation and accountability platforms, and many other global partnerships are supporting accountability, including the H4+, the International Health Partnership (IHP+) and PMNCH. New global health initiatives are adopting accountability mechanisms from the start. For example, the Performance Monitoring and Accountability Work Group was established at the launch of FP2020.

Accountability mechanisms should be sufficiently inclusive to ensure meaningful participation and oversight by all key stakeholders. However, some challenges have been identified related to engaging parliamentarians, communities, civil society and the media. For example, more needs to be done to maximize the crucial role of parliamentarians in holding governments to account, as highlighted in the PMNCH 2012 report. Greater participation by parliamentarians in budgetary oversight is required to ensure that adequate domestic financial resources are allocated to women’s and children’s health. And while there has been stronger engagement of health-related parliamentary committees, increased awareness of and engagement by other parliamentary bodies, such as committees of justice, human rights, finance and poverty alleviation, are also required to ensure a more holistic and sustainable approach to improving women’s and children’s health. Creating linkages between human rights and maternal and child health is critical to achieving health improvements for women and children. Survey respondents also noted that participation by and representation of women’s groups in health-sector reviews need to be strengthened.
9.2 Accountability among commitment-makers

**Finding:** A majority of survey respondents (71% or 82) reported having a transparent mechanism to monitor progress on implementing their Global Strategy commitments. More than two thirds (69% or 80) make their progress reports on implementation publicly available. However, more work is needed to implement the CoIA recommendations to monitor progress towards the goals of the Global Strategy and to strengthen accountability for women’s and children’s health.

The PMNCH 2012 report also had a chapter on accountability. However, the surveys in 2012 and 2013 asked different kinds of questions and therefore no direct comparisons are possible. In terms of accountability among individual commitment-makers, 69% (80) of survey respondents said they publicly share progress reviews on the implementation of their commitments and on the results achieved (Figure 9.1). Therefore, 31% (36) are off track to reach the CoIA recommendation on transparency – i.e. that all stakeholders should publicly share information on commitments, nationally and internationally, by 2013. This was noted in the first iERG Report, which highlighted insufficient progress towards transparency as a serious concern.

Almost two thirds (62% or 72 of 116 respondents) reported having translated their commitments to the Global Strategy into specific annual targets (Figure 9.1). The finding that 38% have not taken such action causes concern. First, a lack of targets hinders the tracking of progress. Second, it indicates that over one third of stakeholders are not following the iERG’s recommendation to “set clearer country-specific strategic priorities for implementing the Global Strategy” (in some cases this may be because countries are drawing on ongoing national processes for target-setting and monitoring and evaluation). Finally, it suggests that more work is needed to implement the CoIA’s recommendation that all Global Strategy stakeholders use the same 11 indicators to monitor progress towards its goals by 2012.

The majority of respondents (71% or 82) reported having a transparent mechanism to monitor and review progress towards the implementation of their Global Strategy commitments (Figure 9.1). Although relatively high, this figure indicates that 29% of stakeholders have not yet implemented the CoIA’s recommendation to establish transparent national accountability mechanisms by 2012. Survey responses suggest that almost 60% of stakeholders take remedial action based on their review of progress and issues identified regarding the implementation of their Global Strategy commitments (Figure 9.1). However, one third (31%) of respondents indicated either that remedial action was not applicable to their case, or that they did not know whether they were taking remedial action.

**Figure 9.1:** Progress in implementing accountability mechanisms

| For the Global Strategy as a whole, there are strong mechanisms to ensure accountability by all stakeholders for their commitments to the Global Strategy | 14% | 50% | 10% | 6% | 15% | 5% | N=117 |
| We have translated our commitment to the Global Strategy into specific annual targets that we can be held accountable for | 28% | 34% | 16% | 3% | 4% | 15% | N=116 |
| We have a transparent mechanism to monitor and review progress relating to the implementation of our Global Strategy commitment | 31% | 40% | 10% | 3% | 3% | 14% | N=116 |
| We publicly share progress reviews conducted on the implementation of our Global Strategy commitment and results achieved | 34% | 35% | 9% | 3% | 3% | 16% | N=116 |
| We take remedial action based on our review of progress and issues identified | 27% | 32% | 6% | 4% | 10% | 21% | N=113 |

Source: Analysis of survey results.
9.3 Financial commitments

**FINDING:** A new international system for capturing RMNCH donor funding was introduced in June 2013.

Several key donors were helpful in providing 2012 data related to their commitments, and efforts to improve reporting to the OECD CRS are well under way. In June 2012, the Informal Task Team on MNCH, established by the OECD Development Assistance Committee (OECD-DAC) Working Party on Statistics following an initiative of the Canadian Government, agreed to use a “4-score (quartile) marker” to capture donor funding for RMNCH based on percentage scoring. Technical guidelines are currently being developed and it is anticipated that the system will be ready for use from 2013/14.

The survey asked stakeholders with financial commitments whether they have a mechanism to track their disbursements and expenditures on women’s and children’s health. Of the 44 stakeholders who responded to this question, over half (59% or 26) reported having such a mechanism. Almost half of the 44 respondents (48% or 21) indicated that they publicly share information on disbursements and expenditures related to their Global Strategy commitments. Twenty (45%) stated that they track and report their implementation progress to other stakeholders, whereas 10 (23%) indicated that they had not yet taken action to track and share such information (Figure 9.2).
9.4 The importance of external audits

**Finding:** Only nine survey respondents (20%) said they conduct or plan to conduct voluntary independent audits of their commitments.

As highlighted in the PMNCH 2012 report, at least two stakeholders conducted independent audits of their Global Strategy commitments in 2011–2012. Save the Children commissioned an independent assessment of its progress on commitments in 2011, including a public report on findings and recommendations. In 2012, World Vision invited an independent accounting firm to undertake a high-level interim review of progress in its commitment to the Global Strategy, focusing particularly on the validation of the strategic alignment of the NGO’s programming practice and an assessment of its total expenditures towards its Global Strategy commitment. The report is publicly available. The assessment was repeated in 2013 and the results will be published on the World Vision website in September 2013.

Such audits should be encouraged. According to this year’s survey, only 22% of stakeholders (20) currently conduct independent external reviews of the implementation of their commitment, or are considering doing so (Figure 9.3).

To encourage and facilitate voluntary commissioning of external audits of individual commitments, this report suggests some general principles and guidelines for such an exercise (Box 9.1).

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**Box 9.1: Key principles for voluntary commissioning of external audits of the implementation of individual Global Strategy commitments**

1. **Key purpose:** The key purpose of voluntary audits is to increase accountability and transparency in reporting progress in the implementation of commitments. Based on the objectives outlined in the original commitment text, audits should describe progress against these objectives. This means that each audit should directly relate to the commitment stated in the commitment text. However, audits can also fulfil other purposes:
   a. Stakeholders may use the audits to report on their broader RMNCH activities and results, i.e. actions over and above the original commitment.
   b. Audits may be used to describe and disseminate best practices and lessons learnt about the implementation of commitments.
   c. An audit can provide an estimation of constraints and enablers to reaching targets, as well as a time-based strategy and recommendations for mapping future strategy and tracking progress.

2. **Independence:** Audits should usually be conducted by an external party to ensure unbiased, independent assessment. This might be a professional auditor, but there are other possibilities. Some stakeholder groups, such as governments, might prefer the development of shadow reports through civil society. Other groups, such as those in the private sector, might wish to establish peer reviews to ensure that their mode of operation is sufficiently independent. This means that, depending on the type of stakeholder, audits need to take into account the different nature of organizations. Purely internal assessments should be the exception. For example, an internal evaluation unit might be sufficient as long as it provides an objective view.

3. **Sound methodology:** The audit should apply methodological standards that guarantee transparency and accountability. The methodological approach and the data used should be transparent. Stakeholders should also describe how their commitment goes beyond their previous activities (if additional efforts were envisioned in the commitment). If the commitment can be quantified, stakeholders should refer to baselines predating the Global Strategy.

4. **Flexible format:** Audits should take into account the different scope, focus and time frame of commitments. There is no “one size fits all” approach; many different formats are possible. However, the structure of the assessment should be clear and systematic. The criteria of assessment should be specified, and a structured approach to the key purpose adopted.

5. **Publication of audits:** Audits should be shared with the wider public and made available on both the stakeholder’s and the Every Woman Every Child websites.

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**Figure 9.3: Independent external reviews of Global Strategy commitments**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>71</td>
</tr>
<tr>
<td>22%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Source: Analysis of survey results.
Chapter 10

Conclusions and Recommendations

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

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

This chapter first highlights Every Woman Every Child as a global movement and the difference it is making to women’s and children’s health and to global health and development. Section 10.2 summarizes progress towards implementing commitments and achieving the Global Strategy’s goals (noting the main catalysts and constraints reported by different constituencies and the different accountability mechanisms they are using). Section 10.3 discusses lessons learnt from producing three annual reports on Global Strategy commitments and asks whether a different approach is now needed. The chapter concludes with recommendations and proposals for next steps.

10.1 The Global Strategy and Every Woman Every Child: a global movement

“The global strategy can be looked at as the point at which the global community came together for women’s and children’s health.”

Survey respondent

As well as directly promoting commitments and catalysing action around its goals (see Box 10.1) the Global Strategy is also having a broader impact on women’s and children’s health, including their sexual and reproductive health and rights, and on the global health landscape. Some of the positive changes produced by the Global Strategy, and noted by stakeholders in interviews and survey responses, are as follows.

Providing a global focus for RMNCH advocacy: the Global Strategy reinforces the importance of RMNCH in
Box 10.1: The Global Strategy’s goals

The overall goal of the Global Strategy is to save 16 million lives by 2015.

Assuming the funds needed each year between 2011 and 2015 are made available, implementing the Global Strategy would dramatically improve access to life-saving interventions for the most vulnerable women and children in the 49 poorest countries. In 2015 alone:

- 43 million new users would have access to family planning
- 19 million more women would give birth supported by a skilled birth attendant
- 2.2 million additional neonatal infections would be treated
- 21.9 million more infants would be exclusively breastfed for the first six months of life
- 15.2 million more children under the age of one would be fully immunized
- 117 million more children under the age of five would receive vitamin A supplements
- 40 million more children would be protected from pneumonia.

This funding would also significantly improve the health infrastructure available to the world’s poorest women and children. In 2015 it would contribute to:

- 85,000 additional health facilities (including health centres, and district and regional hospitals)
- between 2.5 and 3.5 million additional health workers (including community health workers, nurses, midwives, physicians, technicians and administrative staff).

10.2 Progress towards implementing commitments and achieving the goals of the Global Strategy

Progress towards implementing commitments has accelerated substantially.

Table 10.1 provides a snapshot of progress, based on the information included in this report. However, caution is needed when interpreting these data, for several reasons. First, the Global Strategy inputs are not only financial: for example, health systems strengthening, an essential element of the Global Strategy, has been ongoing and is not fully monetized. Second, some information reported is for all low- and middle-income countries, not only the Global Strategy’s 49 focus countries. The US$ 88 billion financial gap, calculated at the launch of the Global Strategy in 2010, emerged from a costing exercise based on 49 countries, using figures from 2008. It would be inappropriate to relate that figure only to disbursed funds to date. All inputs to the Global Strategy are meant to accelerate progress towards the MDGs, and many are not monetized. Finally, the probability of double-counting, if such information were monetized, is very high.

It is clear from Table 10.1 that both disbursements and new/additional funds have increased substantially over the past year. Further, there were three services and systems goals for which we were able to quantify advances in commitment implementation and progress towards the goal, based on trends and projections: access to family planning, educating and training more health workers, and building more health facilities. There have been various degrees of progress in these three areas.

Although new users’ access to family planning has increased substantially, the Global Strategy goal is unlikely to be reached. However, the FP2020 initiative, launched at the London Summit in 2012, has provided an impetus, and its target to reach 220 million women by 2020 could be met if the plans of this initiative are implemented. Progress towards that goal has certainly been made and new commitments (reported in Chapter 5) will undoubtedly help further.

There has been excellent progress in implementing commitments related to the health workforce. About half the global health agenda. Advocacy related to the Global Strategy has helped to raise awareness of women’s and children’s health, and encouraged significant RMNCH financial, policy and service commitments. The Global Strategy presents a new way of doing things: it provides a template on which stakeholders can “pin” their commitments.

Convening new and different stakeholders: the Global Strategy provides a platform for convening all stakeholders, thereby increasing participation from low- and middle-income countries and the private sector. It also creates opportunities for private- and public-sector collaboration, including stakeholders whose mandates and traditional focus areas do not relate directly to RMNCH.

Mobilizing and harmonizing RMNCH-related initiatives: the Global Strategy and Every Woman Every Child have created a foundation on which targeted campaigns and initiatives can be developed and/or positioned. These include, among others, the CoIA, FP2020, the Commission on Life Saving Commodities and A Promise Renewed. In addition to mobilizing campaigns on specific issues, the Global Strategy is helping to harmonize the RMNCH activities of different stakeholders at global and country levels.

Accountability for RMNCH: the Global Strategy’s processes provide a mechanism for stakeholders to review, verify and, if necessary, refine their existing commitments, thus promoting mutual accountability. The iERG serves as a specific mechanism to promote stakeholders’ accountability to the Global Strategy; this report is one contribution to that process.

Overall, the Global Strategy has catalysed increased awareness and action, mobilized additional resources and built a consensus on the priorities and actions needed across the RMNCH continuum of care. It has also set in motion new initiatives, although it is not yet clear whether these operate in a harmonized way to address a range of RMNCH challenges, or whether they have created additional administrative burdens for countries and led to further fragmentation in the field.
of the requirement has so far been met (in around half the time). If the pace of progress increases, the human resources goal of the Global Strategy might be fulfilled.

However, based on the information available for this report, less progress has been made in increasing the number of health facilities. According to survey responses, only about 5% of the commitment has been fulfilled to date. We estimate that only 10% of this key goal is likely to be met by 2015.

Perceived future implementation trends

Several chapters of this report detail tangible progress made by individual commitment-makers towards the Global Strategy’s goals. For example, closing the financing gap (Chapter 3); educating and deploying more health workers and building health facilities (Chapter 4); preventing unintended pregnancies and increasing access to comprehensive family planning (Chapter 5); and preventing newborn deaths and treating neonatal infections (Chapter 7). These and other examples show that the implementation of Global Strategy commitments is well under way.

Stakeholders are making progress in implementing their policy commitments. For example, about three quarters (76%) of survey respondents indicated that their RMNCH financing policies have been formally approved, are operational, or are being implemented and monitored. Policies in other areas (for example, human rights, gender equity, governance and health system reforms) are still at early stages of development or yet to be implemented (Chapter 4).

However, only about half the survey respondents answering this question (57 of 113 or 51%) anticipate fully implementing their commitments by 2015 (Figure 10.1).

### Table 10.1: Synthesis of findings on progress towards implementing commitments to the Global Strategy

#### A. Financial commitments and disbursements, US$ billion

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

Insufficient information to estimate X, Y, Z.

#### B. Services and systems commitments that have not been monetized

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

* Estimated on the basis of doubling estimates for 2013, which is approximately halfway along the Global Strategy’s timeline (September 2010 to December 2015).
### Table 10.2: Synthesis of overall catalysts, constraints and accountability mechanisms, by constituency (aggregated), based on 120 survey responses

<table>
<thead>
<tr>
<th>Constituency</th>
<th>Catalysts</th>
<th>Constraints</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Private sector</strong></td>
<td>Establishing partnerships with a variety of stakeholders to meet commitments. In particular, the support of governments and NGOs (especially those with strong local presence and expertise) has been critical. Investing significant resources and efforts in building local capacity.</td>
<td>The low resource base (human resources, infrastructure and government capacity). Lack of information, stemming from both weak information systems and underdeveloped data collection mechanisms. Many private stakeholders have had to input their own resources and time to fill these gaps.</td>
<td>Various mechanisms (monitoring and evaluation frameworks, management information systems, etc.) are used to support accountability processes. In addition to setting clear goals in grant-making processes, social media and the internet have been used to measure outreach, particularly at the local level. Management information systems and health information systems are used extensively to monitor progress.</td>
</tr>
<tr>
<td><strong>NGOs</strong></td>
<td>Strongly emphasizing targeted/tailored approaches to widen outreach to vulnerable populations. Working with multiple stakeholders to develop comprehensive solutions. Prioritizing training of local health workers. Using advocacy to communicate information about available services and activities.</td>
<td>The low resource base in rural and remote areas. Workforce quality and number: adequately trained technical staff are not always available where required; if available, it is often difficult to employ and retain technical staff, especially in remote locations. Lack of funding for NGO-led programmes. Internal regulations can limit flexibility in operations.</td>
<td>NGOs have established strong monitoring and evaluation mechanisms, including annual reporting tools and strategic results frameworks. Some NGOs receive direct feedback from key stakeholders, and publish results online and in print.</td>
</tr>
<tr>
<td><strong>Low- and middle-income countries</strong></td>
<td>Improving data and information collection mechanisms. Developing national plans, frameworks, and policies aimed at improving reproductive, maternal, newborn, child and adolescent health to guide interventions and scale-up. Improving access and expanding services (e.g. increasing number of services offered in health facilities, improving availability of contraceptives and coverage for family planning).</td>
<td>Significant constraints on meeting human resource requirements. Skilled and qualified health workers are often lacking, or difficult to retain, particularly in conflict and rural areas. Funding constraints limit the ability to further develop health workers’ skills. Poor general infrastructure hinders overall implementation of RMNCH aims.</td>
<td>Various accountability mechanisms are used. While global benchmarks are used, some have established national accountability frameworks, which may include: target indicators, national reviews and census reports, and/or regular review meetings.</td>
</tr>
<tr>
<td><strong>Multilaterals</strong></td>
<td>Using multi-stakeholder consultative process to define priorities.</td>
<td>Not always able to provide support at country level, in terms of staff with appropriate skills, and financing relevant to country engagement. Other constraints include: weak information systems, inadequate technical capacity and skilled health workers, and inadequate infrastructure.</td>
<td>Use annual workplans, mid-term progress reports, financial and grant tracking mechanisms, and joint monitoring mechanisms (with other multilaterals and donors).</td>
</tr>
<tr>
<td><strong>Bilateral donors and foundations</strong></td>
<td>Using market-support mechanisms (e.g. volume guarantees for commodities). Placing stronger focus on neglected areas, such as adolescents and newborns, to improve overall RMNCH outcomes.</td>
<td>Difficulties working in conflict countries and countries with severe political instability. Political commitment is sometimes lacking and priorities are not always clearly defined.</td>
<td>Use annual workplans, mid-term progress reports, financial and grant tracking mechanisms, and joint monitoring mechanisms (with other multilaterals and donors).</td>
</tr>
</tbody>
</table>
Of the other half, some expected that their commitments would not be implemented by 2015 (29 respondents or 25%) and others lacked sufficient evidence to predict when implementation would be completed (27 respondents or 24%).

A similar pattern was reported by respondents with commitments to address unmet need for family planning (as noted in Chapter 5). However, only 45% of stakeholders with advocacy commitments (30 of 66) expect implementation to be completed by 2015 (Chapter 7). Among respondents with commitments to newborn health, only 41% (15 of 37) anticipate that their Global Strategy commitments will be implemented by 2015 (Chapter 7); in the adolescent health thematic analysis (Chapter 6) this figure dropped to 40% (13 of 33).

It is of paramount importance to maintain progress in implementing all the Global Strategy commitments, and catalysts for and constraints to their implementation are listed below.

Catalysts for and constraints to implementation

Understanding and overcoming barriers to implementing commitments is essential if the goals of the Global Strategy are to be achieved. Both catalysts and constraints vary between constituencies. Table 10.2 aggregates the survey responses by stakeholder groups, and includes examples of the accountability mechanisms used by the different groups.

10.3 Lessons learnt from producing three annual reports on commitments

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

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

The present report assesses all commitments to the Global Strategy to date. In addition to the survey, the commitment texts from all 293 stakeholders were analysed and a number of commitment-makers were interviewed. The fact that fewer than half the commitment-makers responded to this year’s survey, despite intense efforts to achieve a higher response rate, raises the question of whether these methods are the most appropriate means of achieving the objectives of the annual PMNCH report. Might different approaches be more effective? Score cards on progress towards implementation, constituency-based accountability reports, and synthesizing data from initiative-specific accountability reports and annual reports from commitment-makers are other possible approaches.
10.4 Recommendations

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

I. ACCELERATING PROGRESS TOWARDS BRIDGING REMAINING GAPS

Improve targeting and implementation of commitments

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

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

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

Mitigate constraints

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

Improve accountability

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

II. RECOMMENDATION RELATED TO THE FOUR THEMATIC ANALYSES

Family planning

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

Adolescent health

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

Newborn health

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

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

III. FUTURE METHODS AND APPROACHES TO TRACK COMMITMENTS

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

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

Address difficulties in monetizing many Global Strategy commitments

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

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

- Define the audience and outcomes expected from any future reporting on commitments to the Global Strategy, and what is needed to drive implementation and accountability.
- Identify synergies across accountability reporting processes (CoIA, Countdown, FP2020, H4+, RMNCH Trust Fund, Decade of Vaccines, etc.) and strive towards greater integration and coordination of reporting, building on iERG’s role to synthesize and analyse all reports provided.
- Recognize that any reporting option and format will require significant effort and resources, both from those providing information (often the same information stemming from different requests) and those collecting it. Declining response rates on self-reported surveys are a considerable accountability challenge and an important steer that new approaches are required to encourage commitment-makers to participate in efforts to monitor progress.
- Consult with partners on innovative, more effective and more cost efficient ways to track progress on the implementation of commitments to the Global Strategy. Some examples might include approaches based on: more targeted national or regional score cards on progress towards implementing specific commitments; a series of concise country-focused reports, constituency led and owned accountability efforts; and synthesizing data from initiative-specific accountability reports and annual reports from commitment-makers.
Annex 1

Methods

This report analyses the commitments made in the context of the Global Strategy. Data for this analysis were collected using the following methods:

- An online survey sent to 268 stakeholders, of which 120 fully completed the survey (45%)
- Key informant interviews based on semi-structured questionnaires
- Specific methods and approaches used in the financial analysis
- A content analysis of the commitment statements from the Every Woman Every Child website
- A desk review of relevant literature and databases.

The methodological challenges and limitations of this commitment analysis were as follows.

- Self-reported data: one limitation of the report is its reliance on self-reported information. As far as possible, data reported by stakeholders were triangulated with other data sources. Still, the data in this report stem largely from self-reporting.

- Survey participation: although significant efforts were made to promote participation by stakeholders in the survey, only 21 low-income and middle-income countries (out of 62 with commitments to the Global Strategy) responded to the online survey (as of 16 May 2013). This limited the ability to report on the progress made by low- and middle-income countries in implementing their commitments and associated accountability mechanisms. Some other key stakeholders also did not participate in the survey or the interviews, despite follow-up. This limited the ability to report on the progress of implementation of their commitments.

- Financial data: more complete data would have been required to fully understand which funding amounts are subject to double-counting, and which are new and additional. The analysis in this report thus presents an estimate. As outlined below, due to the limitations of the OECD-DAC’s CRS database, and the lack of comprehensive National Health Sub-Accounts, some assumptions also had to be made about RMNCH donor disbursements and country expenditures.

- Lack of definition of “commitment”: when the Global Strategy was launched in September 2010 there was no commonly agreed format or guidance for making commitments to the Global Strategy so as not to limit potential contributors. The lack of a common approach means that many commitments are linked to activities that were already being planned, or in operation, before the launch of the Global Strategy.

In the survey, this lack of an agreed definition resulted in a number of stakeholders reporting on activities that were not explicitly expressed in their commitment. (It was sometimes difficult to determine whether stakeholders reported exclusively on those RMNCH activities that they undertake in direct relation to their commitment to the Global Strategy.)

- Difficulties in estimating the early impact of the Global Strategy: estimating the impact of the Global Strategy is difficult because commitments cannot easily be linked to health outcomes and impacts. Also, there are only limited data concerning some outcomes and impact (e.g. the latest maternal mortality data relate to 2010). A related methodological challenge was distinguishing the specific contribution made by the Global Strategy to accelerating the promotion of women’s and children’s health at the global and country levels from progress which might have been made without the Global Strategy.

Online questionnaire

Data on progress in implementing the commitments and their contribution to reaching the Global Strategy goals were collected through an online survey. The development of the online questionnaire applied lessons learned from the PMNCH 2012 report. The 2013 questionnaire was significantly shorter. The draft questionnaire was pilot-tested, revised and subsequently uploaded onto the survey website (Cvent). The survey was open for six weeks from 4 April to 16 May 2013 (and will remain open until PMNCH decides to close it). Invitations to complete the questionnaire were sent to 268 out of 293 commitment-makers. The 13 stakeholders who made a commitment in 2013 were excluded due to the limited time available for the implementation of their commitment. Contact details were not available for some commitment-makers.

The survey results are based on 120 responses (representing a 45% response rate). The online questionnaire generated both quantitative and qualitative data and information. The quantitative data were analysed in Excel, and the open-ended questions were qualitatively analysed. The objectives of the qualitative analysis were to triangulate the findings of the quantitative analysis, and to provide examples to enrich the report. It is worth noting that the nature of data gathering (self-reporting, often consisting of general statements) limited the reliability and level of detailed information generated about the progress of implementation.
A breakdown of survey responses by constituency group is shown in Figure A1.1.

Key informant interviews

Semi-structured interviews were conducted to inform the analysis of financial commitments, national accountability mechanisms and the country case studies. Key informants were selected through purposeful sampling to ensure inputs from a broad range of relevant stakeholders. Interviews were conducted by telephone or face-to-face using a semi-structured questionnaire. In total, 25 interviews were conducted by SEEK Development between April and May 2013, and additional interviews were conducted by CEPA. Informed consent was obtained from all key informants.

Analysis of financial commitments

A mixed-methods approach was used to collect and analyse data in the financial analysis, consisting of:

- a section on financial commitments in the online questionnaire conducted for this report;
- interviews with stakeholders with sizeable financial commitments;
- interviews with technical experts to understand the progress made in tracking the financing for RMNCH;
- a desk review of relevant literature and databases.

The following sections explain how the financial estimates were calculated.

Approach to estimating overall financial commitments to the Global Strategy

In line with the methods used in the PMNCH 2011 report, the starting point of the analysis of financial commitments to the Global Strategy was an analysis of the commitment statements from the Every Woman Every Child website. Only commitments explicitly expressed in financial terms were included. The database on financial commitments to the Global Strategy, established by PMNCH in 2011 and 2012, was updated.

The methods of the PMNCH 2011 report were used to estimate the financial commitments made by 25 low-income countries:

1. Unless otherwise specified, and following the method used by Countdown to 2015, it was assumed that 25% of government health spending would benefit RMNCH. Where a specific proportion was specified in the commitment, this figure was used instead: for example, 30% for the Central African Republic.
2. Based on trends of annual government health spending in 2006–2009, an estimate was made of what total government health spending on RMNCH would have been in 2011–2015 if no commitment to the Global Strategy had been made (the darkest area in Figure A1.2).
3. Total government health spending on RMNCH in 2011–2015, if spending were increased to meet the target in the Global Strategy commitment, was estimated (all areas in Figure A1.2). Unless another target year was specified in the commitment, a linear rate of increase in government health spending until 2015 was assumed.
4. The total additional government health spending on RMNCH in 2011–2015 (the two lighter areas in Figure A1.2) is the estimated value of governments’ financial commitments. The figure also shows the expected share of funding that is potentially subject to double-counting.

Approach to estimating double-counted commitments

Controlling for double-counting in Global Strategy commitments is essential to avoid artificially increasing the funding figures. To avoid double-counting of commitments made by international stakeholders, financing sources were differentiated from financing channels, a differentiation introduced by the IHME. One important instance of double-counting occurs when a source of international financing (for example, a bilateral agency or foundation) channels funding through multilateral organizations, global health partnerships or NGOs, and when both the source and the channel count this funding as part of their commitment.

One particular challenge in this context was to estimate the funding channelled through NGOs. While good data were available for global health partnerships and multilateral agencies, only a small number of NGOs were able to estimate the extent to which their commitment relied on financial resources from international donors (and donors were also unable to specify the proportion of their commitment channelled through NGOs). As described in Table A1.1, a different approach had to be used to estimate the extent to which NGOs’ commitments are double-counted.

**Figure A1.2:** Government health spending on RMNCH in 25 low-income countries, with and without financial commitments to the Global Strategy, 2011–2015

Note: Of the 27 low-income countries that made financial commitments to the Global Strategy, 25 countries made commitments to raise their annual health budget by a specified percentage and two countries (Pakistan and Uganda) committed to increase their family planning expenditures by a specified amount. This figure reflects the government health spending on RMNCH by the 25 low-income countries according to their commitments.

**Table A1.1:** Approaches to controlling for double-counting

<table>
<thead>
<tr>
<th><strong>Multilateral agencies and global health partnerships</strong></th>
<th>Commitments by bilateral and private donors channelled through multilateral organizations and global health partnerships were counted.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Donor commitments were then subtracted from the amounts pledged by the different multilaterals and global health partnerships.</td>
</tr>
</tbody>
</table>

| **NGOs** | NGOs were requested to provide information on the extent to which their commitment relied on funding from international donors. |
|  | To fill data gaps, relevant documents were reviewed to estimate the share of donor funding that was channelled through NGOs (e.g. annual reports, IHME data). |
|  | On average, it was estimated that approximately 60% of NGO commitments are subject to double-counting. |

| **Low-income countries (LICs)** | In order to estimate the amount of external resources for health provided to the government budget of LICs, ODA for health channelled through the public sector was calculated for the 27 LICs which made financial commitments (source: CRS data). |
|  | The proportion of these external resources for health in total government health expenditures in the 27 LICs was calculated (for each LIC, the mean for 2008–2011 was drawn, source: NHA data). |
|  | Subsequently, the interquartile range (IQR) for the 27 LICs was calculated. The IQR is the range of the middle 50% of the data, excluding extreme values (“outliers”). The IQR is considered a more robust statistical measure than the range. |
|  | The calculated IQR (17% and 57% of LIC commitments) was subtracted from projected LIC spending. |

| **Middle-income countries (MICS)** | In order to estimate the amount of external resources for health provided to the government budget of MICs, ODA for health channelled through the public sector was calculated for the three MICs that made financial commitments (source: CRS data). |
|  | The share of these external resources for health of total government health expenditures in the three MICS was calculated (for each MIC, the mean for 2008–2011 was drawn, source: NHA data). |
|  | Subsequently, the mean for the three MICS was calculated. |
|  | The calculated mean of 1.9% was subtracted from amount committed by the MICS.
While low-income countries are also a potential source of funding (i.e. they generate new resources for health, e.g. through taxes), their commitments are likely to be financed partly by external resources, which means that their commitment could also overlap with commitments by international sources.

Approach to estimating additional commitments for RMNCH

Global Strategy commitments included ongoing financial RMNCH investments as well as new investments specifically targeting the funding gap identified in the Global Strategy. Determining the extent to which the financial commitments address this funding gap was a complex exercise: methods and assumptions vary between different stakeholders. For example, the G8 members of the Muskoka Initiative equated new and additional funding with RMNCH-related investments above baseline spending in 2008 (this baseline year was chosen due to lack of more up-to-date data). As described above, to estimate the additional funding committed by 27 low-income countries, a different approach and baseline were used (based on the mean of government health spending in 2006–2009).

A conservative approach was used to estimate the amount of additional funding. Funding was only counted as additional when at least some available evidence supported this assumption in a convincing manner. Stakeholders provided data on the additionality of funding in interviews and the online survey.

This approach led to the following results:

- Since the commitments made at the G8 Muskoka Summit are by definition new funding, the total amount of US$ 7.3 billion pledged by the G8 and other partners to RMNCH can be considered as additional.
- The governments of Norway and the United Kingdom made additional funding commitments on top of their Muskoka commitments. Australia, Denmark, the Republic of Korea and Sweden, which had made no individual commitment to Muskoka, confirmed that part of their commitments is additional.
- Once double-counting is controlled for, commitments by low-income countries can also be deemed additional (there are no commitments to provide additional funding from middle-income countries).
- The funding that GAVI mobilized at its 2011 replenishment conference (US$ 4.3 billion) can be considered as new funding (when double-counting is eliminated). The funding raised at the replenishment is for new GAVI programmes and thus fully adds to GAVI’s previous spending.
- Some funding provided by the Global Fund can also be considered as additional. While the Global Fund disbursed US$ 8.1 billion between 2008 and 2010, it expects to disburse US$ 9.4 billion between 2011 and 2013. The difference between the disbursements in these two time frames (2008–2010 and 2011–2013) is US$ 1.3 billion. Of this amount 46% can be counted for RMNCH according to the Muskoka methodology.

Thus, compared with the 2008–2010 period, a total of US$ 616 million is additional funding.

- Some funding provided by the private sector, foundations and NGOs can also be considered additional according to the commitment text and information provided in interviews and in the survey.

Assumptions concerning the contribution of Global Strategy financial commitments towards closing the US$ 88 billion financing gap

The estimated financing gap of US$ 88 billion to scale up services for women’s and children’s health and save 16 million lives by 2015 was calculated for 49 priority countries (the US$ 88 billion gap does not include costs required to meet other health MDGs). However, the additional resources committed to the Global Strategy include other high-burden countries (for example, India and Indonesia were not among the 49 countries that informed the estimated gap of US$ 88 billion).

For estimating how much of the confirmed additional funding from international stakeholders would be channelled to the 49 Global Strategy countries, the most recent financing data on disbursements to MNCH as calculated by Countdown to 2015 were used as a starting point. Countdown tracks the disbursements to MNCH in 74158 priority countries, which include the 49 Global Strategy countries. For 2010, Countdown estimated that 77.1% of all official development assistance (ODA) for MNCH was allocated to these 74 countries (US$ 5.0 billion out of US$ 6.5 billion), and 60.5% (US$ 3.9 billion) to the 49 Global Strategy countries.

Assuming that the allocation of funding from donor commitments to the Global Strategy follows the same pattern, i.e. that 60.5% of the US$ 13.1 billion in new confirmed funding from international stakeholders will be allocated to the 49 Global Strategy countries, a total of US$ 7.9 billion will flow to these countries. This may be considered a minimum: donors may have allocated

<table>
<thead>
<tr>
<th>Table A1.2: Confirmed new and additional funding commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount considered additional (US$ billion)</td>
</tr>
<tr>
<td>Muskoka pledges (including the Bill &amp; Melinda Gates Foundation)</td>
</tr>
<tr>
<td>Bilaterals in addition to Muskoka</td>
</tr>
<tr>
<td>Low-income countries</td>
</tr>
<tr>
<td>GAVI Alliance</td>
</tr>
<tr>
<td>Global Fund</td>
</tr>
<tr>
<td>Private sector, foundations (except the Bill &amp; Melinda Gates Foundation), NGOs</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
an even higher share of their funding to the 49 priority countries due to the high visibility generated by the Global Strategy since 2010.

As noted above, the financial commitments by low-income countries can also be deemed additional once double-counting is taken into account. After controlling for double-counting, US$ 4.7–9.0 billion in additional funding for 2011–2015 comes from low-income countries. However, only 23 out of the 27 low-income countries with financial commitments are among the 49 Global Strategy countries, and only the funding from these 23 countries contributes to reducing the US$ 88 billion funding gap. The additional funding provided by these 23 countries is estimated at US$ 4.5–8.6 billion.

**Approach to estimating disbursements against Global Strategy commitments**

To estimate the amount of disbursements made by the various stakeholders against their respective Global Strategy commitments, a range of data sources were analysed. The data on disbursements by international stakeholders stem from information provided by the stakeholders through interviews, the online survey and supporting documents. This information was complemented with figures from the CRS database where possible. Only part of the disbursements made by high-income countries was reported via the OECD CRS database or in a format that allowed for a breakdown according to channel and target area.

The information on disbursements made by low- and middle-income countries is based on National Health Account data. The three middle-income countries committed to maintaining their RMNCH or family planning funding levels, (India, Indonesia and the Philippines) have increased their domestic RMNCH spending from US$ 6.8 billion in 2010 to US$ 8.3 billion in 2011. Based on the commitment text, their total commitment amount over five years was estimated at US$ 6.8 billion in the two previous PMNCH reports. It was therefore assumed that these three stakeholders have already exceeded their commitment to the Global Strategy (see Table A1.3 for breakdown of disbursements by constituency group).

**Approach to estimating overall RMNCH disbursements**

Disbursement data were collected by several methods. As described in Chapter 3, the CRS database was used to estimate donor flows for RMNCH. The CRS database includes health ODA until 2011. Given the limitations of the CRS database, the Muskoka methodology was used to estimate RMNCH disbursement levels. The disbursement estimates were then compared with the Countdown to 2015 disbursement estimate. This comparison shows that the Muskoka method seems to underestimate RMNCH ODA provided to the Countdown countries. Countdown to 2015 estimates donor disbursements to maternal, newborn and child health (MNCH), with MNCH disbursement data being available for the years 2003-2010. In 2013, Countdown published an analysis on disbursements for reproductive health covering the years 2009 and 2010. In its analyses, Countdown uses project level data generating more robust results. The combined results allow for calculating global RMNCH expenditures and these can be compared with estimates calculated based on the Muskoka method.

According to Countdown, US$ 7.5 billion and US$ 7.8 billion were disbursed by donors to RMNCH in 2009 and 2010 respectively. When converted to constant 2005 US$, the RMNCH ODA according to the Countdown analysis amounted to US$ 6.5 billion in 2009 and US$ 6.8 billion in 2010. This is on average 13.3% higher than the estimates based on the Muskoka methodology (US$ 5.7 billion in 2009 and US$ 6.0 billion in 2010).

This was considered in the trend analysis (see Chapter 3, Section 3.4: Projection of RMNCH disbursements until 2015) which was based on the mean of the Muskoka-based and the Countdown estimates. To estimate the expenditures of countries, NHA data were used. As noted above, it was assumed that 25% of government health spending will benefit RMNCH.

Some additional 2012 data were collected by the online survey conducted for this report and key informant interviews (after the interviews, stakeholders provided data to inform the analysis of disbursements). Many stakeholders were unable to provide 2012 disbursement data. This was often due to financial year cycles, and the time-lag between disbursement and reporting, rather than unwillingness to provide data. For this reason, the disbursement figures presented in this report are likely to underestimate the amount of resources actually disbursed.

### Table A1.3: Breakdown of disbursements by PMNCH constituency group

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Disbursement amount, US$ million</th>
<th>Share of total disbursement, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-income countries</td>
<td>9343.5</td>
<td>37.4</td>
</tr>
<tr>
<td>Middle-income countries</td>
<td>6796.0</td>
<td>27.2</td>
</tr>
<tr>
<td>Global Fund and GAVI</td>
<td>4515.2</td>
<td>18.1</td>
</tr>
<tr>
<td>NGOs</td>
<td>2265.4</td>
<td>9.1</td>
</tr>
<tr>
<td>Foundations</td>
<td>1034.5</td>
<td>4.1</td>
</tr>
<tr>
<td>Low-income countries</td>
<td>492.8</td>
<td>2.0</td>
</tr>
<tr>
<td>Multilaterals</td>
<td>469.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Private sector</td>
<td>34.7</td>
<td>0.1</td>
</tr>
<tr>
<td>Health-care professional associations and</td>
<td>4.8</td>
<td>0.02</td>
</tr>
<tr>
<td>academia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24 956.1</strong></td>
<td></td>
</tr>
</tbody>
</table>
This annex sets out the methodology for developing the thematic analyses (Chapters 5–8). The approach, which was agreed with the PMNCH 2013 Report Steering Committee and relevant members of the Advisory Group, consisted of:

- a comprehensive literature review
- key informant interviews
- quantitative and qualitative analysis of commitments text and survey responses.

**Literature review**

The literature review considered general documents cutting across all themes (e.g. the Global Strategy for Women’s and Children’s Health; Countdown to 2015 Reports) and theme-specific documents (e.g. UNICEF’s *Progress for Children: A report card on adolescents* (2012); *Lancet* Series on Family Planning (2012); *Born Too Soon: The Global Action Report on Preterm Birth*; and PMNCH Knowledge Summary #16: Parliamentarians). This encompassed a desk-based review of peer-reviewed and grey literature. An initial literature list was supplemented by documents provided by key informants. A targeted web search was also undertaken to ensure that the review was comprehensive.

**Key informant interviews**

Informant interviews provided information critical for understanding the nature and progress of the commitments made in each thematic area.

**Interviews with the Advisory Group**

Interviews were conducted with Advisory Group members at the outset of the analysis, to identify additional literature and data sources, and to discuss emerging issues. Advisory Group members were also invited to comment on draft versions of the thematic analysis.

**Interviews with commitment-makers**

Commitment-makers were selected for interview based on a key-term search of commitments text in order to identify which commitments were most relevant to each theme. Examples of key terms used to identify commitments relevant to each theme included campaign (advocacy), contraception (family planning), youth (adolescent health) and preterm (newborn health).

The selection criteria used to develop the initial list of interviewees sought to ensure a balance between themes and different constituencies, taking into account: the total number of terms across themes; the number of themes covered; and the size of the financial commitment. The approach used to account for the total number of terms across themes and the number of themes covered was:

- Commitments were analysed based on a key-term search, and terms identified based on an initial discussion with PMNCH. In many cases, instead of searching for full words, the roots of words were included to ensure that all variations were captured in the search.

- The “top” commitments in each theme were based on the total number of keywords included in the commitment text. Given the differences in the number of search terms used across the themes, tailored cut-off points were used in each theme to identify the top commitments.
  - Advocacy: eight top commitments identified (those with three or more key terms)
  - Family planning: eight top commitments identified (those with four or more key terms)
  - Adolescents: seven top commitments identified (those with four or more key terms)
  - Newborn health: eleven top commitments identified (those with five or more key terms).

- The top commitments related to each theme were consolidated into a list of 31 commitments and the aggregate score of terms across themes was computed. By first identifying top commitments for each theme (as opposed to selecting based on the aggregate score) bias in any one theme was mitigated, ensuring that the final list of commitment-makers selected was balanced across themes. Aggregating scores also allowed the prioritization of interviewees with multiple thematic focus areas.

Additional stakeholders were also included in the list of interviewees following inputs from PMNCH’s private sector constituency focal point.

A total of 13 phone interviews were conducted by CEPA in April and May 2013 using a semi-structured questionnaire. Additional interviews were undertaken by SEEK Development, and where appropriate, these incorporated interview questions relevant to the themes.

**Quantitative and qualitative analysis**

As noted above, quantitative and qualitative analysis drew on commitments text and survey responses.
1. Identifying commitments related to each theme

Apart from advocacy, no survey questions were directly related to the themes, so the survey was not sufficient on its own to categorize commitments by theme. Therefore, three separate approaches were triangulated to identify which commitments were relevant to each theme: SEEK’s analysis of non-financial commitments; CEPA’s non-financial commitments analysis based on keyword searches; and survey responses. This was carried out for all themes, including advocacy. The added benefit of this approach was to verify self-reported accounts from stakeholders.

- **Commitments text keyword analysis**: this analysis identified which commitments were related to each theme using an automated search based on keywords. The approach is similar to the method to identify the relevant commitments for stakeholder interviews, as described above. However, the list of search terms was revised to ensure that the terms were specific to each theme, based on feedback from AG members (see Table A2.1).

- **Survey analysis**: stakeholder responses to the survey were also considered in order to determine whether a commitment contained elements of a particular theme. In particular, responses to Q3 on essential interventions were used to identify commitments relevant to adolescent health, family planning and newborn health. Advocacy commitments were identified based on responses to Q22 regarding advocacy focus areas.

- **Commitments text continuum of care and advocacy analysis**: SEEK disaggregated non-financial commitments into research, policy, service delivery/health system strengthening and advocacy commitments, and also against the different essential interventions. The relevance of commitments to each of these areas was assessed using a manual search based on descriptions of different types of commitments.

Triangulating between the three sources, a commitment was deemed to be relevant to a particular theme in these circumstances:

- where all three approaches indicated that the commitment was/ was not related to the theme;
- where the survey analysis and the keywords analysis both indicated that the commitment was/ was not related to the theme;
- where the survey analysis and the continuum of care and advocacy analysis indicated that the commitment was/ was not related to the theme;
- where there were no survey responses, but the keywords and the continuum of care and advocacy analysis both indicated that the commitment was/ was not related to the theme.

### Table A2.1: Key search terms in each theme

<table>
<thead>
<tr>
<th>Theme</th>
<th>Advocacy</th>
<th>Family planning</th>
<th>Adolescent health</th>
<th>Newborn health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accountab*</td>
<td>* Men</td>
<td>Adolescent*</td>
<td>Asphyxia</td>
</tr>
<tr>
<td></td>
<td>Advoca*</td>
<td>Abortion</td>
<td>Boy</td>
<td>Babies</td>
</tr>
<tr>
<td></td>
<td>Campaign</td>
<td>Condom</td>
<td>Child marriage</td>
<td>Baby</td>
</tr>
<tr>
<td></td>
<td>Champion</td>
<td>Contracep*</td>
<td>Early marriage</td>
<td>Birth attendant</td>
</tr>
<tr>
<td></td>
<td>Empower</td>
<td>Family plan*</td>
<td>Forced marriage</td>
<td>Helping babies breathe</td>
</tr>
<tr>
<td></td>
<td>Encoura*</td>
<td>Fertil*</td>
<td>Gender</td>
<td>Infection</td>
</tr>
<tr>
<td></td>
<td>Influen*</td>
<td>Implant</td>
<td>Girl</td>
<td>Kangaroo mother care</td>
</tr>
<tr>
<td></td>
<td>Internet</td>
<td>Intrauterine device</td>
<td>HPV</td>
<td>Neonatal; Neo-natal</td>
</tr>
<tr>
<td></td>
<td>Media</td>
<td>IUD</td>
<td>School</td>
<td>Post natal; Postnatal</td>
</tr>
<tr>
<td></td>
<td>Mobi*</td>
<td>Long acting</td>
<td>Sexual education</td>
<td>Post partum; Post-partum</td>
</tr>
<tr>
<td></td>
<td>Parliament</td>
<td>Long-acting</td>
<td>Sexuality education</td>
<td>Prematur*</td>
</tr>
<tr>
<td></td>
<td>Politic*</td>
<td>Pill</td>
<td>Sexually transmitted*</td>
<td>Preterm; Pre-term</td>
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<tr>
<td></td>
<td>Press</td>
<td>Planned parent</td>
<td>STD</td>
<td>Resus*</td>
</tr>
<tr>
<td></td>
<td>Social media</td>
<td>Pregnan*</td>
<td>Teen</td>
<td>Skin contact</td>
</tr>
<tr>
<td></td>
<td>Web</td>
<td>Pre-pregnan*</td>
<td>Violence</td>
<td>Still birth; Stillbirth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Right</td>
<td>Young people</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unintended pregnancy</td>
<td>Youth</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unmet need</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* indicates that the root of the word was included in the search.

Note: Terms that were searched for but not included in any commitment text are not included in this table.
In the following cases further evaluation was carried out to determine whether a commitment could be classified into a particular theme:

- Where only the survey analysis indicated that the commitment was relevant to the theme, a manual check was necessary to determine whether the commitment was, in fact, relevant. Some stakeholders indicated that their commitment was relevant to a theme in the survey, even though this was not apparent in their initial commitment to the Global Strategy.
- Where there was missing data other than the circumstances outlined above (e.g. commitment was not considered in the continuum of care and advocacy analysis, or no survey response had been received) judgement was used to decide on relevance to the theme.
- In all other circumstances commitments were manually checked for relevance to the theme.

2. Disaggregating commitments by constituencies

For family planning, adolescent health and newborn health themes, the commitments text was used to disaggregate commitments by constituency. This source had a broader list of constituency categories than the survey, which only covered four categories.

3. Proportion of commitments by region and country

Survey responses to Q2 were used to identify the number of commitments within a theme that focused on a particular geographical region or country. As some stakeholders did not indicate their regional focus in the survey, this number was divided by (N), the total number of commitments within the theme less the number of blank survey responses.

4. Percentage of survey responses highlighting different advocacy focus areas (advocacy only)

Survey responses to Q22 were used to identify the number of advocacy commitments within a particular advocacy focus area (e.g. service delivery, RMNCH financing). This number was divided by (N), the total number of advocacy commitments less the number of blank survey responses.

5. Proportion of commitments by number of advocacy focus areas (advocacy only)

Survey responses to Q22 were used to identify the number of advocacy focus areas commitments to which each advocacy commitments was relevant. This varied between one and all five focus areas included in the survey (service delivery, RMNCH financing, accountability, policy and social determinants/human rights/equity). The number of advocacy commitments were divided by (N), the total number of responses indicating at least one focus area.

6. Progress in implementing commitments by theme

Survey responses to Q28 were used to determine the level of agreement of stakeholders within each theme, with the statement: “The implementation of our Global Strategy commitment will be completed by 2015”. The relative proportions of the different levels of agreement were computed by dividing the number of responses indicating a particular level of agreement by (N), the total number of responses for the question. Respondents were therefore able to select more than one option. Additionally, the qualitative responses to Q22.2 (advocacy), Q24 (adolescent health), Q25 (family planning) and Q26 (newborn health) provided examples of progress achieved in implementing commitments.

7. Progress in implementing advocacy commitments disaggregated by focus area (advocacy only)

Survey responses to Q28 by stakeholders with advocacy commitments were disaggregated in terms of the different advocacy focus areas. Within each advocacy focus area, the total number of responses indicating a particular level of agreement was divided by (N), the total number of responses for the question. The denominator thus varied across the advocacy focus areas, due to blank responses and differences in the number of stakeholders with commitments in a particular advocacy focus area.

8. Extent to which the implementation of commitments is: (a) affecting the health of women and children, and (b) contributing to the specific outcomes and goal of the Global Strategy

Survey responses to Q28 also indicated the level of agreement of stakeholders within each theme with these statements:
- “We have early evidence that the implementation of our commitment is improving the health of women and children.”
- “We have early evidence that the implementation of our commitment is contributing to the specific outcomes and goal of the Global Strategy.”

The proportions of the different levels of agreement for each statement were determined according to the method described in Analysis 6. In other words, the total number of responses for each level of agreement was divided by (N), the number of overall responses for the question.

The qualitative survey responses to Q28.1 and Q28.2 were analysed to identify examples of evidence demonstrating the impact of commitments in terms of improving the health of women and children and/or contributing to the advancement of the Global Strategy. Qualitative analysis of the impact of commitments was further informed by responses to Q22.2 (advocacy), Q24 (adolescent health), Q25 (family planning) and Q26 (newborn health).
9. Constraints in implementing commitments
Survey responses to Q29 were used to infer the number of stakeholders within a particular theme that encountered each of the listed constraints in the implementation of their commitments. The proportion of commitments by constraints was determined by dividing this number by (N), the total number of commitments within that theme, less the number of blank responses and the number of stakeholders who indicated that they had not encountered a significant constraint.

Responses to Q29.1 provided inputs into qualitative analysis of the constraints encountered in the implementation of commitments.

10. Impact of advocacy commitments (advocacy only)
Survey responses to Q22.1 were used to determine the impact of advocacy commitments in a number of areas. Within each area, the relative proportions of the different impact levels were computed by dividing the number of responses indicating a particular impact level by (N), the total number of responses within that impact area.
## Annex 3

**Stakeholders that made financial commitments by constituency**

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Number of financial commitment-makers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-income countries</td>
<td>26</td>
</tr>
<tr>
<td>NGOs</td>
<td>26</td>
</tr>
<tr>
<td>High-income countries</td>
<td>17</td>
</tr>
<tr>
<td>Foundations</td>
<td>16</td>
</tr>
<tr>
<td>Private sector</td>
<td>11</td>
</tr>
<tr>
<td>Health-care professional associations</td>
<td>6</td>
</tr>
<tr>
<td>Middle-income countries</td>
<td>5</td>
</tr>
<tr>
<td>Global partnerships</td>
<td>4</td>
</tr>
<tr>
<td>Academic and research institutions</td>
<td>3</td>
</tr>
<tr>
<td>Multilaterals</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>117</strong></td>
</tr>
</tbody>
</table>
## Annex 4

### Per capita disbursements to Countdown to 2015 countries*

#### Countries receiving the highest amounts of disbursements per capita

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>54.6</td>
<td>Botswana</td>
<td>50.5</td>
<td>Solomon Islands</td>
<td>23.8</td>
<td>Sao Tome and Principe</td>
<td>30.1</td>
</tr>
<tr>
<td>Sao Tome and Principe</td>
<td>24.7</td>
<td>Solomon Islands</td>
<td>17.3</td>
<td>Swaziland</td>
<td>21.7</td>
<td>Solomon Islands</td>
<td>29.8</td>
</tr>
<tr>
<td>Equatorial Guinea</td>
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<td>Zambia</td>
<td>14.9</td>
<td>Lesotho</td>
<td>17.9</td>
<td>Swaziland</td>
<td>23.3</td>
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<td>Solomon Islands</td>
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<td>17.6</td>
<td>Lesotho</td>
<td>21.7</td>
</tr>
<tr>
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<td>13.2</td>
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<td>16.1</td>
<td>Zambia</td>
<td>16.7</td>
</tr>
<tr>
<td>Liberia</td>
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<td>Djibouti</td>
<td>13.1</td>
<td>Liberia</td>
<td>15.2</td>
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<td>Liberia</td>
<td>14.6</td>
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<td>Sao Tome and Principe</td>
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<td>12.1</td>
<td>Haiti</td>
<td>13.1</td>
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<td>Lesotho</td>
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<td>Haiti</td>
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<td>10.8</td>
<td>Mozambique</td>
<td>11.1</td>
</tr>
<tr>
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<td>Kenya</td>
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<td>8.1</td>
<td>Guinea-Bissau</td>
<td>9.4</td>
<td>Sierra Leone</td>
<td>8.7</td>
</tr>
</tbody>
</table>

#### Countries receiving the lowest amounts of disbursements per capita

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Egypt</td>
<td>0.9</td>
<td>Bangladesh</td>
<td>1.1</td>
<td>Pakistan</td>
<td>1.2</td>
<td>Morocco</td>
<td>0.9</td>
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<td>Azerbaijan</td>
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<td>Morocco</td>
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<td>Peru</td>
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<td>Turkmenistan</td>
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<td>Turkmenistan</td>
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*In US$ 2010 prices
Second scenario for projections of RMNCH disbursements until 2015

The more negative scenario projects RMNCH expenditures until 2015 based on the average annual increase between 2009 and 2011, the years most strongly affected by the global financial crises. This scenario estimates that the RMNCH expenditures of the 49 Global Strategy countries would increase to US$ 3.1 billion by 2015 (in constant 2005 prices and excluding external resources). This means that their total additional RMNCH funding from their own resources would be US$ 3.3 billion over the 2008 baseline (Figure A5.1).

Based on the same projections, RMNCH ODA to the same 49 countries would increase to US$ 5.4 billion by 2015 (also in US$ 2005 prices). This would result in a total of US$ 7.0 billion in additional RMNCH ODA to these countries over the 2008 baseline.

Combined spending (RMNCH expenditures of the 49 countries and RMNCH ODA received by these) would therefore reach US$ 8.5 billion by 2015, resulting in a total of US$ 10.3 billion in additional funding for RMNCH in the period 2011–2015 over the 2008 baseline. This covers 11.7% of the financing gap identified by the Global Strategy.

Estimating progress towards two outcome targets of the Global Strategy: family planning and immunization

Projections on funding for family planning

According to the Global Strategy, in 2015 alone 43 million new users would have access to family planning if the financing gap identified by the Global Strategy were closed. The estimated additional programme costs for the period 2011–2015 for scaling up services related to family planning in the 49 lowest-income countries are estimated at US$ 4.89 billion (background paper “Financial Estimates in the Global Strategy”).

The additional funding available for family planning was projected for the period 2011–2015 based on the mean annual increases of ODA for family planning (CRS sector code 13030) between 2008 and 2011 and domestic expenditures for family planning by the 49 Global Strategy focus countries (assuming that 3% of total government expenditures for health is used for family planning interventions).

According to these projections, ODA for family planning would increase by a total of US$ 1.4 billion between 2011 and 2015 (over 2008 levels in constant 2005 prices). This would provide an estimated 12.5 million new users.

Figure A5.1: Projection scenario 2 for RMNCH disbursements until 2015

Government expenditures and gross ODA disbursements in US$ billion, 2005 prices

Source: Calculations based on data from the OECD Creditor Reporting System, National Health Accounts and Countdown to 2015.
with access to family planning in 2015. Domestic expenditures for family planning would increase by a total of US$ 432 million between 2011 and 2015 (over 2008 levels in constant 2005 prices). This would provide an estimated 4.7 million new users with access to family planning in 2015.

The combined expenditures for family planning (ODA for family planning and domestic expenditures for family planning) would increase by a total of US$ 1.9 billion between 2011 and 2015 (over 2008 levels in constant 2005 prices). This would close 40% of the financing gap identified in the Global Strategy and provide an estimated 17.1 million new users with access to family planning in 2015 (Figure A5.2).

Progress towards the immunization target

According to the Global Strategy, in 2015 alone, 15.2 million more children under one year of age would be fully immunized if the financing gap identified by the Global Strategy were closed. The estimated additional programme costs for the period 2011–2015 for scaling up services related to immunization in the 49 lowest-income countries are US$ 5.04 billion (background paper “Financial Estimates in the Global Strategy”).

At the 2011 GAVI pledging conference, GAVI secured US$ 4.3 billion in new funding for the period 2011-2015. In 2012, GAVI used 91.7% of its disbursements on new and underused vaccines support. Basic immunization (e.g. DTP3) is covered through other funding sources, including domestic funding. Globally, GAVI expects to immunize a total of 243 million additional children across all of its approved vaccine programmes between 2011 and 2015. Given that there are also new pledges for polio vaccination, and assuming that funding for basic immunization will be provided by other sources, a much larger number of children would be fully immunized than expected by the Global Strategy.

Figure A5.2: Projections of family planning spending trends until 2015

Source: Calculations based on data from the OECD Creditor Reporting System and National Health Accounts.
2. MDG 5 has two targets. Target 5A is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; target 5B is to achieve, by 2015, universal access to reproductive health.
4. The US$ 88 billion is in addition to the estimated cost of US$ 81 billion of other costs for scaling up to meet the health MDGs. These include the remaining half of health-systems costs, plus costs for diagnosis, information, referral and palliative care for any presenting conditions; remaining treatment costs for major infectious diseases, such as TB, HIV/AIDS and malaria; and costs associated with nutrition and health promotion.
5. On the issue of global reporting, the CoIA proposed a time-limited iERG be established and operate until 2015. Starting in 2012 and ending in 2015, this group is reporting regularly to the UN Secretary-General on the results and resources pertaining to the Global Strategy and on progress in implementing the CoIA’s recommendations.
6. In 2012 the online survey was fully completed by 167 of 220 stakeholders.
7. Small subsamples used for some parts of the analysis limit the ability to report on the progress made by low- and middle-income countries in implementing their commitments and associated accountability mechanisms.
9. Due to the time frame for the 2012 report’s analysis, it was not possible to include commitments made in conjunction with the launch of Born Too Soon: The Global Action Report on Preterm Birth in May 2012, at the Child Survival Call to Action in June 2012, or at the London Summit on Family Planning in July 2012.
10. The number of stakeholders is based on commitments listed on the Every Woman Every Child website at http://www.everywomaneverychild.org. Some commitments were made by more than one stakeholder, so the total number of stakeholders exceeds the total number of commitments.
11. Specific commitments to the UN Commission on Life-Saving Commodities for Women and Children and Committing to Child Survival are not explicitly listed as Global Strategy commitments on the Every Woman Every Child website, unlike FP2020 and Born Too Soon.
13. There is no similar assessment available for progress towards MDG 5B: to achieve universal access to reproductive health.
16. Mali has replaced Pakistan.
17. The countries with the highest absolute funding are not necessarily those with the highest per capita amount (see Chapter 4).
24. In an effort to estimate the total value of financial commitments made (including by low- and middle-income countries), all commitments to provide or increase funding for family planning according to the respective commitment texts were estimated and added. The result of this was: US$ 246 million committed by high-income countries, US$ 201 million committed by low-income countries, US$ 15 million committed by one middle-income country and US$ 30 million committed by NGOs.
25. It is noteworthy that these investments are part of a significant increase in MDG 4 and 5 funding by Norway. In conjunction with the United Nations General Assembly in 2012, Norwegian Prime Minister Stoltenberg pledged an additional US$ 100 million in the budget year of 2013 to the follow up of MDG 4 and 5 of which US$ 85 million would be for the follow up of the UN Commission on Life-Saving Commodities including family planning and the Saving Mothers, Giving Life partnership and US$ 15 million additional to GAVI.
28. Previously existing funding relates to pre-Global Strategy spending levels for RMNCH that stakeholders committed to sustain and that have now been brought under the umbrella of the Global Strategy.
29. OECD, Development Co-operation Directorate. Creditor

31. For a detailed list of the imputed percentages as well as the purpose codes and multilateral organizations which contribute to RMNCH according to the “Muskoka Methodology for Calculating Baselines and Commitments: G8 Member Spending on Maternal, Newborn and Child Health”, see http://www.canadamernational.gc.ca/notfound.aspx?q=04%3B/g8_summit_summet/2010/muskoka-methodology-muskoka.aspx (accessed 17 May 2013)


33. The proxy chosen in this analysis may underestimate the real share of government health expenditures benefiting RMNCH. More recent NHA subaccounts data show that a mean of 25.4% of total health expenditure is channelled to reproductive and child health.

34. For example, the United Kingdom counts all disbursements to RMNCH made between April 2010, the start of UK fiscal year 2010/2011, and March 2013, the end of fiscal year 2014/2015, as part of its Global Strategy commitment. Germany counts only additional expenditures (over 2008 levels) on RMNCH as part of its commitment.

35. This is in part explained by the scarce data on disbursements made by private-sector stakeholders.

36. As the Bill & Melinda Gates Foundation has only reported to the CRS since 2009, 2009 data were used for these analyses in order to ensure comparability between 2008 and 2011.


40. In 2009, US$ 3.4 billion was disbursed for child health, US$ 2.5 billion for reproductive health (R*) and US$ 1.5 billion for maternal and newborn health. In 2010, US$ 3.5 billion was disbursed for child health, US$ 2.7 billion for reproductive health (R*) and US$ 1.6 billion for maternal and newborn health. R*(defined as ODA to family planning, sexual health and STIs, include HIV) in constant 2010 US$.

41. Only Azerbaijan and the Gambia, which were among the bottom 10 recipients in 2008, were not among the bottom 10 recipients in 2011.

42. Funding for reproductive health includes funding reported under population policy and administrative management; reproductive health care; and personnel development in population and reproductive health fields.

43. No complete data available for Burundi, Democratic People’s Republic of Korea, Ethiopia, Guinea, Guinea-Bissau, Mauritania, Somalia and Zimbabwe.

44. Calculated in constant 2005 prices; same basis used to calculate the gap in Global Strategy.

45. The group is composed of three low middle-income countries, six upper middle-income countries and one high-income country (Equatorial Guinea).

46. External funding was excluded by discounting the mean share of external resources of total government expenditures for health received by the 49 focus countries in the period 2008–2011.

47. These are: support of 19 million women by a skilled birth attendant; treatment of 2.2 million additional neonatal infections; exclusive breastfeeding of 21.9 million additional infants for the first six months of life; vitamin A supplements for an additional 117 million children under five; protection of 40 million additional children from pneumonia.


52. If the category “other” is not taken into account (accounting for only five responses).


58. Defined as the proportion of women aged 15–49 years who are married or in a union and who have met their need for family planning, i.e. who do not want any more children or want to wait at least two years before having a baby, and are using contraception.


60. DFID, Bill & Melinda Gates Foundation. Summaries of commitments. 8 May 2013.

61. DFID, Bill & Melinda Gates Foundation. Summaries of commitments. 8 May 2013.


65. Based on analysis carried out by SEEK Development.

66. Survey responses.


68. The median figure for the 37 Countdown countries with data on this parameter is 61%.


70. USAID, Population Council, Government of Pakistan.
71. The PMNCH 2013 Report

72. The wheel contains the medical eligibility criteria for starting to use contraceptive methods. It tells family planning providers if a woman presenting with a known medical or physical condition is able to use various contraceptive methods safely and effectively. The wheel includes recommendations on starting to use six common types of contraceptives.

73. Senegal committed to achieving a contraceptive prevalence rate of 45% under its original Global Strategy commitment, but has indicated in its survey response that it is now working towards achieving a target of 27% by 2015.

74. The Jadelle Access Programme is a partnership between Bayer HealthCare, the Bill & Melinda Gates Foundation, the Clinton Health Access Initiative, UNFPA, the Children’s Investment Fund Foundation and the governments of Norway, Sweden, the United Kingdom and the United States of America.


76. Data for 2012 provided by International Planned Parenthood Federation.

77. Analysis by SEEK Development.


79. Analysis by SEEK Development.

80. Centre for Reproductive Rights and UNFPA. The right to contraceptive information and services for women and adolescents. New York, UNFPA, 2010.

81. This is well documented by a USAID study on the experiences of Ethiopia, Malawi and Rwanda with family planning programmes. Three successful sub-Saharan Africa family planning programs: Lessons for meeting the MDGs. Washington, DC, USAID, 2012.

82. Commitments and progress by private-sector stakeholders such as Bayer, Merck and the Female Health Company point to the potential benefits of engaging the private sector further.


94. Commitments analysis and survey analysis of 115 responses received to date.


99. Although these were not specific to adolescents, WHO notes that female genital mutilation is mostly carried out on young girls sometime between infancy and age 15. In Africa an estimated 101 million girls 10 years old and above have undergone female genital mutilation: http://www.who.int/mediacentre/factsheets/fs241/en (accessed 15 July 2013).


112. These are Bangladesh, Brazil, China, the Democratic People’s Republic of Korea, India, Iraq, Morocco, Nepal, Peru, the Philippines, Solomon Islands and Viet Nam.


117. These interventions are: immediate thermal care (to keep the baby warm); initiation of early breastfeeding (within the first hour); hygienic cord and skin care; neonatal resuscitation with bag and mask (by professional health workers for babies who do not breathe at birth); kangaroo mother care for preterm (premature) and for babies weighing less than 2000 g; extra support for feeding small and preterm babies; management of newborns with jaundice (“yellow” newborns); initiating prophylactic antiretroviral therapy for babies exposed to HIV; presumptive antibiotic therapy for newborns at risk of bacterial infection; use of surfactant (respiratory medication) to prevent respiratory distress syndrome in preterm babies; continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome; and case management of neonatal sepsis, meningitis and pneumonia.


121. These are Angola, Guatemala, Botswana, Gabon, Swaziland, Peru, Azerbaijan, Turkmenistan, Iraq and Equatorial Guinea.


123. For example, 2800 signatories pledged their support for the Committing to Child Survival: A Promise Renewed campaign, including from 173 governments. See: www.apromisefornewborns.org

124. This commitment was made by the Global Alliance for Clean Cookstoves at UNF. Financial commitments from Australia/Australian Agency for International Development and the Bill & Melinda Gates Foundation were excluded due to double-counting, and a financial commitment from the March of Dimes was excluded as it related to a fundraising effort.


149. The Global Fund is investing US$10 million for monitoring and evaluation and improving data quality in 20 priority countries and GAVI supports data quality strengthening and facility surveys. Information provided during interviews with representatives of the Global Fund and GAVI.


151. The Inter-Parliamentary Union Resolution on Women’s and Children’s Health: An Initial Framework for Accountability Reporting. Geneva, Inter-Parliamentary Union, 2013.


156. It is legitimate that both the source and the channel count the funding as part of their commitment.

157. This estimate is based on an analysis using a mixed methodology of reviewing survey responses, interviews and other information provided by the NGO, such as annual reports.

158. No data are available for South Sudan, the 75th Countdown country.


161. This did not consider the frequency of each keyword being included in commitment text. The description of commitments varies significantly between commitment-makers. Taking into account the frequency of keywords being included in commitments would have implied commitments with more detailed descriptions being deemed more relevant to a particular theme than commitments with brief descriptions. To avoid this bias, analysis of keywords was binary, i.e. the analysis looked for the inclusion of each term, not how many times it was included.

162. This does not equal the sum of the top commitments in each theme, as some commitments featured in the top commitments list of more than one theme.


164. This estimate is based on a proxy referring to the share of total health ODA that was invested in family planning in 2011.

165. Does not add up due to rounding.

166. Includes hepatitis B vaccine, *Haemophilus influenzae* type b (Hib) vaccine, measles vaccine (second dose), pneumococcal vaccine, rotavirus vaccine and yellow fever vaccine.
### Acronyms

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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>CARMMA</td>
<td>Campaign for Accelerated Reduction of Maternal Mortality in Africa</td>
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<tr>
<td>CoIA</td>
<td>Commission on Information and Accountability for Women’s and Children’s Health</td>
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<tr>
<td>CRS</td>
<td>Creditor Reporting System</td>
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<td>EmONC</td>
<td>Emergency obstetric and newborn care</td>
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<td>FALAH</td>
<td>Family Advancement for Life and Health</td>
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<td>FCI</td>
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<td>GAIN</td>
<td>Global Alliance for Improved Nutrition</td>
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<td>GVAP</td>
<td>Global Vaccine Action Plan</td>
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<tr>
<td>H4+</td>
<td>Comprises UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>HPV</td>
<td>Human papilloma virus</td>
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<tr>
<td>IBP</td>
<td>International Budget Partnership</td>
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<tr>
<td>ICATT</td>
<td>IMCI Computerized Adaptation and Training Tool</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and communication technology</td>
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<tr>
<td>iERG</td>
<td>independent Expert Review Group</td>
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<tr>
<td>IHME</td>
<td>Institute for Health Metrics and Evaluation</td>
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<td>IHP+</td>
<td>International Health Partnership</td>
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<tr>
<td>IMCI</td>
<td>Integrated management of childhood illness</td>
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<tr>
<td>IMPACtt</td>
<td>Integrated Management of Pregnancy and Childbirth training tool</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>IPTp</td>
<td>Intermittent preventive treatment</td>
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<td>IPU</td>
<td>Inter-Parliamentary Union</td>
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<td>KimMNCHip</td>
<td>Kenya Integrated Mobile Maternal Newborn and Child Health Information Platform</td>
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<td>MDG</td>
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<td>MNCH</td>
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<td>NCDs</td>
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<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
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<td>RMNCH+A</td>
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<td>Sexually-transmitted infection</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VACS</td>
<td>Violence against children surveys</td>
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<td>WAGGGS</td>
<td>World Association of Girl Guides and Girl Scouts</td>
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<td>World Health Organization</td>
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The Partnership for Maternal, Newborn & Child Health would like to express its gratitude to all those who have taken part in the survey and interviews and provided information more generally during the report’s development process.

Advisory Group

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

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

Executive Committee of the PMNCH Board

Anuradha Gupta, Government of India; Sabaratnam Arulkumaran, International Federation of Gynecology and Obstetrics; Craig Friderichs, Global System Mobile Association; Flavia Bustreo, World Health Organization; José Miguel Belizán, Institute of Clinical Effectiveness and Health Policy; Nicole Klingen, World Bank; Rajiv Tandon and Francesco Aureli, Save the Children; Ruth Lawson, UK Department for International Development; Sharon D’Agostino, Johnson & Johnson.

PMNCH Secretariat


Countdown to 2015

Jennifer Requejo.

 Consultants

Independent consultant: Joanne McManus.


SEEK Development: Marco Schäferhoff, Christina Schrade, Emil Richter, Anita António, Janina Schnick, Raimund Zühr, Tanja Cohrs.

Other support

Barbara Bulc, Rachael Hinton, Nick Green, Elizabeth Noble, Onochie Esenawah, Tammy Farrell and Caroline Nakandi.

Editing and production

Editing: Robert Taylor Communications Ltd
Design: Roberta Annovi
Web: www.pmnch.org