Final report

External Evaluation of the Partnership for Maternal, Newborn and Child Health

July 2008
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Executive Summary

Three years after it was established, there is still strong support for the original goals of the PMNCH. However, there is lack of clarity about where the organisation can add value and which functions it should perform. There is an urgent need to review the focus of effort, and to ensure that all partners can support the direction in which PMNCH is moving.

There are a number of basic differences in vision which affect the whole underlying principles of PMNCH, from the appropriate role of PMNCH, to where it should work and whether it should be a funding body or not. These differences need to be resolved to make the PMNCH functional, but also to ensure there is corporate cohesion on purpose, functions, plans etc.

Despite the importance of its focus, PMNCH is not viewed as a major player amongst global health partnerships. This may, in part, relate to it not being a funding body, but it also appears to relate to its cross-organization engagement.

1. Continuum of care
The concept of the continuum of care has gained significant currency and credibility, and is now seen as a more strongly held value. PMNCH can claim credit for much of the increased visibility and acceptance. Equally, it has generated greater focus on the needs of the newborn, and therefore of the mother and child dyad as the critical focus for care and services. PMNCH can also claim credit for extending of the Countdown 2015 initiative to include MDG 5 as well as MDG 4.

2. Future functions
PMNCH should only continue in its present form if it can identify where it provides added value. Since it was set up, the global context has changed and there is a perception that there are many strong players in this field who are better placed to undertake some of the functions originally identified (Health Metrics / IHP etc). PMNCH should consider focusing on a new limited “niche” role, initially in global advocacy with a focused and realistic costed work plan. In time there may be agreement as to whether this can extend to include, for example, a regional focus. Discussions at the last Board meeting would seem to confirm this approach, but it will not gain universal approval as there is strong expressed desire for country-level action and implementation.

There is a body of opinion which believes that PMNCH can add value under some circumstances acting as intermediary to develop an MNCH strategy in countries. It is suggested that this might be appropriate as a demand-led function which could be available to countries without internal coordination mechanisms. It must be recognised that there are other bodies who could fulfil this function, but these might not have a sole commitment to MNCH. It might therefore be appropriate to identify which high incidence countries have neither plans nor mechanisms for creating a harmonised plan, and offering to fulfil a facilitator role, possibly using partner organisations in-country or regionally who will adhere to PMNCH principles.

PMNCH has also provided two functions that were not an explicit part of its original remit. One of these is to provide an opportunity for certain constituencies (notably health care professionals) to become more collegiate. This is reported as having significant benefits and every opportunity should be taken to use “internal advocacy” to ensure a strong and unambiguous approach on the continuum of care and the package of effective interventions to ensure buy in.

The second, which is closely related, is the convening role of PMNCH. This is largely, but not solely a process function. Convening the costing tools workshops (and publishing the findings in the public domain) and leading the work on tracking of resources for MNCH is a clear example of the brokerage role played by PMNCH. There is also strong evidence that the organisations and people involved in PMNCH have improved both communication and coordination as a result of their engagement. PMNCH was seen as being an honest broker between constituencies that have previously competed for limited resources. This should become a specific and recognised objective using advocacy as the focus.
3. Membership
Membership of PMNCH is not meaningful; it is not clear what national organizational members contribute to PMNCH or what their obligations are, or what membership benefits they secure from it. There also appears to be marked differences in the level of involvement and engagement of different constituent groups.

4. Working Groups and support functions
If there is agreement that advocacy should form the core function of the PMNCH then both the working groups and the Secretariat function will need modifying. It is suggested that there should be only two standing working groups; advocacy and finance. Time-limited, activity-focused groups should be used as required. For instance, they might be used to prioritise the agreed effective interventions and to undertake a review of delivery on funding commitments. It is essential that partner organisations are prepared to commit time to these groups for them to be effective, and that resources be found to support them where necessary.

5. Board structure and processes
Recognising the inherent conflict between funders and potential recipients on the same board, never the less the underlying structure of the Board appears acceptable. However, there is a need to change Board processes to increase its effectiveness and efficiency. This includes the need to:

- Draw up a schedule of meetings in advance taking into account the need to synchronise with the host organisations processes (planning / budgeting)
- Agree an accountability / monitoring schedule
- Improve the availability of supporting information for decision making
- Develop mechanisms for conflict resolution

6. Secretariat
The institutional framework identifies that the Secretariat is primarily a support and coordination body. Once there is agreement on the future function of PMNCH, the Board needs to confirm the functions it requires of the Secretariat, and the Director and senior staff then need to review the implications of this for their job descriptions, and more importantly for the way they spend their time. Support and facilitation needs extensive communication and networking (not necessarily face-to-face). Staff must be given the opportunity to acquire these competences but must also accept and demonstrate commitment to this new role.

There is an urgent need to strengthen managerial, financial and administrative functions in the Secretariat. The Board must clarify the role, responsibilities and accountability of the Director and provide a schedule of accountability / delegation and operating instructions within which the post-holder should work. This may require amplifying his current post description and being more explicit about dual accountability. Given that the current post-holder does not come from a primarily managerial background, consideration should be given to offering high-level personal development in this field together with independent coaching and mentoring. This is a normal support mechanism for CEOs and Directors in both the public and private sector.

7. Planning and implementation
Planning processes have improved over the life of PMNCH and the use of a value-added work plan should be retained, with more quantifiable indicators for all activities and reporting refined. The work plans and reports should be posted on the website in a clearly signposted, visible location to enhance ownership by members.

There needs to be permanent capacity established in the Secretariat to undertake this process ensuring adequate consultation and buy in. Performance management (objective setting and appraisal) is in place but needs to be used to deliver the work plan. This means setting demanding individual objectives with measurable indicators including budget compliance. It should be supported by funded personal development possibly over and above that offered by WHO.
8. Financial management
Financial management by the Secretariat is improving, however it is not happening as quickly as one might have hoped. Budgeting for work plans needs to be addressed at the most senior level of the Secretariat, and attention paid to expenditure against these work plans.

Financial management needs to be taken more seriously within the PMNCH. This means ensuring adherence to a budgeting and monitoring process and ensuring accurate, timely information is received by the board and individual funders. It is also essential that financial management is exercised to ensure that expenditure is in line with budget. This is essential to reassure current and future donors that their funds are being used in the most efficient and effective manner, and encourage them to use PMNCH reporting cycles. It will also allow a much more effective management of the work programme, staff time, and expenditure against budgets.

9. Finance Committee
Priority should be given to establishing the Finance Committee suggested at the December 2007 Board meeting. The terms of reference have been developed, and the first meeting is due to take place before the July 2008 Board meeting. The role of the committee would be to monitor financial performance, and report to the Board. A finance report (showing expenditure by work plan activity) should be included in the Board agenda as an item “for information” at each meeting. The Board must sign off the annual budget and work plan. A senior financial controller / officer should also be appointed, with responsibility for managing and monitoring the use of all funds.

10. Resource mobilisation
The Secretariat needs to develop a fundraising / resource mobilization strategy that sets out exactly what they need to collect to undertake agreed activities and the mechanisms for doing this. It may be necessary to engage the services of a skilled fundraiser / grant application designer to advise the Secretariat on the most effective mechanisms. PMNCH should also seek advice from other partnerships particularly those which are in a position to fund activities both globally and in specific countries.

11. Hosting
The PMNCH should continue to be hosted by WHO but should seek to make the relationship more functional. It is recognized that WHO is a bureaucratic organization and this does not enhance flexible working. However there are major advantages to being part of a UN organization. PMNCH is not suitable to become an independent trust and any change in hosting is a diversion which should be avoided at this critical time.

There is a requirement for a clearer understanding on the accountability arrangements and greater engagement by the Director. Other global partnerships have found that whilst processes may be cumbersome, most problems can be solved through excellent communication and nurturing the relationship. Ideally a more detailed MOU should be sought with agreed schedules of deliverables and standards. This needs to be considered before the current MOU expires in January 2009.

12. Alignment at country level
While PMNCH is supportive of the spirit of alignment with country priorities, there is some evidence to suggest that the funding from the Bill and Melinda Gates Foundation in particular has led to a supply, rather than a demand-led approach in the countries where it has been active.

13. Alignment with other GHPs
GHPs which provide funding streams for specific issues have the potential for demonstrating impact in reducing health burdens globally and contributing to the health MDGs. GHPs without specific funding for implementation but which focus on advocacy, provide technical assistance and service support to countries have a greater challenge in demonstrating direct impact. This is a potential problem for PMNCH, however one that can be reduced by developing much stronger links with GHPs working on similar goals (achieving MDGs 4 and 5) to identify the potential for overlap and duplication and ensure synergies are maximized.
14. Board alignment
There continues to be a lack of alignment between both individual board members and constituencies at board level. This may be inevitable given the inherent tensions between funders and those seeking funding. However there is evidence that these divisions go further and are based both on the bringing together of three very different groups (Maternal, Newborn and Child Health) but also on historic tensions between some partners. The need for greater board alignment is critical to the future of PMNCH. There needs to be unanimity not only on the overall goals (which exists) but also on the added value of the Partnership and its future functions.

15. Evaluation Report
This report contains 9 sections, as outlined below:

- Section I: Background and rationale
- Section II: Evaluation objectives
- Section III: Methodology
- Section IV: Assessing Effectiveness
- Section V: Assessing Relevance
- Section VI: Assessing Alignment
- Section VII: Assessing Governance
- Section VIII: Assessing Management
- Section IX: Key findings and recommendations

The five main sections (as outlined in the TOR) report the findings of the evaluation team and give recommendations for each area. These recommendations are summarised in the final section, with some measure of which are most critical, and when decisions need to be made.

Section IV, Assessing Effectiveness, reports on PMNCH achievements as measured against past progress, current priorities and work plans. Section V, Assessing Relevance, identifies selected global health partnerships that also contribute to maternal, newborn and child health, and reviews any complementarities and possible duplication with the goals and objectives of PMNCH. Section VI, Assessing Alignment, looks at alignment achievements across the range of PMNCH activities, from country level to success in developing a common purpose among partners in advancing MDG 4 and 5, beyond the differences of mandates of the partners.

Sections VII and VIII, Assessing Governance and Management look at the structural elements and governance functions of PMNCH, and the management functions. All governance structures are reviewed, from the Forum, Partners, Board, Working Groups and Secretariat to the relationship with the host organization. All key management functions are reviewed, from work planning and implementation, reviewing and reporting, administrative efficiency and performance assessment to stakeholder communication, resource mobilization and regulatory compliance.

Section IX summarises the key findings and recommendations, and identifies which ones, in the view of the evaluation team, are critical for the existence and effectiveness of PMNCH, and when the Board is likely to make decisions on the issues. The recommendations of the evaluation team are also included throughout the report under the relevant sections (in bold).

Key points and recommendations from each country visit are included as annexes, along with the list of persons interviewed, the semi-structured interview proforma that was used by the evaluation team, brief overviews of the evaluation team members, and more detailed information on other global health partnerships and on PMNCH financial status.
Section I: Background and Rationale

The Partnership for Maternal, Newborn and Child Health (PMNCH) was established in 2005. A Memorandum of Understanding signed by the Chair of the Interim Steering Committee and WHO defined the hosting arrangements of the PMNCH Secretariat by WHO. PMNCH brought together three predecessor bodies:

- The Partnership for Safe Motherhood and Newborn Health (launched in 1987 as the Safe Motherhood Initiative, and re-launched in 2003)
- The Healthy Newborn Partnership (launched in 2000)
- The Child Survival Partnership (launched in 2004)

It was established as a collaborative mechanism between members. It had no independent existence and was hosted by WHO.

1. Vision
The Vision of PMNCH was to intensify and harmonize national, regional and global action to improve maternal, newborn and child health.

2. Goal
The Goal was to support the achievement of Millennium Development Goals 4 & 5, reducing maternal, newborn and child mortality through:

- Strengthening and accelerating coordinated action at global, regional, national, sub-national and community levels
- Promoting rapid scaling up of proven cost-effective interventions
- Advocacy for increased commitment

3. Priorities
The Priorities as outlined in the conceptual and institutional framework document are:

1. **Country support**: To support national efforts to accelerate universal coverage of essential interventions for maternal, newborn and child health in high mortality countries.

2. **Advocacy**: To establish the priority of, and mobilise the necessary financial investment in, maternal, newborn and child health, globally and at national levels.

3. **Effective interventions**: To promote the development and adoption of evidence based, cost-effective interventions for maternal, newborn and child health, and promote effective delivery strategies; To promote the development of new interventions.

4. **Accountability**: To promote stakeholder coordination and accountability in meeting commitments regarding a) resources and b) policy and programme implementation; To actively monitor and evaluate progress in the implementation of key interventions through the use of robust data.

4. Value of PMNCH
At the time of its conception, the value of PMNCH was identified as follows:

“Through developing and promoting a clear vision around maternal, newborn and child health, PMNCH would represent a powerful, unprecedented collaboration to achieve MDGs 4 & 5 by:

- Coordinating, harmonizing and aligning the activities of individual partners to scale-up proven, cost-effective interventions;
- Integrating efforts to develop solutions that no one partner can achieve alone;
- Enhancing advocacy by forging a clear, unified message that carries the weight of all members standing together;
- Filling gaps in the total solution through the strategic alignment of partner contributions.”
5. Rationale for the Evaluation
In common with other partnerships, an independent evaluation was planned after approximately
two to three years (and stated in the MOU). It was recognised that any such evaluation would
focus more on governance and process than on outputs and outcomes. This is inevitable at this
stage of institutional maturity.

It is recommended that evaluation of partnerships be the responsibility of their governing bodies¹.
In its December 2007 meeting, the Board of PMNCH called for an expedited evaluation. Having a
governing body commission an evaluation which includes governance can result in a potential
conflict of interests. This evaluation was therefore commissioned and overseen by a sub-group of
the Board (the Evaluation Committee) in line with the procedure recommended.

Evaluations can have a number of purposes:

- To review whether the original guiding principles have been adhered to
- To identify progress towards agreed strategic goals
- To examine issues relating to value for money
- To review whether the governance and management arrangements are functional
- To improve accountability mechanisms
- To contribute to learning and knowledge sharing
- To satisfy the needs of funders

This evaluation fulfils a number of these functions but also, most importantly, aims to provide
independent information to allow the Board to consider whether it needs to review the original aims
and to refocus in the light of a changing global context.

Independent Evaluation Group (IEG)-World Bank and OECD/DAC Network on Development Education
http://www.worldbank.org/ieg/group
Section II: Evaluation Objectives

1. Purpose of the evaluation
The purpose of the evaluation, as outlined in the Scope of Work (3-3-08), is to assess the main strengths, achievements, weaknesses and missed opportunities of PMNCH to date, and the options for addressing them. The evaluation questions were framed in the SoW as follows:

1. **Effectiveness**: Has PMNCH achieved its objectives as outlined in the Conceptual and Institutional Framework and its 2006 and 2007 approved work plans? Has PMNCH successfully harnessed and harmonized the individual efforts of the partners to improve the survival outcomes of women, newborns and children (or to accelerate progress towards meeting MDGs 4 and 5) through better networking, advocacy, knowledge creation, technical assistance or investments?

2. **Relevance**: Does PMNCH add value within the context of the changing global landscape of multiple, continually changing partnerships and global health priorities? Does PMNCH add something that would not be possible without it? Are PMNCH's activities carried out at the most appropriate level — global, regional, national, or local — in terms of efficiency and responsiveness to the needs of beneficiaries? Does the work of PMNCH and its Secretariat complement, add to and enhance the work of individual partners?

3. **Alignment**: Has PMNCH complied with best practice principles for global health partnership activities at country level? Has the PMNCH effectively reflected the broader principles of the Paris Declaration on harmonization and alignment?

4. **Ownership**: Are the partners and the Secretariat contributing to the success and effectiveness of PMNCH as outlined in the Conceptual and Institutional Framework and its 2006 and 2007 approved work plans? Is there a sense of ownership on the part of various constituencies, both those represented on the Board and those that are not?

5. **Governance**: To what extent have governance functions been effectively implemented by the Board and by Board-established committees and supported by the Secretariat?

6. **Management**: To what extent have management responsibilities been effectively discharged by the Secretariat?

7. **Other**: Are there any major gaps in issues that the PMNCH should be addressing?

The evaluation team was asked to address structural elements of PMNCH: governance issues; strategic objectives including issues of “value added”; expected results measured against past progress and current priorities; and PMNCH’s ability to leverage financing, policy and programmatic results for maternal, newborn and child health globally and at country level.

In addition, the team was asked to examine the role and function of the Secretariat as well as the relative contribution of partner organizations and institutions, the Board and its membership and PMNCH’s standing working groups and committees.

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3. Strategic direction, Management oversight, Stakeholder participation, Risk management, Conflict management, Audit and evaluation.
5. Leveraging funding here does not refer to obtaining funding for the Partnership and its work but to leverage funding for maternal, newborn and child health activities globally and at country level.
Section III: Methods

1. Introduction
As recommended in the Scope of Work, the methods for the evaluation were inspired by the principles and standards for evaluating global partnerships developed by the World Bank and OECD/DAC\(^6\), and draw on lessons learnt from evaluations of other global health partnerships.

The key components of the evaluation can be summarized as follows:

- Initial team briefings
- Document review and analysis
- Semi-structured telephone interviews including triangulation of information already received
- Country visits (countries selected by Evaluation Committee)

The evaluation was undertaken over a period of 7-8 weeks, starting in May 2008, with presentation of the final findings and recommendations at the Board Meeting to be held in London in July 2008.

2. Evaluation Team
The evaluation team were chosen to ensure full coverage of the programmatic and policy issues involved in understanding the continuum of MNCH, and the individual technical areas, as well as in conducting evaluations of complex institutions and partnerships.

The HLSP Evaluation Team were:

- Liz Ollier: Team Leader - Governance and management Lead
- Oona Campbell: MNCH Technical Lead - Pakistan and Cambodia visits
- Karen Newman: Advocacy and Communication Lead - Pakistan and Cambodia visits
- Catharine Taylor: MNCH Specialist - Ethiopia country visit
- Eva Tezcan: MNCH Specialist - Burkina Faso country visit
- Emma Denton: Health Economist - VFM aspects and team coordination
- Yasmin Hadi: Research Assistant - Review of other global health partnerships

Details of the Evaluation Team’s expertise are shown in Annex I.

All members of the Evaluation Team are independent of PMNCH. One team member had an involvement supporting the establishment of the Child Survival Partnership (consulting on support for the concept, advising on governance issues and the conceptual framework) however this involvement was declared at the outset.

3. Evaluation Committee
The decision to undertake an evaluation was approved at the December 2007 PMNCH Board meeting. During this meeting an Evaluation Committee was established to oversee the evaluation. Evaluation Committee members are shown in Annex II.

The Evaluation Committee is accountable to the Board, and will approve the final evaluation report and recommend endorsement by the full Board. The Board will endorse the final evaluation report following presentation of the findings and recommendations at the Board meeting in July 2008. The report will be in the public domain.

Although the evaluation team was contracted by WHO, the Evaluation Committee has been responsible for overseeing the direction of the work, and has had a number of consultations with the Evaluation Team during the course of the work.

4. Involvement of Secretariat

- The management of PMNCH (the Secretariat) has purely provided a role relating to logistics and making available documentation.
- The Secretariat supported a useful initial visit by the Evaluation Team to Geneva at the beginning of the process, which was used to meet the Secretariat team members and learn about PMNCH, the work plans and the management and financial processes, and to gather key data and documents.
- The Secretariat were given the opportunity to review the report (as well as the Evaluation Committee) to correct factual errors but not to change any findings or recommendations.

5. Evaluation Data Sources and Methods

Information for the evaluation was obtained from:

- Data and documents supplied by the Secretariat, by interviewees during country visits, by the Gates Foundation of previous similar evaluations and data and documents obtained on the web, and through a literature review of partnerships.
- Semi-structured interviews, with questions based on the sourcebook, experience from other evaluations, document review and an inception call with the Evaluation Committee. Stakeholder interviews were reviewed, triangulating information and backing information with written evidence where possible.
- Effectiveness was assessed by comparing progress reports against work plans and by identifying key themes which emerged on effectiveness from interviews with Board members, the Secretariat and other stakeholders.

All interviews were undertaken in the strictest confidence and, although the interview records were shared among team members, any reference in the report is non-attributable.

6. Consultation

The evaluation has involved extensive stakeholder participation, through semi-structured telephone and face-to-face interviews, and country visits. The full list of interviewees is listed in Annex III, and the interview proforma is included in Annex IV.

The following groups were consulted:

- Board members from all six constituencies. Although all Board members were contacted it was not possible to arrange interviews with some, particularly country representatives
- Members and Chairs of Working Groups
- Stakeholders within the hosting body (WHO)
- Allied stakeholders and interested parties (other global health partnerships / interested individuals and external organisations)
- Country level informants including MoH staff, development partners and UN agencies, although it was not possible to interview any politicians that had been involved with PMNCH
- The Director and Deputy Director of PMNCH were also interviewed to gain their perspective on key issues.

A list of potential interviewees was shared with the Evaluation Committee for approval before the interviews were started. Unfortunately some people were unavailable (despite being contacted on a number of occasions); however some extras were added to the list on advice of interviewees and two people contacted the evaluation team directly.

Every effort was made to ensure there was a fair representation of constituencies. The groups who were probably least represented were senior level country officials (despite exhaustive efforts) and partners who had no involvement at board or working group level.

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7 The six constituencies of PMNCH are: Partner Countries, Multilateral Organisations, Professional Associations, NGOs, Research and Academic Institutions and Donors / Foundations.
7. Country visits
Short country visits were undertaken to four countries identified by the Evaluation Committee:

- Ethiopia
- Burkina Faso
- Cambodia
- Pakistan

The purpose of these visits was to assess the role of PMNCH at country level, including an assessment of its contribution to accelerating progress towards MDGs 4 and 5 at this level. Four of the evaluation team members participated in country visits. During these visits, they reviewed PMNCH, MoH and partner activities through documentation review prior to the visit and by meeting with as many local stakeholders as possible including the ministries and development partners.

Interviews were written up in a similar format to the telephone interviews and shared with other evaluation team members to ensure lesson-learning across the team, and a summary of key points and recommendations from each visit were prepared. These are in Annexes V-VIII.

The countries visited were selected by the Evaluation Committee. During the May 7-9 discussions with the Partnership Secretariat, it became clear that none of the countries selected were countries where PMNCH had significantly engaged. The Evaluation Team sought clarification of this, particularly in the light of Secretariat suggestions that the team might wish to instead visit India and/or Tanzania, where there had been significant advocacy work.

The Evaluation Committee explained that the country selection included Ethiopia and Burkina Faso as countries where PMNCH had been working directly, and Cambodia and Pakistan as countries where expectations had been raised, but not fulfilled. The Evaluation Team attempted to balance the lack of countries where there had been any Deliver Now advocacy activities by contacting potential interviewees in Tanzania and India to gain additional perspectives. Contact was also made with the Malawi SWAp to ascertain the role of PMNCH in the construction of a harmonised strategic plan. Their responses to specific questions were solicited by email and interviews, and the responses received incorporated into the report.

8. Analysis
Written notes of all interviews were shared among evaluation team members and read carefully. The team also had a face-face meeting in London following completion of the consultation exercise and country visits to discuss the major themes which had emerged.

Individual team members were responsible for drafting different sections of this report but all were asked to comment and bring in supportive or challenging information that they had obtained through their interviews and data analyses. If differences of opinion or uncertainties about facts remained, additional interviews were carried out. It would be inappropriate to quantify findings from in-depth interviews but indications are given as to whether the view was held by a majority of people, a few or just one.
Section IV: Assessing Effectiveness

1. Introduction
Effectiveness is defined as “the extent to which the program has achieved, or is expected to achieve, its objectives, taking into account their relative importance”. The assessment of the effectiveness is undertaken to:

(a) Demonstrate the degree to which the original objectives are being met,
(b) Indicate whether the program should adjust or restate its objectives or strategies to reflect changing circumstances,
(c) Show whether the program needs to put in place additional safeguards or compensatory measures to mitigate any negative unintended results.
(d) Provide accountability to the international community given limited development resources.

2. Achieving Work Plan Activities
Undertaking a systematic assessment of effectiveness is hampered by PMNCH’s lack of a good monitoring framework in the initial years, and by the newness of the PMNCH programme. Table 1 shows the available monitoring framework, namely PMNCH work plans and progress reports.

Table 1: PMNCH Work Plans and Progress Reports

<table>
<thead>
<tr>
<th>Planning document/Work plan</th>
<th>Date started/produced</th>
<th>Date ended</th>
<th>Date reported on</th>
<th>Months operational before revised, superseded or reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Ten year strategic plan</td>
<td>Sept 2005</td>
<td>Sept 2015</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td><a href="http://www.who.int/pmnch/events/2007/10yearsstrategy.pdf">http://www.who.int/pmnch/events/2007/10yearsstrategy.pdf</a></td>
<td></td>
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<tr>
<td>(2) PMNCH Work plan for 2 and 5 years</td>
<td>30 Oct 2006</td>
<td>30 Oct 2008 (24 months); 30 Oct 2011 (60 months)</td>
<td>NA. 2007 work plan mentions high level meetings to high burden countries; approval of a $35 million grant from the Gates Foundation; and publication of Opportunities for Africa’s Newborns.</td>
<td>(2) superseded at 6.5 months by (3)</td>
</tr>
<tr>
<td><a href="http://www.who.int/pmnch/about/steering_committee/200712_item3_2007work_planimplementation.pdf">http://www.who.int/pmnch/about/steering_committee/200712_item3_2007work_planimplementation.pdf</a></td>
<td></td>
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<tr>
<td>(3) Secretariat work plan, 2007</td>
<td>17 May 2007</td>
<td>31 Dec 2007</td>
<td>(4) Implementation of the 2007 Secretariat Work plan. 2-3 Dec 2007</td>
<td>(3) reviewed at 6.5 months by (4)</td>
</tr>
<tr>
<td><a href="http://www.who.int/pmnch/about/steering_committee/20080207_work_plan1.pdf">http://www.who.int/pmnch/about/steering_committee/20080207_work_plan1.pdf</a></td>
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<tr>
<td>(5) 2008 Value-added work plan</td>
<td>1 Jan 2008 (prepared 2-3 Dec 2007)</td>
<td>31 Dec 2008</td>
<td>(6) 2008 Value-added work plan 5 month progress report (Jan-May 2008)</td>
<td>(5) reviewed at 5.5 months by (6)</td>
</tr>
<tr>
<td><a href="http://www.who.int/pmnch/about/steering_committee/20080207_work_plan1.pdf">http://www.who.int/pmnch/about/steering_committee/20080207_work_plan1.pdf</a></td>
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3. Ten year strategic plan (Sept 2005)
The first document is a ten-year strategic plan endorsed by the interim steering committee in Sept 2005 with eight strategic objectives (SO):

1) Include MNCH as a core component of national development and investment plans
2) Mobilize resources and advocate for increased commitment to maternal, newborn and child health.
3) Align partner resources and action.
4) Catalyze implementation at scale of national MNCH plans and essential packages of interventions.
5) Strengthen national health systems, including human resources, to support MNCH.
6) Improve equity in coverage of essential MNCH services.
7) Increase demand for essential MNCH services.
8) Monitor progress towards the achievement of MDGs 4 and 5 and feed results into decision-making processes at all levels.

4. PMNCH work plan for 2 and 5 years (30 Oct 2006)
A work plan based on the 10-year plan was prepared late in 2006, with milestones/results planned for partner and Secretariat activities at 2 and 5 years. There was no progress report for this plan. The lack of clarity on focus countries was identified as problematic however, and the decision to focus on Africa initially was contested by some, particularly in Asia, on the grounds that Asia had large numbers of deaths and potentially more capacity for implementation.

5. Secretariat work plan, 2007 (17 May 2007)
Within half a year the October 2006 work plan was superseded by a revised work plan for 2007 with activities under strategic objectives (SO)1, 2, 3, 4, 5, and 8, grouped in four main areas:

A) Country support (SOs 1, 4, 5);
B) Global Political Advocacy (SO 2);
C) Aligning partners and increasing aid effectiveness (SO 3);
D) Monitoring and accountability and governance (SO 8).

The omission of SOs 6 and 7 in this 2007 work plan seems appropriate, and was not challenged by stakeholders. The 2007 work plan specified focus countries, but did not distinguish between secretarial and partner activities. A total of 34 activities / milestones were included in the plans, but not all activities were funded. It is not easy to determine the extent to which activities had been carried out because quantitative indicators were lacking. Nevertheless it appears that 15 activities were completed, 12 were partially completed, 5 were not done, and 2 were cancelled (one with substitution). Most activities were either conducted by the Secretariat or were WG activities; at least 5 however (linked to the Bill and Melinda Gates Foundation grant activities in Burkina, Malawi and Mozambique) were partner activities.

6. 2008 Value-added work plan (1 Jan 2008)
The 2008 Work plan has five main groups of activities:

1) Work area 1 Global political Advocacy (formerly B and SO 2)
2) Work area 2 Country support (formerly A and SO 1, 4, 5);
3) Work area 3 Aligning partners and increasing effectiveness (formerly C and SO3);
4) Work area 4 Monitoring (formerly D and including accountability and governance (SO8);
5) Work area 5 Core PMNCH functions (a new work area)

Recommendations
The nature of the early work plans makes it nearly impossible to judge the effectiveness of PMNCH in delivering its outputs. The format used for the 2008 value-added work plan is much improved and should be continued and strengthened with more quantifiable indicators. Indicators should be developed for all activities included. For the final progress
reports, WG leaders need to ensure partners report on the status of activities. Posting work plans in a more visible or clearly signposted location on the website might give Partners a better understanding of PMNCH activities and possibly even avoid duplication.

7. Overall Effectiveness of Work areas
PMNCH work was to be carried through the working groups in the four main work areas, presented below.

8. Effectiveness of the Advocacy Work Area
Advocacy is widely identified as an area where PMNCH can add value, both at international level, to mobilize resources for the attainment of MDGs 4 and 5, and at regional and national levels, to mobilize across sectors and disciplines to generate the political will to fund the necessary information, training and services.

PMNCH Director Dr Francisco Songane is widely regarded as a passionate and persuasive speaker, and he has promoted PMNCH and its aims at several high-level international meetings and conferences.

The PMNCH website\footnote{http://www.who.int/pmnch/activities/delivernow/en/index.html} states that Deliver Now for Women & Children is a new global campaign to reduce maternal and child deaths, and that it is being coordinated by PMNCH. This campaign was an identified part of the Global Campaign for the Health MDGs, which was launched in September 2007; it is to the credit of the Partnership that it was identified as the co-ordinating organization. The campaign, in particular its September 2007 launch, has, however, been widely criticized for a variety of reasons, which include:

- Problems with the name chosen - Deliver Now - which was difficult but not impossible to translate, and which invites confusion with the Women Deliver initiative\footnote{http://www.womendeliver.org/initiative/index.htm}, which held a global Conference one month later, in October 2007.

- The branding exercise associated with Deliver Now had an impossibly tight time-frame, since it had been decided to launch the campaign in New York at the same time as the unveiling of the Global Campaign for the Health MDGs. Expensive PR firms were engaged, and the launch went significantly over budget. There was not time to build consensus on the branding, and the name was itself not settled until just before the launch. The launch - an event in Bryant Square - was not seen as having had much impact - it was suggested that an Op-Ed piece in the New York Times might have had more. Unlike the Women Deliver website\footnote{http://www.womendeliver.org/index.htm}, which is constantly updated, the Deliver Now website\footnote{delivernow.org - About Deliver Now} is out of date, refers to events in October 2007 in the future, and the press materials have fact sheets for child and newborn, but not maternal health.

- Virtually no interviewees in countries visited by the HLSP Evaluation Team had seen the Deliver Now website, or were aware of the Campaign. The Evaluation Team were unable to visit India or Tanzania - countries where the Deliver Now campaign has been active at national level, but the low visibility was nevertheless disappointing, given Deliver Now’s claim to be a Global Campaign.

- The extent to which PMNCH is committed to generating awareness of Deliver Now is uncertain; this would not be such a problem if its website did not claim that PMNCH is coordinating this “Global Campaign”.

Work is ongoing in Tanzania and India to spearhead an advocacy campaign, through local partners coordinated by the national White Ribbon Alliance. It is too early to assess the impact of this work.
It has become clear through the country visits that the concept of the continuum of care has gained currency and credibility, and is now seen as a more strongly held value (although in Cambodia the concept was said to have generated confusion because the HIV/AIDS professionals also use the term for care issues related to PMTCT). PMNCH can claim some credit for the increased visibility and acceptance of the continuum of care concept. Equally, it has generated greater focus on the needs of the newborn, and therefore of the mother and child dyad as the critical focus for care and services.

PMNCH can also claim credit for extending of the Countdown 2015 initiative to include MDG 5 as well as MDG 4. One interview respondent and subsequently an Evaluation Committee member expressed the view that PMNCH had enabled the UN agencies to co-opt the Countdown 2015 initiative and had ‘defanged’ its watchdog functions.

The timing of the Countdown Conference to coincide with the Inter-Parliamentary Union meeting in Cape Town in April 2008 was identified in Cambodia (and by some other interviewees) as having been valuable, as it enabled Parliamentarians to become informed, which has created valuable opportunities for subsequent follow-up in-country. PMNCH may have a role to play in helping with follow-up with Parliamentarians.

It is important that PMNCH clarify what kind of advocacy it wants to do. It is not well placed to carry out social mobilization; mobilizing mass campaigns to rise up to tell their leaders to deliver. Other groups, such as White Ribbon Alliance, are better placed to carry out this work, for which activists need to be on the ground, recruiting and motivating people, and enthusing them to campaign for improved maternal, newborn and child health services. However, these groups need messages, goals and targets. They need to know how much money is needed from the government; what is needed for, and by when and where to find information on any shortfalls. People need to be indignant that women are dying and that the necessary health services do not exist, or are seriously deficient, and need to challenge their leaders to explain why they have not put resources into this. Individuals, providers and mothers need to know that others are asking for the same. A strategy is needed for communicating with people, and keeping teams equipped with news, updates etc. For all of these crucial advocacy tasks and strategies, PMNCH could play a vital direct and/or facilitative role.

PMNCH could benefit from two advocacy drives - internal advocacy, which “beams in” messages designed to build consensus and cohesion within the various constituent groups that make up PMNCH; and external advocacy, which “beams out” messages for the outside world on what the priorities are in maternal, newborn and child health. In each case, advocacy work - building support for the cause - will involve valuable consensus building on the content of core messages, key target groups, and the identification of effective advocates - clarifying clearly what is being advocated, to whom and by whom. How to advocate effectively will differ by context, audience and message.

In terms of internal advocacy, membership of PMNCH was not found to be meaningful (particularly for non-Board members). It is not clear what national organizational members contribute to PMNCH, or what they secure from it. Although the PMNCH website identifies membership criteria, responsibilities and benefits, it is not clear who or what Secretariat function is responsible for monitoring adherence, ensuring accountability, etc. Regular, focused communication with members (“beaming in”) could facilitate a greater sense of being part of a global partnership, including having access to the latest news concerning best practice, etc, and ensuring that the contact person for PMNCH within member or partner organizations are encouraged to disseminate information to relevant professionals within their organizations. Regular communication with members, possibly targeting different sectors with different information or seeking input could be useful. The newsletter is a first stage towards this communication but it needs to be more strongly focused and not merely report on activities.

The 2008 value-added work plan includes a Global, Regional and Country Political Advocacy Plan with four pillars - Define, Unite, Shout, Track - which has the potential to generate consensus and
galvanize political will and funds for maternal, newborn and child health; in particular, the Define element, which is aimed at creating common messaging platforms, and the Unite element, highlighting PMNCH’s convening and coordinating role. This programme offers the opportunity to build on PMNCH’s advocacy achievements, and generate greater civil society involvement at national level for securing its objectives.

Recommendations

Given strong support from all constituencies that advocacy is a value-added function of PMNCH, agreement needs to be reached on the question “Advocacy for What and to Whom? And By Whom?”

Consensus-building within PMNCH (internal advocacy) would be valuable to identify the core components of and priorities within the elements within their portfolio - Maternal Health, Newborn Health, Child Health - possibly identified by the factors that cause the most morbidity and mortality.

Generating increased awareness of global consensus messages on the key factors needed to improve maternal, newborn and child health – e.g. for maternal health, the “three pillars to save women’s lives” agreed at the Women Deliver Conference as being key for improving maternal health - comprehensive reproductive health care, skilled care during and immediately after pregnancy and childbirth and emergency care when life-threatening complications develop.

Ensuring that partners and members are aware of these messages, and the existence of materials that clarify and expand on them. Ensure that partners within each constituency have materials / newsletters / web links that they can easily share throughout their organization / professional association / constituency.

Facilitate partnerships at national level to drive advocacy, generate civil society involvement and provide advocacy training and support signposting where requested to do so. Facilitating regional-level sharing of expertise and experience could be a valuable role for PMNCH.

There may be a need to strengthen capacity in political advocacy in the Secretariat recognising that this is a specialised competence.

The PMNCH website could be usefully overhauled to render it more user-friendly, and easier to navigate and access key information.

9. Effectiveness of the Country Level support work area

Support to countries was not judged to add value or to be effective by most Board members, despite having an active CLS working group.

Country engagement by the Secretariat and the CLS WG is variable. In two of the countries visited (Pakistan and Cambodia), there had been no country-level support inputs. However, in-country interviewees in both these countries disagreed with the statements made to us by some that previous partnerships (for example the CSP) had been more successful or influential in spurring implementation of programmes.

There was some disagreement about the extent to which PMNCH was responsible for developments in planning for MNCH in Tanzania. The creation of a national PMNCH in Tanzania appears beneficial, but there was already a well established donor co-ordination group and there had been extensive work undertaken by UNICEF, the White Ribbon Alliance and, latterly, UNFPA. Indeed the “road map” for MNCH has been written more than once within in a relatively short time period with support from different UN bodies and bi-lateral donors. It was not possible to compare the iterations but this suggests substantial transaction costs.
The lack of effective mechanisms for PMNCH to engage at country level, the overlap and rivalry with partner functions, and the calibre and capacity of the Secretariat team including lack of appropriate Secretariat technical expertise were all mentioned as contributing factors to the lack of perceived effectiveness. On its part, the Secretariat expressed frustration at not being able either to fund relevant country activities or to link countries rapidly to alternative funding streams. In their experience, countries either had raised expectations which led to disengagement when there was no response or follow-up, or did not engage at all, since there appeared to be little benefit. They also pointed out that some Donor grant mechanisms were not aligned with Paris Principles. An ability to link quickly to funding streams once plans were approved was also mentioned by in-country interviewees as a mechanism to gain credibility and clout for the PMNCH. “If you have money, you have influence”.

Many Board members were in favour of dropping the CLS work area. They felt that short term (albeit high profile) interventions were less valuable than an ongoing commitment based on the continuum of care by established partners. Several interviewees referred to “too much launching but not enough follow-up capacity.”

Country level interviewees and some Board members by contrast spoke strongly of the need to work at country level. “Too much talk and not enough action where it matters...in country”. “We are all coming together, but need help to overcome implementation bottle necks [at country-level].”

When challenged on how PMNCH could work at country level, given it was not a fund and was never likely to have country offices and staff, some suggested a link to an in-country partner agency that would be the PMNCH’s voice in the field. This suggestion was tempered by a concern that such a focal person would have to have special skills to be trusted by all partners and was unlikely to always reside in the same UN agency. Many people commented that country support work could not be undertaken by the Secretariat given that their role was very different.

Other interviewees expressed the desire to have regional offices. “You cannot plan [relevant in-country activities] from Geneva” stated one in-country interviewee. However no in-country members in Asia were aware of the new consultant coordinator for MNCH in Asia based at the UNICEF regional office, in part to liaise with the Coogee Beach Consultative Group. This may have been because the position has only been filled in the last few months. The sitemap of the office in Thailand, a setting with few MNCH problems was perceived as inappropriate.

The work on costing tools is well appreciated and web information on these costing tools is well laid out and organized (http://www.who.int/pmnch/topics/economics/costing_tools/en/index.html). PMNCH has been instrumental in this review of 13 costing tools relevant to the health MDGs, working with development partners including NORAD, UNFPA, UNICEF, UNAIDS, UNDP, WHO, World Bank, USAID through the Health Systems 20/20 and BASICS Projects to assist countries in the use of such tools. A technical consultation, convened by PMNCH in Senegal in January 2008 had 61 participants, including country level staff working on costing, and the tool developers.

**Recommendation**

PMNCH needs to consider whether it adds value at country level and whether this work stream should continue or be modified. If CLS work continues, concrete modalities for working in-country need to be identified. The respective roles of the Secretariat, PMNCH and individual partners need to be clarified to ensure the most effective deployment in the interests of the country. Board members that are donors need to consider clarifying how PMNCH might liaise with, and direct countries to, major MNCH funding streams. These reviews of country level work may affect the need for the CLS WG, and certainly its function needs to be rethought. The activities and location of the consultant based in Asia also need to be revisited.

The major area identified by interviewees as a focus for country work was in relation to supporting the development of MNCH strategic plans (see Section VI) where there was no alternative facilitating machinery.
10. Effectiveness of the Monitoring and Evaluation Work Area

This work area did not have the necessary support structures to sustain this function. Monitoring and evaluation WG functions were not perceived to have progressed well apart from contributions to the Countdown activities. In-country, Countdown outputs were valued and used with governments.

Consideration needs to be given whether the monitoring and evaluation function is needed beyond Countdown, given that there are other bodies in this field including Countdown, the Health Metrics Network, the Institute for Health Metrics & Evaluation, and more specialized groups such as Immpact and AMDD. There was some desire expressed in-country for more synthesis and production of indicators that would provide detail beyond those produced in Countdown.

Recommendation
Given the changing global context and the emergence of other parties who have taken on this role it is suggested that M and E should not be focal priority for PMNCH. The position for a Secretariat M & E staff member that is about to be advertised should be reconsidered in light of this decision. Ad hoc working groups could be brought together to flesh out more intermediate indicators of inputs that could be used at national level and to feed into global advocacy messages. Tracking of delivery of both national and donor commitments will be needed for advocacy but this can be provided from a feeder either external or internal (e.g. an ad hoc working group).

11. Effectiveness of the Effective Interventions Work Area

The effective interventions WG activities were not perceived to be successful. There have been few meetings and little progress. Some view the identification of effective interventions as WHO’s role and see the challenge as the need to clarify and prioritise the many existing norms and procedures. Others see the need to bring in and assess effective interventions identified by others with technical expertise. The PMNCH was not seen as a truly independent force driven by evidence, so it was felt by at least one interviewee that it would be better to leave this role to others such as CHERG.

Recommendation
In view of the lack of progress in this area, PMNCH needs to consider whether this work stream should continue or be modified. It also needs to decide if it is endorsing WHO technical norms and sees its role as clarifying and prioritising them or whether it wishes to have separate mechanisms for bringing in other technical expertise. If it chooses to do the latter, the structures of the WG need to be reconsidered.

12. Effectiveness in other areas

Interviews suggested an area of particular effectiveness and value-added was that PMNCH created a platform for very disparate, but essential groups, to come together. This was generally perceived as very beneficial, although some dissent was expressed by some UN agency staff who felt Board membership gave undue prominence to NGO groups or academics that were not accountable in the same way as the UN. Others felt that partners not represented on the Board did not have the same chances of engaging with PMNCH work.

PMNCH was largely perceived as playing the role of honest broker between maternal, newborn and child health constituencies. For example, the PMNCH was often credited with introducing the “M”, with relevant indicators, into the Countdown process and with playing an important role in persuading Norway to target MDG 5 in addition to MDG 4. One interviewee mentioned PMNCH ensured more newborn health was included in the Women Deliver conference. That said, there was slightly more dissatisfaction at global level among those representing a maternal and newborn health constituency, with a perceived bias to child health, particularly among North American donors, and a sense that child health constituencies were stronger. This was not the case at national level (Cambodia and Pakistan).
One person expressed concern that the expansion of MDG 5 to include reproductive health as a second part was problematic inasmuch as it brought on a whole other set of issues and potential strategies, at the expense of maternal health. It also has potential consequences in terms of its effect on the commitment of some partners. Perusal of the partners does not suggest this constituency of stakeholders is well represented, for example by NGOs working in family planning.

Another effective core function was giving a platform for Health Care Professionals (HCP). In addition to having a voice (one professional association Board member felt “this is the only game in town for us”) and engaging with UN agencies and donors, the HCP had formed a Working Group that appeared to function particularly well despite not having a formal recognition in activities. HCP workshops were also viewed as being effective regional level activities. Other constituencies might benefit from the approaches which have achieved a collegiate presence amongst HCPs but it is important that this voice is used constructively.

Whist it is difficult to identify many effective collaborative activities with other GHPs, there appears to have been a constructive working relationship between the GHWA and PMNCH on matters of mutual interest.

Developing country interviewees at global and country level also described the engagement with parliamentarians at global events as effective and promising.

There has been little effective engagement with non Board partners, beyond some Board members that feedback to specific constituency groups. This is not possible for all constituencies (see Section VIII).

The web pages are poorly designed for finding materials, be they minutes and work plans or actual tools and resources. Major pieces of work are given the same weight as lesser results. Some links are broken and others do not link to the advertised materials. Internal jargon is used (for instance HCP is used without information for outsiders). The e-fora are described as effective communication mechanisms but these are by invitation only and are not advertised on the site.

**Recommendations**

The creation of a common, balanced platform was not specified as a work plan activity but is a major added-value that could be put under core function activities.

Expansion of the scope of PMNCH to include all aspects of reproductive health may be counter-productive at this time, when focus is needed. If reproductive health is to be included, then the broader membership and constituents represented on the Board may need to be expanded.

Careful thought needs to be given on how best to capitalize on the high level and political contacts that have been engaged thus far and to helping countries understand how to engage with parliamentarians.

The website needs to reviewed and redesigned as the main access and dissemination point for non-Board partners. Some thought needs to be given to better mechanisms for tapping into broader partner expertise, such as opening out e-fora to membership of all interested parties.
Section V: Assessing Relevance

1. Introduction
PNMCH is among a growing number of Global Health Partnerships (GHP) and alliances that work towards similar objectives, primarily achieving the health MDGs.

A brief desk review of 11 GHPs and alliances was undertaken to identify linkages with PMNCH, possible complementarities, obvious areas of duplication and overlap. Two of the groups reviewed are partners in PMNCH (Countdown to 2015 and White Ribbon Alliance). They have been included in this review as they are working in the same area, indeed many of their activities overlap greatly with PMNCH Focal Areas.

The review took the form of a web-based search and was supplemented with information gathered during key informant interviews. The information gathered during the web-based review is contained in Annex IX. The GHPs and alliances reviewed are included in the box below:

Table 2: Examples of Global Health Partnerships and Alliances

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Main Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Global Campaign for MDGs 4 and 5&lt;sup&gt;13&lt;/sup&gt;:</td>
<td>Advocacy</td>
</tr>
<tr>
<td>International Health Partnership (IHP)</td>
<td>Advocacy / Financing</td>
</tr>
<tr>
<td>The Catalytic Initiative to Save a Million Lives Support</td>
<td>TA / Service Support</td>
</tr>
<tr>
<td>Providing for Health Initiative (P4H)</td>
<td>TA / Service Support</td>
</tr>
<tr>
<td>Innovative Results-Based Financing</td>
<td>Financing</td>
</tr>
<tr>
<td>2. Countdown to 2015&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Advocacy / R&amp;D</td>
</tr>
<tr>
<td>3. White Ribbon Alliance</td>
<td>Advocacy</td>
</tr>
<tr>
<td>4. Global Fund to Fight AIDS, TB and Malaria (GFATM)</td>
<td>Financing</td>
</tr>
<tr>
<td>5. Global Alliance for Vaccines and Immunisation (GAVI)</td>
<td>Financing</td>
</tr>
<tr>
<td>7. Global Health Workforce Alliance Support</td>
<td>TA / Service Support</td>
</tr>
<tr>
<td>8. Health Metrics Network Support</td>
<td>TA / Service Support</td>
</tr>
<tr>
<td>9. Implementing Best Practices in Reproductive Health (IBP)&lt;sup&gt;15&lt;/sup&gt;</td>
<td>Advocacy / R&amp;D</td>
</tr>
<tr>
<td>10. Roll-Back Malaria Initiative (RBM)</td>
<td>Advocacy</td>
</tr>
<tr>
<td>11. Stop TB</td>
<td>Advocacy / Financing</td>
</tr>
</tbody>
</table>

The GHPs focus reviewed address a range of health MDG related issues, including:

- maternal, newborn and child health more broadly including nutrition, poverty and immunisation
- disease specific conditions such as HIV and AIDS, TB and Malaria
- research and development, monitoring and evaluation, technical assistance and service support including human resource development and management

2. Organisational similarities and differences
The GHPs and alliances were reviewed using a number of organisational criteria, including vision, mission, objectives, membership and Board, host agency and funding sources.

<sup>13</sup> Includes the advocacy drive Deliver Now and The Network of Global Leaders for MDGs 4 and 5.
<sup>14</sup> PMNCH has been collaborating with the Countdown to 2015 efforts since its inception (in September 2005), and the PMNCH Secretariat has been asked to facilitate the planning and execution of events in 2008.
<sup>15</sup> Established another GHP in the shape of the Global Alliance for Nursing and Midwives.
PMNCH is a relatively new partnership, having been established in 2005. However, the PMNCH is a merger of 3 existing partnerships, the Safe Motherhood Inter-agency Group which oversaw the Safe Motherhood Initiative (1987-2003) and subsequently formed the Partnership for Safe Motherhood and Newborn Health (2003); the Healthy Newborn Partnership (2000), and the Child Survival Partnership (2004). Thus the PMNCH is in a fairly unique situation of having to bring together 3 established groups.

Among the other global partnerships reviewed Roll Back Malaria, the White Ribbon Alliance, GAVI, the GFATM and GAIN are more mature, having been established between 1999 and 2002. These partnerships are very different in terms of how they were established and the levels of funding available. In particular the White Ribbon Alliance was established as a grass roots organisation, focusing on ensuring that individuals, communities and NGOs have a voice.

The GHPs and alliances bring together many organisations, different constituencies and agendas. Some are mechanisms to provide funding flows towards specific interventions or diseases such as the GFATM and GAVI, although of late they are increasingly focusing on health system strengthening. Others do not fund project activities but focus attention on advocacy for increased political will and resource allocation, technical assistance and service support. PMNCH is among the latter with relatively small amounts of funding for fairly specific pieces of work, from different donors.

Of the 11 global health partnerships and alliances, 8 are hosted by WHO in Geneva. Many of the groups are financed by the Bill and Melinda Gates Foundation. Several rely entirely on the Bill and Melinda Gates Foundation for funding and at least nine identify the Bill and Melinda Gates Foundation as their single largest donor.

Funding levels among the global health partnerships and alliances vary dramatically, from the White Ribbon Alliance which has an annual budget of less than US $2,000,000 to the GFATM which has received US$11.4 billion between 2001 -2007. However, despite the large funding streams for some GHPs, one study suggested that GHPs have an average 60% deficit in funding.

Membership amongst the GHPs and alliances is diverse. Some of the organisations such as the PMNCH and WRA have quite a wide membership, including individuals, government and non-government organisations. Among others, membership is limited to include multi and bilateral donors, UN organisations, academic institutions and the countries receiving funds for activities.

Many of the partnerships and alliances share members, with a number of organisations being active members of more than one. Indeed some partnerships and alliances are members of allied partnerships (White Ribbon Alliance being a member of PMNCH for example). Most of the partnerships include donors, government groups and academic institutions but there appears to be more limited non-government or private organisation membership.

In reviewing the country focus, a small number of countries have at least 4 global health partnerships or alliances operating; these include Ethiopia, Mozambique, Tanzania, Zambia, India and Pakistan, however, most of the 68 high burden countries have only two operating, usually GAVI and the GFATM.

Given the different operating modalities and country focus, it is difficult to compare the global partnerships directly in relation to their relative successes. Therefore the review focused on possible duplication and overlap of efforts and the complementary nature of GHPs and alliances.

For the purposes of this review we looked more specifically at advocacy, although we acknowledge that GHPs and alliances are also involved in financing, technical assistance and service support.

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3. Advocacy for MDG 4 & 5

Many of the partnerships and alliances reviewed either identify advocacy as one of their focus areas or state their activities provide much needed statistics and information required as the basis for advocacy activities. The organisations reviewed in terms of advocacy are in the table below.

**Table 3: GHPs and Alliances Focused on Advocacy**

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMNCH</td>
<td>Advocacy for maternal, newborn and child health</td>
</tr>
<tr>
<td>Global Campaign for MDGs 4 and 5(^{18})</td>
<td>Advocacy for maternal, newborn and child health</td>
</tr>
<tr>
<td>International Health Partnership (IHP)</td>
<td>Advocacy/financing improvements in global coordination, harmonisation and alignment</td>
</tr>
<tr>
<td>Countdown to 2015(^{19})</td>
<td>Advocacy/R&amp;D towards MDG 1, 4 &amp; 5</td>
</tr>
<tr>
<td>White Ribbon Alliance</td>
<td>Advocacy for Safe Motherhood and Newborn health</td>
</tr>
<tr>
<td>Implementing Best Practices in Reproductive Health (IBP)(^{20})</td>
<td>Advocacy/R&amp;D for best practices in RH including safe motherhood</td>
</tr>
<tr>
<td>Global Health Workforce Alliance</td>
<td>Advocacy for health worker training, support and retention</td>
</tr>
<tr>
<td>Health Metrics Network</td>
<td>Advocate for and support improvements country Health Information Systems</td>
</tr>
</tbody>
</table>

The International Health Partnership (IHP) was launched in September 2007, by a number of Prime Ministers and Ministers from developing and donor countries and leaders from the major UN health agencies, as part of the Global Campaign for Health MDGs. The International Health Partnership aims to improve the way that international agencies, donors and poor countries work together to develop and implement health plans, creating and improving health services for poor people and ultimately saving more lives. This high level advocacy effort supports the PMNCH advocacy activities.

The PMNCH advocacy efforts focus on coordinating the Deliver Now Campaign which was launched in New York in September 2007. Deliver Now is a key part of the new Global Campaign for the Health Millennium Development Goals, unveiled September 26, 2007, by Prime Minister Jens Stoltenberg of Norway.

The Deliver Now Campaign is being rolled out within individual countries, presently India and Tanzania. At a country level, Deliver Now aims to bring together local government agencies, civil society, media and other national and international members of the initiative to allocate resources and more effectively bring basic health services to women and children. However, these countries also have thriving White Ribbon Alliance country groups that have already been campaigning successfully for improvements in Maternal and Newborn Health.

It unclear why Deliver Now was established in the same countries in which White Ribbon Alliance has its origins are at a grassroots level. They have a small

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\(^{18}\) Includes the advocacy drive Deliver Now and The Network of Global Leaders for MDGs 4 and 5.

\(^{19}\) PMNCH has been collaborating with the Countdown to 2015 efforts since its inception (in September 2005), and the PMNCH Secretariat has been asked to facilitate the planning and execution of events in 2008.

\(^{20}\) Established another GHP in the shape of the Global Alliance for Nursing and Midwives.
global Secretariat which acts to support and build capacity amongst the 11 country groups. Its membership is inclusive of individuals, UN organisations, bilateral organisations and NGOS. There is a strong volunteerism amongst the membership and all members are integral to the White Ribbon Alliance decision making processes. At present they have members in 97 countries and a membership of 188 organisations.

White Ribbon Alliance is a member of the PNMCH Advocacy working group and attempts to work closely with them. Sarah Brown, in a speech to the Countdown conference in Cape town in April 2008, called for the international community to endorse the PMNCH and White Ribbon Alliance as the leading advocacy groups for maternal and newborn health and to commit funds for in-country and global advocacy campaigns.

The Implementing Best Practices in Reproductive Health partnership (IBP) advocates for improvements in health care through focusing on knowledge sharing, coordination and utilisation of best practices. The IBP works with 27 partnerships, organisations and alliances including WHO, UNFPA, USAID, CORE, White Ribbon Alliance, Engender Health and others. This partnership is complementary to the other GHPs and alliances as it has a specific technical and scientific brief. However, it is not clear how this GHP and PMNCH coordinate on the issues of best practice, which is also a PMCNH focus area. For instance in Ethiopia key stakeholders felt that facilitating best practices was the role of the IBP and not the PMNCH.

While the IBP focuses on reproductive health, and family planning, Countdown 2015 focuses on reducing maternal, newborn and child health, and is more focused on tracking progress, so the potential for duplication is limited. The Countdown 2015 initiative tracks progress made towards the achievement of the MDGs 1, 4 and 5 and promotes evidence-based information for better health investments and decisions by policy makers regarding health needs at a country level.

PMNCH and Countdown 2015 initiative collaborate closely, with PMNCH providing the platform for the Countdown conference in Cape Town in April 2008. Critics have questioned the added-value of their close collaboration and whether Countdown 2015 really needs the support of the PMNCH as a platform as it has a strong constituency in its own right. This does not recognise that PMNCH has helped ensure more maternal and newborn inputs.

The Health Metrics Network provides technical assistance and service support towards improving country Health Information Systems. Improved data are potentially a powerful advocacy tool for improvements within health systems. The Network has 21 partners including multi and bilateral donors, UN agencies and Ministries of Health at a country level. The HMN provides support in the form of tools to assist countries to apply for round 8 of the GFATM and was involved in the Countdown 2015 meeting in Cape Town in April 2008.

The Global Health Workforce Alliance advocates for health workers to be trained, supported and retained in sufficient number to ensure accelerated progress towards the health MDGS. The Alliance works in 35 countries led by Norway, the Bill and Melinda Gates Foundation and others. While in some counties the other partnerships, such as the WRA in Tanzania, are advocating for Governments to provide more human resources, the GHWA provides specific technical assistance and service support to counties who aim to improve their human resource situation. There appears to have been a constructive working relationship between the GHWA and PMNCH on matters of mutual interest.

4. GHPs focusing on MDG 1 and 6
The other GHPs and alliances reviewed focus more on financing, technical assistance and service support for specific diseases such as TB, HIV and AIDS and Malaria and reduction in the effects of poverty, such as malnutrition. Their activities also directly affect maternal, newborn and child health in very specific ways, including malnutrition leading to anaemia in pregnancy, the contribution of HIV and AIDS to maternal, newborn and child deaths and the role of PMTCT, the effects of malaria on pregnancy, and maternal and child morbidity and mortality, and the role of immunization in preventable childhood diseases.
However, from the literature reviewed and the discussions held, the links between these partnerships and alliances and PMNCH and whether PMNCH has any influence on their agendas is unclear. Both in the countries where they are all working and at a global level in setting funding priorities, there is limited evidence of collaboration or coordination. There does not seem to be an enthusiasm in the PMNCH Secretariat to work across organizations, and other partnerships and alliances do not appear to perceive PMNCH as a major or influential player. This lack of clear linkages is disappointing given that many of these partnerships are hosted by WHO or are at least situated in Geneva. These partnerships and alliances are listed in the table below.

Table 4: GHPs and alliances focusing on MDG 1 and 6 located in Geneva or hosted by WHO

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Fund to fight AIDS, TB and Malaria (GFATM)</td>
<td>Financing</td>
</tr>
<tr>
<td>Global Alliance for Vaccines and Immunisation (GAVI)</td>
<td>Financing</td>
</tr>
<tr>
<td>Global Alliance for Improved Nutrition (GAIN)</td>
<td>TA and Service Support</td>
</tr>
<tr>
<td>Roll-Back Malaria Initiative (RBM)</td>
<td>Advocacy</td>
</tr>
<tr>
<td>Stop TB</td>
<td>Advocacy / financing</td>
</tr>
</tbody>
</table>

5. Conclusions

GHPs which provide funding streams for specific issues have the potential to demonstrate impact in reducing health burdens globally and contributing to the health MDGs. Partnerships and alliances without specific funding for implementation but which focus on advocacy, technical assistance and service support to countries have a greater challenge in demonstrating direct impact.

Given the number of partnerships and alliances in existence, there is general confusion amongst those not closely aligned to them as to their roles, functions and coordination mechanisms.

In addition, there is concern that partnerships and alliances tend to be exclusive and do not facilitate broader debate amongst civil society, communities and women in particular. Of course, within the HIV and AIDS arena there is particular attention paid to the views and expectations of people living with HIV and AIDS but there is little evidence of this within the maternal, newborn or child health field. White Ribbon Alliance appears to be the exception to this rule, and there is some evidence that global human rights groups are moving into this field (e.g. Amnesty International in maternal health).

The fact that so many GHPs are hosted by WHO and funded by the Bill and Melinda Gates Foundation should provide a good basis for coordination and collaboration and less likelihood of duplication and overlap. Furthermore many of the other GHPs have their headquarters in Geneva. However, it is unclear if these factors are exploited to streamline operational modalities and governance.

In the context of this complex environment, PMNCH should be discussing options for collaboration with a number of organisations, partnerships and alliances, and ensuring that global partnerships and alliances are following programmes which directly influence the quality and coverage of care for women, newborns and children. Some examples of the ways that PMNCH could work with existing GHPs could include:

- GAIN – look at ways of improving maternal and infant nutrition
- GAVI – look at how to link immunisation with maternal postnatal care
- GFATM – look at ways to link family planning and other reproductive health services with HIV/AIDS services, ensuring that antenatal care and PMTCT is linked, that women can gain access to ARVs through antenatal services, that postnatal care of the baby includes care of the mother and the family, including ARV therapy, nutrition, immunisation, PCR testing etc.
Recommendations
PMNCH should increase its efforts to link with and collaborate with other global health partnerships and alliances and build synergies to ensure that all programmes directly influence the quality and coverage of care for women, newborns and children.

Given that WHO is the host for many GHPS there should be a review of the different governance structures and whether the management and coordination of these bodies can be streamlined and if the most is made of the possible synergies. The possibility of establishing a “cross GHP” group within WHO should be explored. This group would help to build synergies and reduce unnecessary duplication within the technical and administrative areas. PMNCH could liaise with other GHPs on their openness to this.

In many of the high burden countries only a small number of GHPs operate while in a small number, four or more are operational. This provides an opportunity for further review to identify how these various initiatives are coordinated and how they add value in achieving the MDGs at a country. It is important that all GHPs operating in country adhere to the Paris principles of harmonization.

While some of the GHPS have large funding streams, others such as the PMNCH do not. The rationale for the different focus and resource allocation is not clear and perhaps there should be further work on whether GHPs such as the PMNCH can really achieve their goals with such uncertain and small scale funding; in particular with very limited funding for facilitating in-country coordination and scale up. Alternately, it may be necessary for PMNCH to recognise that it can only be effective in relation to other functions such as advocacy and to modify its conceptual framework accordingly.
Section VI: Assessing Alignment

1. Introduction
The 2005 Paris Declaration on Aid Effectiveness has established best practice for Aid, based on the following five “Partnership Commitments”:

- **Ownership**: Partner countries exercise effective leadership over their development policies, and strategies and co-ordinate development actions
- **Alignment**: Donors base their overall support on partner countries’ national development strategies, institutions and procedures
- **Harmonisation**: Donors’ actions are more harmonised, transparent and collectively effective
- **Managing for Results**: Managing resources and improving decision-making for results
- **Mutual Accountability**: Donors and partners are accountable for development results

The High-Level meeting that launched the Paris Declaration took place in February 2005; later that year, in November, these commitments were further developed, to ensure consistency with the work of global health partnerships. This work resulted in the Best Practice Principles for Global Health Partnership Activities at Country Level. This chapter will assess the extent to which PMNCH work has upheld and respected these principles.

2. Alignment at country level of PMNCH supported activities
While PMNCH is supportive of the spirit of alignment with country priorities, there is some evidence to suggest that the funding provided by the Bill and Melinda Gates Foundation has led to a supply, rather than a demand-led approach in the countries where it has been active. In effect PMNCH was used as a vehicle for funding which could not be achieved in other ways. The priorities for much of this money have been decided by the grant administering body (WHO) not PMNCH but this distinction is not well understood.

The grant has, in some cases, led to tensions between the PMNCH obligation to satisfy the donor, and the country perception that this is a “PMNCH” programme, and not one for which they feel real ownership. This tension has come to a head in cases where funds have been used for nationally identified priorities that are not necessarily seen by the donor as being catalytic - the purpose for which the funds were given. Similarly, in-country preference for basket-funding - an approach in line with the Paris Principles - is not an approach preferred by some donors that are PMNCH members. The view was expressed that the relative lack of engagement of country government representatives on the PMNCH Board could reflect a perception on their part that PMNCH may not be in a position to help them to realize national goals and priorities.

In Cambodia, several governmental and non-governmental sources stated that maternal and child health were the top priorities for the government, and yet donors were offering significantly larger sums of money for HIV/AIDS. Even within the pooled funding that is likely to be available for the new health sector strategic plan, it is anticipated that funding will be earmarked for specific activities by some donors, and there is still a big burden related to reporting.

In Burkina Faso, all partners were supportive of the MoH and its seriousness to implement the existing national health development plan. The view was expressed that all funding mechanisms (such as the PMNCH support funded by the Bill and Melinda Gates Foundation) should support the plan, and funds disbursed through existing mechanisms. The UN agencies in-country felt strongly that the grant should be disbursed as part of the common basket as a means to strengthen a very promising approach of MoH. “PMNCH must not come to replace what the country is doing” was a view expressed by one agency.

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The Government perspective is possibly best captured by this perception “It is bizarre that from one side they encourage “compacts” and on the other side they want such project oriented approaches”; however Government would have accepted a project approach not to lose the funds, but would not have liked it. Similarly, a non-governmental organization expressed surprise “that the country has to convince PMNCH to accept national priorities, while they would have thought, that the PMNCH mandate is to promote this”.

In Tanzania, the view was expressed that PMNCH has brought different agencies together to work on maternal, newborn and child health, but that the White Ribbon Alliance is there too, as is a Safe Motherhood group, and that there is little evidence of overall co-ordination. There was also a sense that there was a lot of “launching”, but “little focus on actual results”.

The Evaluation Team struggled to get a sense from within Malawi of the extent to which PMNCH has had a presence there. However, there is a well developed SWAp and inclusive co-ordination mechanisms, yet engagement with these seemed less than one might expect.

In Pakistan it was clear that the UN agencies are working closely together with the Ministry of Health to implement the Government’s MNCH programme. The programme was prepared through a collaborative exercise involving government and the various UN agencies working smoothly and constructively together. PMNCH was not mentioned by anyone as an active participant; the High Level Forum convened by the Child Support Partnership in 2005 mobilized political will, but there was national motivation to work on maternal, newborn and child health before then. Alignment among the UN agencies was felt to be good, but it was noted that Pakistan is one of the pilot countries for the One UN reform initiative.

The choice of countries where PMNCH has worked appears to be a combination of those where the previous three initiatives had some history of working, plus the grant countries; there were criteria, but the choices appear not to have been very strategic. It is also not clear how PMNCH can respond to demands from countries in the absence of funds.

**Recommendation**

PMNCH did not intend to be a funding body at its inception. This has been distorted by the funding for country level support provided by the Bill and Melinda Gates Foundation which has given mixed messages which are not helpful. Should further funding be undertaken in the name of PMNCH then it is important that there is consensus on whether activities reflect overall PMNCH priorities but also whether it should be more aligned with country plans and priorities.

Partners need to show their commitment to alignment with PMNCH principles in all their activities. This means developing a common purpose among partners in advancing MDG 4 and 5, beyond the differences of mandates of the partners.

PMNCH may have a role at global level in advocating alignment in countries where the international donor activities and funding do not reflect national prioritization of MNCH.

There is a body of opinion which believes that PMNCH can add value under some circumstances acting as “honest broker” to develop an MNCH strategy in countries. It is suggested that this might be appropriate as a demand led function which was available to countries without internal co-ordination mechanisms. It might therefore be appropriate to identify which high incidence countries neither have plans nor a mechanisms for creating a harmonised plan and offering to fulfil a facilitator role, possibly using partner organisations in country or regionally who will adhere to PMNCH principles. It is acknowledged that there are both regional and global mechanisms available on a demand basis (Harmonisation for Health in Africa for example) but PMNCH may have a unique role in supporting a harmonised technical response.
3. Partner Alignment
There is some evidence that PMNCH has harmonised Board members and other partnerships to focus on maternal, newborn and child health, and facilitated dialogue amongst partners. The concept of continuum of care is widely accepted now across the three UN agencies, and, within countries, it has also gained a wide degree of acceptance. While it is difficult to attribute this solely to PMNCH, it is likely that its work has had a synergistic effect in focusing attention, expertise and resources on achieving MDGs 4 and 5.

4. Constituency Alignment
There was also a degree of consensus that PMNCH has facilitated valuable alignment of perspectives and priorities among Health Care Professionals. Previously different disciplines were promoting different strategies and priorities. There would appear to be valuable lesson learning from the way this has been done which might be extended to other constituencies.

Recommendation
The effectiveness of PMNCH could be enhanced by greater alignment among partners and constituencies on key issues, priority and messages. Regular internal advocacy and an improved website could facilitate sharing of information and experience; “beaming in” messages to ensure consistency and coherence within the different constituencies, members and partners of PMNCH.

5. Board Alignment
Whilst the PMNCH has achieved a degree of alignment on “big picture” issues (the continuum of care, the need to keep MNCH high on the global agenda) there continues to be a lack of alignment on the added value of PMNCH, its functions and its priorities between both individual board members and constituencies at board level. This may be inevitable given the inherent tensions between funders and those seeking funding. However there is evidence that these divisions go further and are based both on the bringing together of three very different groups (Maternal, Newborn and Child Health) but also on historic tensions between some partners. There continues to be a feeling, expressed by a large number of interviewees, that there is an uneven “balance of power” although perceptions about where the power lies vary. In general however there is a recognition that funders and UN agencies have significant influence. There is no clear consensus and certainly no quantifiable evidence, that one of the focal areas (Maternal, Newborn or Child Health) dominates.

Recommendation
The need for greater board alignment is critical to the future of PMNCH. There needs to be unanimity not only on the overall goals (which exists) but also on the added value of the Partnership and its future functions.
Section VII: Assessing Governance

1. Vision and goal
The stated Vision of PMNCH is to intensify and harmonise national, regional and global action to improve maternal, newborn and child health. This is lucid and compelling, but it is not entirely clear exactly what discrete role PMNCH sees itself taking towards achievement of this vision.

The Goal is identified as supporting the achievement of Millennium Development Goals 4 & 5, (reducing maternal, newborn and child mortality) through:

- Strengthening and accelerating coordinated action at global, regional, national, sub-national and community levels
- Promoting rapid scaling up of proven cost effective interventions
- Advocacy for increased commitment

Only the advocacy component of these three activities has been developed to any great extent. Whilst PMNCH has undoubtedly increased collaboration at global level there have been limited regional or national initiatives and these do not appear to have been initiated solely by PMNCH. There is no evidence of any initiatives relating to the new senior consultant based in Thailand and, indeed, partners interviewed in the region are not aware of the new position and function. This may be because it is a recent development. The one successful example identified, which involved work to align health care professionals, has been seen as very valuable providing opportunities for mutual learning and greater understanding. There is little indication of any initiatives relating to action at sub national or community level.

An extensive listing of effective interventions across the continuum of care have been identified, however these do not appear to have been prioritised for use where the full range is unaffordable or undeliverable due to resource constraints. It has not therefore, as yet, been possible to fulfil the goal of scaling up.

Achieving the goals requires an ambitious agenda, and given that PMNCH relies on partner inputs "over and above the day job" (as some interviewees described it), it is perhaps not surprising that there has been less progress than anticipated. There seems an urgent need to refocus and rationalise efforts to ensure that they are realistic but also complement the efforts of other bodies and add value.

2. The Structure of PMNCH
The structure of PMNCH is broadly similar to a number of other Global Health Partnerships. It attempts to reconcile the desirability of a broad based membership with the need to act in a timely manner. Given the number of members who are drawn from six constituencies, this is inevitably a difficult, if not impossible, reconciliation. It is complicated further by the merger of three initiatives to form PMNCH, and the competing priorities for attention and resources of maternal, newborn and child health, each of which have different cultures. There are inherent tensions having funders and constituencies seeking funding working to agree future activities. There remains an atmosphere of competition and lack of trust although this is reported as having improved.

The key essentials would appear to be:

- Mechanisms which ensure that Board and other members feel involved, informed and, where appropriate, consulted
- A functional Board which has mechanisms which enable it to set strategic direction, agree work plans and resolve differences of opinion
- Support mechanisms which ensure that the Board can make timely decisions based on accurate and comprehensive information
- Systems for implementation and monitoring
• Excellent communication mechanisms with other key stakeholders (e.g. other global health partnerships, departments within WHO etc)

Once a structure has been set up it is relatively difficult to change it radically without potential discord. Any rationalisation may appear to be a disenfranchisement of one or more constituency. A restructuring would take significant time and effort and divert from the core purpose. There is already a strong feeling amongst some partners that too long has been spent looking at process at the expense of substance and a further reconfiguration would be likely to trigger some major partners withdrawing.

Recommendation
It would therefore seem pragmatic to attempt to modify the structure where strictly necessary rather than attempt a complete redesign. Areas which would appear to require modification include the structure for Working groups, the need for a finance committee (already in train), clarification on the use of alternates and some changes to the Secretariat organogram.

3. The Forum
The Forum has met once in Tanzania in April 2007. Approximately 230 people attended over a period of four days. During the forum, there were opportunities for the constituencies to meet and confirm their Board members as well as agree communication and governance issues. In addition there was a short period of time for the first meetings of the four working groups.

Of the 230 people attending, approximately one hundred were from northern locations (North America and Europe) and the remainder gave their country as southern. Of the one hundred and thirty southern delegates, over seventy were from Tanzania with eighteen from the Ministry of Health. A high proportion of delegates were employed by UN agencies (fifty one) suggesting more limited outreach to partners at large.

The initial forum divided time between a number of presentations by lead partners and senior staff from the Secretariat, with sessions to establish the working groups and the constituencies. This was an appropriate use of time for a first meeting but there needs to be clarity how the forum is going to be used in future.

Members who are individuals or small organisations may not find it possible to afford the time and attendance costs, yet it is important to keep them engaged. Merely attending a conference may not be sufficient incentive and delegates will need to feel that their contribution is both sought and heard and that the benefits of attendance outweigh the costs.

Recommendation
A date needs to be agreed for the next forum meeting well in advance and planning needs to involve all constituencies to ensure that the event has value and relevance beyond a series of progress reports to the membership. This will increase the possibility of getting stronger attendance from constituencies who may not have had incentives to engage in the past. The Forum should be seen as a platform for both internal and external advocacy.

If the Board has rationalised the proposed strategic direction and the activities supporting this, then this should probably form the major part of the event. It is important that there is buy in to any rationalisation and that members understand the reasons why certain earlier objectives cannot be pursued. This will require time to be allocated for discussion and debate.

It is of the utmost importance to achieve greater coherence within constituencies (internal advocacy) and this could be achieved by building on lessons learnt within the health professional constituency. If the forum could provide opportunities for some constituencies to achieve better alignment this would strengthen the external advocacy. Likewise, the
opportunity could be taken to facilitate networking within constituencies to share good practice on leveraging additional funding, strengthening co-ordinated planning etc.

The venue should be identified to minimise costs for members with limited access to resources. Every opportunity should be taken for members to participate actively preferably in small groups, through presentations of innovative work, through networking events etc. Members need to go back to their organisation feeling that they have actively contributed but also that they have brought something away with them in terms of knowledge of effective interventions, tools and models, expanded networks and useful case studies.

4. The Board
The Board is relatively large which inevitably means that formality is increased. It is difficult to strike a balance between adequate representation of a diverse and geographically dispersed membership and having a Board where members feel that their contribution is actively sought and heard. The size of the Board is not atypical for similar global partnerships and many have similar membership constituencies although PMNCH is wider than most.

To be effective the Board needs to demonstrate the following characteristics:

- A Board which has clarity on its strategic direction, priorities, work plans, role and processes
- A functional Board which has mechanisms which enable it to resolve differences of opinion
- An inclusive Board which allows members from all constituencies to participate fully and appropriately
- Support mechanisms which ensure that the Board can make timely decisions based on accurate and comprehensive information
- Regular reporting mechanisms covering finance, activities and the outputs of the working groups
- Transparent processes which assure non Board partners that decisions are made in accordance with good governance
- Follow up mechanisms that ensure agreed actions are implemented

The current Board appears to lack a number of these characteristics. A number of Board members interviewed expressed the view that some constituencies appear to have more influence and tend to dominate both debate and decision making. Some felt unable to speak. It was interesting to note that there was some differences of opinion about which were the most dominant. However, in general, it was felt that the UN bodies and the donors carried a disproportionate “say” both in formal meetings but also informally and in influencing the agenda. This is perhaps inevitable given that they are the major players in terms of funding and delivery.

It is difficult to judge retrospectively but it also seems that the Secretariat have considerable, and perhaps undue, influence on the issues to be considered. There is no agreed process for scheduling and prioritising agenda items although there are processes established for circulating them for comment. Some Board members felt their comments on draft agendas were not taken into account but this may be a result of conflicting feedback and the need to respond to the majority.

An examination of the minutes suggests that some constituencies are significantly better represented at meetings than others. Despite having funding available to attend meetings, country representatives are probably the least well represented. It was suggested that this may reflect the minimal benefit they feel is likely to accrue from their attendance and, thus, some have “voted with their feet”. It was suggested by interviewees that recently retired senior country representatives may have more time than national Ministers of Health.

There may be value in team-building work to facilitate the process of representatives of different partners and constituencies coming together to work as trustees of a separate entity; blending their
obligation to represent their own organization and constituency with the equally important
obligation to make decisions in the best interest of PMNCH as a whole.

A further issue relates to scheduling of meetings. A number of members commented on the poor
forward planning for meetings. Dates were not agreed in advance and were changed at short
notice. This makes arranging time to participate and travel extremely difficult (see section on Board
Processes).

Interviews make it very clear that there are wide differences of opinion within the Board. These
relate to major issues including the appropriate role of PMNCH, where it should work and whether
it should be a funding body. Until these issues are resolved, PMNCH will never be able to present
a co-ordinated front nor achieve universal and wholehearted support from partners. In most cases
these differences appear to stem from deeply held convictions about the potential role of PMNCH.
However, it appears that some board members do not recognise that their wishes are
unachievable and instead focus on ensuring unanimous support for the core purpose. There is a
real feeling of frustration amongst some key supporters (including major past funders) who have
indicated that they will not continue active involvement unless there are real signs of unified action
in the very near future. Too much energy continues to be expended on process at the expense of
substantive productive work and the regular absence of some board members from meetings is
becoming an indicator of their belief that PMNCH is not worth supporting. This can be turned
around but needs urgent resolution and refocus.

These issues have been acknowledged from an early stage, yet there does not appear to be an
agreed mechanism for resolving them. It seems unlikely that resolution will emerge from a formal
Board meeting although technically it could be taken to a vote. This would not, however, ensure
the support of the various partners outside the meeting. It is also not likely that consensus could be
reached amongst over twenty Board members with separate agendas and with other stakeholders
in the room.

Recommendation
There are number of basic differences which affect the whole underlying principles of
PMNCH. These need to be resolved both to make the PMNCH functional but also to ensure
there is corporate cohesion on purpose, functions, plans etc. The only realistic way to
achieve this may be to undertake a facilitated exercise, perhaps building on feedback
received during the evaluation. It is recommended that this is undertaken as a matter of
urgency.

Lesser differences of opinion need to be resolved promptly and this requires early
identification by the Secretariat, informal exploration of potential compromises and
consequences of non agreement, excellent briefing of the Chair (both formal and informal)
and time-limited discussion with clear explanation of the consequences of non agreement.

5. Identification of Board Members
There appears to be a process in place for replacement of Board members and although this has
not yet been used frequently, the experience of those constituencies where it has occurred
suggests that it is adequate.

There continues to be considerable differences of opinion however about the extent to which the
allocation of seats reflects the membership. Given the large number of NGO partners there was a
suggestion that their allocation of seats does not “feel fair”. However there is recognition that
influence is not merely a factor of the number of seats held.

Recommendation
The current allocation of seats appears reasonably fair and the processes for identifying
Board members have recently been clarified by the governance group. There will never be
agreement from all parties but any change would be an unnecessary diversion.
6. Status of Alternates
There is a problem with Board members finding time to participate in Board meetings. Indeed this has also affected the new Chair. Whilst alternates are important given the commitments of the Board members, their status needs to be clarified; this has already been identified by the Governance committee.

It is important that alternates are kept in the picture and thus are able to participate fully in the absence of the Board member. However, there are real disadvantages if they become too actively involved in a duplicative way. If all papers are sent to alternates and they have the right to comment, this both creates additional transaction costs but also risks getting two different responses from a single organisation. Likewise, if alternates routinely attend all Board meetings, this increases the number of the participants present and means that, inevitably, proceedings become more formal with less space for discussion and debate. This tends to militate against compromise and consensus. The number of alternates attending has varied but has routinely been around ten.

Recommendation
If individuals agree to be on the Board it is essential that they have adequate time to fulfil their commitment. This is particularly true for those who have an additional role as chair or co-Chair. Only Board members should routinely attend Board meetings although it should be possible for alternates to attend for specific items as non contributing observers only. It should be the responsibility of the Board member to brief the alternate when they need to attend a meeting on the member’s behalf. It is recommended that alternates should not routinely receive correspondence seeking comments, although they should receive Board papers and minutes for information.

7. Board Processes
Basic Board processes appear weak and are causing considerable dissatisfaction among partners. The major issues appear to be scheduling of Board meetings, agenda setting and preparation. All partners have a requirement to plan ahead. This is currently not possible with Board meetings not being scheduled in advance nor venue agreed until late in the process.

Management of the agenda also seems less than adequate. Although draft agendas are circulated for consultation there is a feeling that comments are not always taken into consideration. There does not appear to be an annual schedule and structure established for the agenda with regular reports, identified dates for considering work plans (to synchronise with WHO processes) as well as non recurring items. Some items appear to be introduced onto the agenda by the Secretariat without the support of Board members. Indeed it is reported that members have declined to consider items which they feel should never have been raised at that level.

In order for Board meetings to be effective, much work needs to be undertaken in advance by the Director and the Secretariat. Not only should routine reports be prepared well in advance (progress against work plans, financial reports etc) but papers need to be prepared for non recurring topics so that the Board knows why the issue is being considered, what decisions need to be made, what the context is and what the options are. These papers seem largely lacking but they are an essential part of the key role of the Secretariat in managing upwards.

Papers for Board information or discussion may be drawn up by partners, working groups, external consultants as well as Secretariat staff but it is the ultimate responsibility of the Director to ensure that the Board is able to make decisions in a timely manner having had the opportunity to consult internally with their own organisation and to have the full information available to make an informed decision.

Notes of Board meetings appear to be produced in a reasonably timely way and in appropriate detail. It is not always clear who is responsible for follow on action and no time limits are recorded. There is appropriate transparency in the circulation and availability of minutes.
Recommendation
A schedule of dates for Board meetings together with venues should be drawn up for the next two year period. The dates should synchronise with WHO processes which require the Board to consider work plans before they are incorporated.

An agreed accountability / monitoring schedule should be drawn up identifying routine reports which should be received by the Board. These should include finance reports, progress against work plan, reports from working groups etc. This schedule should be widely circulated together with the dates by which reports need to be received by the Secretariat. Meetings of working groups need to synchronise with the dates of Board meetings so that recommendations can be passed to the Board in a timely manner. Likewise Board and working group meetings considering future plans need to be synchronised with WHO planning frameworks.

A suggestion was made at the December 2007 Board meeting that a finance committee be set up to monitor financial performance. This is underway and would appear appropriate, both in terms of budgetary approval and also monitoring but it is still recommended that a summary finance report (showing expenditure by work plan activity) be included in the Board agenda as an item “for information” at each meeting. The Board must sign off the annual budget and work plan.

Agenda setting will incorporate both routine and one off items. Any agenda items which require debate and decision making should be supported by papers explaining the context and giving a full analysis of options. This should be the responsibility of the Secretariat although they may not actually write the paper.

No items should be tabled and Board papers need to be sent out at least two weeks before the date of the meeting.

Board papers should be drafted to ensure that Board discussions are relevant and oriented towards decision-making in the best interest of PMNCH. They will differ in content and scope, but it is often useful to include a section on the history of the issue and its relevance to PMNCH; a section on the current position, which clarifies why it is important that the Board discuss this issue now, and a section on options for moving forward, which should guide the discussion at the meeting.

Notes of Board meetings should incorporate an action section identifying a named individual responsible for follow up together with a time limit. It should be the responsibility of the Secretariat to ensure that action has been taken and to report on completion to the Chair.

8. Corporate Cohesion
Although there is general support for the broad aim of achieving MDGs 4 and 5, it is very clear, from interviews held, that there is little or no corporate cohesion within the Board. Board members appear to act as representatives of their own organisation first and foremost and as a member of their constituency second. Many people appear to see the Secretariat as the only manifestation of PMNCH. This may be inevitable at this relatively early stage and may resolve over time but it has significant consequences in relation to PMNCH activities and profile.

There is also an understandable desire to preserve consensus by avoiding topics which could result in a conflict, or the manifestation of differences of opinion on topics related to maternal, newborn and child health, particularly maternal health, which can involve discussion of controversial issues. However, this gravitational pull to consensus by conflict avoidance can also have the damaging effect of ensuring that PMNCH never quite reaches clarity on what its position is on specific issues, with the result that people are not quite sure what PMNCH stands for when it comes to key issues (and are therefore unlikely to take it seriously). That may be too high a price to pay for preserving consensus.
There is a widely held view that PMNCH brings together a very disparate group of interests. Interviewees likened it to “a forced marriage” and “to the passengers on a bus which happened to be going in roughly the right direction when they got on”. They come with different agendas and different priorities and, given that many cannot agree to any proposals without the mandate of their constituency and their own organisation as well, it is difficult to get consensus and thus there are relatively few principles or activities that have universal support. In some ways this situation is no different to that experienced in other partnerships but, as the PMNCH is largely not a funding body, it lacks some of the leverage to achieve consensus that is available to others. The situation may be exacerbated by some board members who, in effect, have no institutional mandate and therefore are responding purely in a personal capacity.

Without a clearly articulated common purpose, many of the members see PMNCH as a focus for internal lobbying. This is unproductive as, in some cases, what they are lobbying for (such as funding for country level activities) is controlled by partners who have an opposing viewpoint or where a decision is not made by PMNCH but in other fora. Frustration is therefore inevitable.

The interviews with Board members show broad support in only a few areas namely:

- The importance of the continuum of care approach and the need to promote this and continue the integration of the three target populations
- The value of PMNCH in global advocacy
- The value of PMNCH as a convening point for both individual constituencies and for all the constituencies to come together

There is little opposition to PMNCH acting as a knowledge and signposting function for effective interventions although many interviewees felt there was little comparative advantage over WHO or other organisations and mechanisms. Likewise a substantial majority felt that there was now no role to play in monitoring and evaluation beyond support to Countdown (recognising that PMNCH undertakes a secretariat function) and indeed this might even set up parallel systems.

There is substantial disagreement on the following issues:

- Whether PMNCH should be a funding body
- Whether PMNCH has a role to play at country or regional level (including country level advocacy)

There is certainly no general agreement on where PMNCH can (or could) add value beyond in a global advocacy role and as a convening mechanism and even here there is a feeling that it may lack the political engagement to make this successful.

This is a matter of grave concern for an organisation which has been running for nearly three years in its interim and substantive form. The question is whether substantive added value can be identified and whether these differences can be reconciled without losing the support of key constituencies and individual stakeholders.

It is perhaps not surprising in the light of this, that some of the “external”(non Board) stakeholders also found it difficult to identify the function and added value of PMNCH. Many felt that the global context had changed since it was set up and there was no obvious niche.

It should be noted however that some partners and stakeholders at country level expressed a strong desire for country level action and implementation.

It was clear from a number of interviews that whilst all stakeholders had been strongly committed to bringing the three original partnerships together, there was a real feeling that this marked “make or break time” for the future of PMNCH. Several interviewees urged that the Board have the courage to disband PMNCH. Most people interviewed, however, expressed the view that the need
for strong advocacy as a minimum function and felt that the potential of PMNCH to support this was too important to lose at this stage, although it was clear that the benefits of PMNCH were not universally perceived to balance the time expended.

One of the reasons why certain constituencies wish to continue engagement in certain functions which do not command universal support is that the PMNCH has provided one of the few platforms where their voice is heard. This can be seen very positively if it is used to good effect. However, there is a strong feeling that Board meetings are being used for internal lobbying for issues which do not contribute to the achievement of PMNCH goals.

There appears to be a real need for finding a way to provide meaningful engagement within and between the constituencies but this may not be through the PMNCH. This is actually not one of the forums where major decisions on funding and direction for MNCH take place, and lobbying is thus not productive and is currently a diversion. Several interviewees felt that there needed to be some mechanism for views from these constituencies being fed into G8, IHP etc.

Recommendation
PMNCH should only continue in its present form if it can identify where it provides added value. Since it was set up, the environment has changed and there is a perception that there are many strong players in this field who are able to undertake some of the functions originally identified and may be better placed to do so (Health Metrics / IHP etc). PMNCH should consider focussing on a new limited “niche” role, initially in global advocacy with a focused and realistic costed work plan. In time there may be agreement whether this can extend to include, for example, a regional focus. Discussions at the last Board meeting would seem to confirm this approach but it will not gain universal approval as there is strong expressed desire for country-level action and implementation.

As described in Section VI (point 2), some interviewees felt that PMNCH could add value in some circumstances by supporting countries without internal coordination mechanisms to develop an MNCH strategy (at their request). It should however be recognised that there are other bodies who could fulfil this function. It might therefore be appropriate for PMNCH to identify which high incidence countries neither have plans nor a mechanisms for creating a harmonised plan and offering to fulfil a facilitator role, possibly using partner organisations in country or regionally who will adhere to PMNCH principles.

PMNCH has also provided two functions that were not an explicit part of its original remit and were not in the original strategic objectives. One of these is to provide an opportunity for certain constituencies (notably health care professionals) to become more collegiate. This is reported as having significant benefits and every opportunity should be taken to use “internal advocacy” to ensure a strong and unambiguous approach on the continuum of care and the package of effective interventions to ensure buy in (see Section VI).

The second which is closely related is the convening role of PMNCH. This is largely a process function but there is strong evidence that the organisations and people involved in PMNCH have improved both communication and co-ordination as a result of their engagement. PMNCH was seen as being an honest broker between constituencies that have previously competed for limited resources. This should become a specific and recognised objective using advocacy as the focus.

9. Corporate Identity
It was widely reported that partner representatives (including staff at country level) do not wish to have the name of their organisation subsumed when they are taking part in MNCH activities. Attribution is clearly a matter of contention, although it should be recognised that this is a problem experienced by many partnerships.

Although this is partially addressed by the “value added” work plan which incorporates the concept of including any new activity or an extension of a current activity which will be undertaken because
of membership in PMNCH and which contributes to the achievement of PMNCH’s Strategic Objectives, and falls beyond regular responsibilities, it may not go far enough to provide an overview of the totality of effort.

It has been suggested that there needs to be a further mechanism developed which captures all work planned / undertaken by partners, yet recognises the co-ordinating and catalytic role of PMNCH as well as giving attribution to the partner organisation. This would obviate the comments often heard that “X activity was ‘our’ activity and nothing to do with PMNCH”. This might be achieved by another annex to the work plan which captures all activities and initiatives which single organisations are undertaking which are harmonised with the goals of PMNCH. Whilst this would make the production of the work plan more complex, a more focussed approach purely on global advocacy (at least initially) would actually reduce the content and allow for fewer, more major, initiatives. This would almost certainly be more realistic in gaining partner involvement.

Likewise there may need to be a policy which creates a “strapline” for PMNCH. A strapline is a British term used as a secondary sentence attached to a brand name (eg USAID, WHO, DFID, BRAC) under certain circumstances. Its purpose is to market a specific corporate image or connection to a product or consumer base. It is widely used by airlines (e.g Lufthansa is the brand name but “a member of Star Alliance” is the strapline) A suitable strapline might be “undertaken as a member of the Partnership for Maternal, Newborn and Child Health”. This would give credit to the respective roles of both organisations and would highlight the role of PMNCH in co-ordination as opposed to implementation. This method was successfully used for the highly regarded publication “Opportunities for Africa’s Newborns” but probably needs to be extended.

Recommendation
To be effective PMNCH needs to develop a corporate image with principles that all partners agree to adhere to. A narrower focus on global advocacy with a strong focus on identifying opportunities for synergy with individual initiatives by partner organisations should be pursued. A way of capturing the “umbrella effect” without losing individual attribution should be sought.

10. Constitution of the Working Groups
Whilst there are four working groups identified in the institutional framework, two of these have not, in reality, been fully implemented. It is difficult to ascertain the reason for this but it appears to be due to lack of Secretariat support (consequent on delays in appointing senior advisors) but also lack of time on behalf of chairs and members to commit to working group activities.

The selection by working groups of their respective chairs and co-chairs was carried out at the forum and this appeared to be transparent.

There is a clear difference of opinion between people interviewed, about the extent to which partners will contribute to the various functions. The institutional framework implies that partners on working groups will contribute both to the planning process but also to the implementation of agreed activities. Whilst there have been some agencies which have been prepared to commit significant time of senior staff to working group activities (notably USAID), in practice, this has not proved possible for most partners. This is not surprising given that some constituencies involve a high proportion of independent individuals or small organisations where there is no funding to support involvement in external activities. Likewise country representatives may find it difficult to commit additional time over and above the four meetings per year planned.

There still seems a lack of clarity about the roles of the working groups and their levels of autonomy. In general the communication both between working groups and between individual groups and the Board does not seem consistently adequate and this has led to some activities being undertaken which some members of the Board have found hard to support. There needs to

\[23\] http://en.wikipedia.org/wiki/Brand
\[24\] http://en.wikipedia.org/wiki/Corporate_image
be agreement about the format for working group communication. Whilst presentations such as those given to the December 07 board meeting are helpful, this does not completely fulfil the need.

Given that the functions (and therefore number) of working groups may change as a result of this evaluation and subsequent review, this will provide an opportunity to ensure that there are mechanisms which ensure that their planned activities are both realistic and feature in the agreed work plan and that there is some form of reporting mechanism to Board members.

**Recommendation**

There needs to be a radical review of working groups to bring them into line with the future focus of the PMNCH. This will probably mean that only two permanent working groups are required (advocacy and finance) but there may be a number of short term task focussed groups established for specific purposes over time. These seem likely to attract more engagement as they will be seen to be delivering a product.

The accountability, working arrangements and accountability / communication methodologies for these groups need to be clearly specified together with the envisaged time commitment for members and the support provided by the Secretariat.

**11. Functions of the Working Groups**

When PMNCH was established four areas of focus were identified. These were:

- Advocacy
- Country Support
- Effective Interventions
- Monitoring and Evaluation

Each of these activities were to be supported through a working group. The function of each working group was to provide a platform to guide and co-ordinate the input of the members and to jointly design and implement strategies that will lead to increased resources and activities for MNCH in countries.

**12. Advocacy Working Group**

There is no disagreement that the advocacy working group has been very active, although there is not universal clarity about the purpose of the advocacy which should be undertaken by PMNCH nor at what level it should be undertaken. Interviewees have expressed the need for both “internal” and external advocacy. Internal advocacy could be defined as aiming to ensure that partners and constituencies have a common approach, access to common resources (tools, knowledge) and promote a common continuum of care model incorporating agreed effective interventions. This activity has not, up to this time been an explicit focus for the advocacy working group.

**Recommendation**

If there is agreement that advocacy should be the current focus of PMNCH (and this might change over time as the external environment changes) then the advocacy working group needs to be retained and strengthened. It should probably be a standing working group but might develop topic specific, time limited sub working groups for purposes such as agreeing the exact nature of the package and prioritisation of interventions to be advocated or the definitive list of tools which advocacy will promote.

**13. Monitoring and Evaluation Working Group**

The role of the monitoring and evaluation working group appears to have always caused some confusion as to whether its function was to monitor and evaluate PMNCH initiatives or to contribute to a wider M and E scenario reaching agreement globally on information to be collected and supporting system development.

The Countdown initiative is felt by many to have confirmed that there is no “added value” role for PMNCH in this area and there is a view that there are already several players in this field and
PMNCH has no additional or special contribution, despite the PMNCH having been the secretariat. However there seems evidence that PMNCH can claim credit for extending the scope of the Countdown initiative to monitor MDG 5 as well as MDG 4. Some partners and stakeholders have expressed the view that this function might be undertaken as part of the work of country level MNCH co-ordination groups who would monitor both donor delivery against expressed commitment but also any increase in local funding together with agreed international key indicators. Karen to add

Recommendation
It is recommended that this working group be discontinued. However there may be a need for a limited life working group to pull together monitoring information generated by third parties to feed into the advocacy process. Similarly, there may be a need to identify more detailed indicators that can be used at country level to monitor specific programme areas in greater depth or to track delivery against commitment by donors and countries.

The discontinuance of this function as a major focal area will have implications on the Secretariat structure. There is probably no need to pursue the appointment of a senior advisor on a permanent basis and any work to identify “feeder” information or more detailed indicators could be done by a contracted specialist consultant.

14. Effective Interventions Working Group
Likewise there are mixed views on the Effective Intervention working group. The majority of people interviewed expressed the view that there was already a well defined consensus on effective interventions as documented in the Lancet series, although this knowledge was not universally accessible at country level. A common view was expressed that there was the need for a one-off activity prioritising the long lists of interventions and drawing them into a model MNCH essential package which could be one element of the advocacy programme encouraging its use at country level to ensure that there were planning across the continuum of care.

It could be used locally both to advocate for resources (where elements were not yet in place) but also to act as the basis for training curricula etc. However other interviewees felt that this model package already existed and the role of PMNCH should be confined to advocating for its universal adoption.

The view was that an effective interventions working group was not needed, as such, in the long run, although a knowledge and signposting function might still be desirable.

Recommendation
There is already good consensus on effective interventions but not a prioritised package. There needs to be confirmation of this so that it can be promoted by PMNCH (possibly at the next forum meeting although the time scale is probably too long) This may require some “internal advocacy” efforts as it appear unclear whether PMNCH is adopting WHO technical norms or whether recommendations by others with technical expertise (and money) have a role too. Once this has taken place the working group should be discontinued and the PMNCH role should be confined to advocating for the universal adoption of the prioritised package. Again this may have implications for the staffing required in the long term by the Secretariat.

15. Country Level support Working Group
The country level support team was very active at an early stage of PMNCH but many interviewees, particularly those from donors and UN agencies, express the view that the approach was probably, with hindsight, inappropriate. There are already well established donor co-ordination mechanisms in many of the countries which have been the venue for activities by PMNCH (e.g. those connected with the Malawi SWAp and the Tanzanian Health Development Partners forum, led by a troika of countries).
Although a minority of partners feel that PMNCH should fund activities at country level, there is little support for this and certainly none of the funding partners seem likely to contribute to this through PMNCH in the future. Many of the bigger partners have significant presence in countries already and do not see the added value of small scale input from PMNCH.

Given that this may be a duplicative role and that little or no funding is likely to be available, the only potential function for PMNCH is to act as a co-ordinator in countries which have neither co-ordinating groups not established MNCH plans. To accord with Paris principles, this should be country led. In addition PMNCH could provide some advocacy support to MNCH co-ordinating groups in country where they exist. This might be done through advocating for increased resources and advocating for the effective package of interventions and the use of the tools which have been developed.

**Recommendation**
The country level working group is unlikely to be a standing requirement in future if this is no longer a focal function and if there is no funding to support activities.

The one possible area for PMNCH involvement at country level might be in facilitating donor co-ordination where no forum exists. As long as this initiative was undertaken at the request of the countries involved, this could accord with Paris principles although there are other generic facilitating agencies.

The need for Secretariat support in this area may need to be changed. It might be envisaged that there could be a need to facilitate country access to the tools and knowledge advocated for at global level.

**16. Communication between Working Groups and the Board**
Proper regularised communication functions do not yet appear to be in place. This is partially a symptom of wider problems in agenda setting for the Board and lack of clarity about accountability.

**Recommendation**
The Board needs to agree which standing working groups are required. In addition there needs to be agreement on which functions currently need input from ad hoc limited life groups.

At a minimum, the working group(s) should identify their proposed activities in the work plan and there should be regular progress reports incorporating financial reports. All work plan activities should incorporate stronger indicators for monitoring purposes.

**17. Support to the Working Groups**
Currently support to the working groups varies significantly and the role and accountability of support staff is a matter of differences of opinion. This is partially because not all working groups currently have specialist support technical staff appointed. Whatever working groups exist in the future, it is essential that clarity is achieved about whether support staff fulfil a purely administrative function or whether the working groups look to them for implementation of work plan objectives in that function.

Given that working group members have limited time, it is essential that members’ time is optimised. This will mean continuing to use virtual meetings. To maximise the output, support staff need to ensure that members have the information they need to assess options and opportunities, make decisions and monitor implementation. There is clearly a lack of preparation in some working groups where it could reasonably be expected that papers outlining and evaluating options might be produced. This seems to stem from different understandings of role between the Secretariat and the Board. Ultimately the Secretariat is a support, facilitation, co-ordination and (sometimes) implementation body. Thus, working groups need to be supported and serviced.
The accountability of senior advisors is rightly through to the director, but it would seem desirable that the chair of the working group(s) is involved in objective setting.

**Recommendation**

**There needs to be a review of the support provided to working groups and the following outputs should be achieved:**

- A process for ensuring that objectives are based on working group priorities and focus on facilitation, co-ordination and support
- An appraisal process which involves the Chair of the working group.

In addition it is important that working groups are fully serviced and meetings are supported by appropriate preparation. Some Chairs do not perform this role as part of their employed role and consideration needs to be given to reimbursement

**18. Processes for Confirmation of Membership**

Whilst it is encouraging that the membership of PMNCH has grown so rapidly, it is evident that there has been little screening of members beyond a web-based commitment to the general principles of the PMNCH. This has resulted in a large number of organisations who are relatively unknown and have not been independently assessed for probity and alignment becoming partners.

It is not possible to ascertain the motivation of small organisations becoming members, but there is a widely held feeling that some have expected financial support. It is not clear what membership means; what PMNCH offers to members, and what it may expect of them in return. Likewise there has been a feeling expressed that some of the larger partners have failed to deliver on commitments and need to be held to account.

It is important that there is a mechanism agreed for ensuring that:

- Members are credible individuals or organisations
- Members understand and are committed to the goals of PMNCH
- There are ways of implementing the stated aim of PMNCH in respect of holding members accountable to the principles of PMNCH and to any commitments they have made
- Regular communication with members to ensure that they know what resources are available from PMNCH, and how they can contribute to achieving its objectives
- Commitment from members to disseminate and cascade PMNCH information within organisations (to country offices as well as headquarters) and among colleagues

The ad hoc governance group has been examining this issue following the April 2007 Board meeting and, in its report to the Board, confirms a process for initial screening and obtaining commitment. It does not address the issue of ongoing accountability however which is more problematic with such a big membership, with many prestigious partners and little leverage beyond advocacy and publicity.

**Recommendation**

It is probably not possible to monitor whether all members are fulfilling their commitment to PMNCH principles but there should be a mechanism by which any member who appears to be promoting contrary principles is identified and the matter referred to the Chair. Holding partners to their commitments in terms of activities and funding is difficult but the value added work plan and procedures for regular monitoring are part.

**19. Communication with Members**

There do not appear to be well developed, comprehensive communication mechanisms with members apart from through ad hoc circulations and the website. Whilst the evaluation team were not able to undertake an extensive survey of members’ understanding of PMNCH nor their expectations, it was evident that there was a lack of clarity about function and unrealistic expectations. This may suggest inadequate communication and engagement.
Given that “internal advocacy” to build consensus amongst members appears to be an important function, this needs to be improved with the active involvement of constituency members at Board level. Currently not all Board members feel it their role to communicate and consult with their constituency, although there are notable exceptions.

Members need to be aware of the strategic goals of PMNCH, of activities under the aegis of PMNCH, need to receive information on the work plan and also information on products and tools and to be aware of advocacy messages and events. This is not currently happening systematically. In the original conceptual and institutional framework it was envisaged that there would be regular meetings, conferences, articles etc. Whilst there has been activity, it is not clear whether it has been comprehensive and involved / reached all members (particularly password-protected e-fora).

There was agreement that a monthly e-bulletin would be produced and circulated. This is a sensible way of disseminating information effectively and cheaply. Whilst some bulletins have been produced, this has not been to the agreed frequency.

Recommendation
Board members are busy people working at senior level. Whilst some may have support to consult and communicate, this is not universal, particularly for southern NGOs, academics and health professionals. Likewise country representatives may not be able to communicate fully for reasons of language or diplomacy.

It would seem an appropriate part of the work undertaken by the Secretariat to support them in this function through targeted mail-shots etc, particularly if the internal advocacy and convening functions of PMNCH are formalised. Likewise it should be the responsibility of the Secretariat to ensure that all members are involved in consultation, learning and dissemination activities as appropriate. The e-bulletins should be resurrected and should be produced to time so that they can be relied on by members. All members should also be able to participate in e-fora of interest, and they should be well advertised on the website.

20. Transparency
The PMNCH minutes are accessible on the website but are not always possible to understand fully without background papers. Financial information is much harder to access and indeed is not fully made available to Board members or partners. Work plans are not widely available and, despite a request from a Board member, have not been circulated to partners. Some workplans are on the Webpage, but are not clearly signposted.

Recommendation
The Board needs to consider a schedule of precisely what information it reserves to itself, what is shared with partners and what becomes part of the public domain. If there is a commitment to wider accountability and transparency then more information needs to be systematically shared. In particular, considerations should be given to posting the detailed work plans so partners can avoid duplicating activities or can contribute to planned ones.

21. Function of the Secretariat
The function of the Secretariat as documented in the institutional framework is as follows:

a) Provides support to the Forum, Steering Committee and Working Groups and, as requested in connection with their participation in PMNCH, to the Members;

b) Is responsible for carrying out and managing the day-to-day operations of The Partnership and coordinating the implementation of the work plan;

c) Prepares the work plans and budgets of PMNCH in collaboration with the Working Groups for approval by the Steering Committee;

d) Prepares and submits for scrutiny by the Steering Committee, a six-monthly progress report on implementation of the plan and budget;
e) Facilitates coordination of the provision of technical support by partners in agreed key countries;
f) Facilitates PMNCH’s delivery of high-level advocacy at global and country levels;
g) Represents PMNCH and its goals and objectives in international fora, countries and with other key stakeholders, in accordance with the agreed work plan;
h) Supports the members of the Steering Committee in the mobilisation of funds and other resources for the work of PMNCH at global and national levels;
i) Supports the Working Groups in the tracking of resource flows and collation and dissemination of best practices.

Whilst these functions are undertaken in a technical context, much of the work involves management, co-ordination, facilitation and the provision of administrative support. This may not have been recognised in designing the Secretariat organogram where the emphasis appears to have been less on support and facilitation and more on delivery. A copy of the organogram (developed in December 2006) is attached at Annex X.

Recommendation

The Board needs to confirm the functions it requires of the Secretariat and the Director and senior staff then need to review the implications of this for their job descriptions but more importantly for the way they spend their time. Support and facilitation needs extensive communication and networking (not necessarily face to face) Staff must be given the opportunity to acquire these competences but must also accept and demonstrate commitment to this new role. They must be able to justify the identified purpose for any networking activities (i.e. attendance at a global meeting is not enough, there have to be agreed deliverables both formal and informal).

22. Secretariat Structure

The formal structure of the Secretariat is based on the four functional areas but there are a number of additional posts which are currently in place which do not feature in the agreed organogram. Given a potential clarification and refocusing of the PMNCH, there needs to be a review of the organogram to ensure that both “form follows function” but also that there is agreement about which posts should be permanent (as there is ongoing need for the function and a requirement to maintain consistency of approach and institutional memory) and which should be temporary or filled using consultants. Given the importance of forming alliances and networking it is important to achieve as much stability as possible.

The structure should ensure that spans of control are manageable (no more than six people accountable to a single line manager) and that the seniority of the post is appropriate.

The Secretariat has two principle roles; to support PMNCH processes and to support and facilitate implementation of Board decisions. This constitutes a major managerial role as well as administrative and technical functions.

Currently all senior posts are filled by staff who are primarily technical. Whilst technical / contextual knowledge is essential for credibility, it is equally important to have staff with high level managerial and leadership skills. The current structure is not sufficiently differentiated and the person specifications may not be stringent enough.

Certain managerial processes are reported to be inadequate (e.g. HR recruitment, budgeting, costing and financial reporting) and, whilst some of these are being supported by WHO through the MOU, they still need to be led from high level in the Secretariat itself. This requires both engagement with WHO functional departments (which is not strong) and an understanding of management processes. Thus finance reports will be produced using WHO systems but the format, frequency and coding needs to be determined by the Secretariat. This requires knowledge and skills in financial processes. There has already been acknowledgement of the need for a designated and qualified Finance Officer at senior level.
Administrative functions are reported to also require strengthening particularly in respect of ensuring the Board processes (scheduling of meetings, provision of supporting papers etc) are undertaken to time and rigorously.

**Recommendation**
Once the function of PMNCH has been reviewed and agreed it is recommended that the structure of the Secretariat is also revisited. In addition to the support needs in technical areas, the requirement to strengthen managerial, financial and administrative functions should be considered.

**23. Accountability of the Secretariat**
The accountability arrangements for the Secretariat follow the same pattern as many global health partnerships with line management through WHO but with accountability to the chair of PMNCH. The Institutional Framework states that:

“The Director is accountable to the Chair who is responsible for his/her performance management. This recognizes the employment status of the Director within the host organisation.”

In practice there is a lack of clarity which is resulting in tensions and lack of mechanisms for alignment with PMNCH goals. It is made more difficult because PMNCH itself is not united on its own direction and objectives, but currently accountability is lacking. The change in Chair has made it more difficult to ascertain how performance management is discharged but it would seem that there is scope for the Director and the Secretariat staff to “fall between two stools”.

It is of the utmost importance that there is a system agreed that ensures strong coordination between the Chair of PMNCH and the Assistant Director General (Family and Child Health, WHO) in ensuring that all staff have stretching yet realistic objectives and ensuring delivery. Although there has been an improvement, the objectives set for the last two years have been somewhat imprecise (not measurable) and also have tended to focus on ongoing responsibilities (“to hold the forum” “to have the key documents endorsed”)

The basic problem partially stems from the appraisal system which requires the Director to identify his own goals. This is perfectly appropriate if there is agreement on how they should be selected (based on agreed strategic goals and the agreed work plan) and if there is a rigorous process whereby they are ratified by both the Chair of PMNCH and his line manager. At the moment there appears a lack of clarity who is supposed to do this but in the future it needs to be both parties. Likewise both parties need to be involved in reviewing his performance although formal sign off will be with the ADG. This process is also reflected in less than focused objectives throughout the organisation.

There are also problems which stem from a lack of understanding of the Board: Secretariat relationship. The Secretariat is not the PMNCH and nor can it act independently. Basically it should support and facilitate but, at all times, it must act in a way which is aligned with PMNCH principles and agreed strategy. It is important that all staff are aware of their limits of authority and the independent scope they have to commit resources (people/ time/ money) or to take actions. Ultimately they must be held to account for these.

There may be a need to be more explicit about the Director’s level of autonomy and likewise his degrees of delegation to staff. This might be expressed in a written schedule of delegation/accountability. Some of the elements of this already exist (financial limits etc) but most schedules of delegation also cover issues such as release of statements to third parties, autonomy to recruit, sanction travel etc.

All staff have job descriptions but it is not clear whether these have been reviewed since appointment. Certainly, some of those examined appear not to match the current job. They are not clear about who post holders manage, what budgets they hold or what budgetary authority they are
allowed. There appears to be a lack of clarity within the Secretariat on staff reporting lines and who is responsible for individual personal appraisal.

**Recommendation**

*Accountability flows through the Director.* The objective setting and appraisal system for the Director needs to be clarified. Both the Chair of PMNCH and the ADG need to be involved with his annual objectives and his appraisal. Objectives must be in line with the work plan and should be clear in respect of measurable indicators, timing and use of resources.

Currently the accountability arrangements laid down in the institutional framework do not entirely accord with WHO rules and processes which allows the opportunity for ambiguity. It is strongly suggested that there is a much stronger accountability / delegation framework agreed which ensures that all staff know:

- Who they are accountable to
- What they are accountable for (resources, ongoing functions)
- What levels of responsibility they have (including financial responsibility)
- Who reports to them
- What they are expected to achieve (year on year) and how it will be measured

This should be complemented by a personal development plan to ensure that they have the opportunity to acquire/ maintain the appropriate competences for the post. Again the systems for personal development exist within WHO but do not appear to be being used to the full.

The respective roles of the ADG and chair need to be specified and understood by all parties. The ADG and Chair should not be involved in the objective and appraisal process for staff below the Director but should have oversight of their objectives to satisfy themselves that they are aligned and appropriate.

**24. Secretariat staff competence**

It was neither possible nor appropriate to undertake a review of all staff to ensure that their experience, qualifications and competences were appropriate for the posts they were holding. There are clearly a number of staff who are well suited to their roles. There is however a substantial body of anecdote and uncorroborated evidence that not all staff have the appropriate personal profiles. This may be because the person specifications do not reflect the current roles which have changed from what was originally intended but, in some cases, it would appear that the post holders fall short of what is required. There is a clear shortfall, which is evident from the operation of PMNCH, in managerial, administrative and financial capacity. (e.g. “managing upwards”, financial control, financial reporting, diary management,)

**Recommendation**

A review based on the evaluation may necessitate some restructuring of the Secretariat. This should not be confined to technical areas but the opportunity should be taken to review the requirements of the Secretariat in other functions. This should not necessarily mean staff being made redundant but it might mean a reallocation of work so that it is undertaken by staff with appropriate capabilities. It is important that no fixed or short term contracts are renewed or confirmed whilst this review is underway as this will reduce flexibility.

Although some training and development is available through WHO, it is suggested that all staff should have personal development plans over and beyond the requirements of the PMDS and that additional funding should be identified to support them in obtaining the competences needed to do their jobs.

**25. The Post of Director of the Secretariat**
The post of the Director is a difficult one given its dual accountability and the need to work with multiple stakeholders. It is both a support role (to PMNCH) and a managerial one (managing the Secretariat but also managing relationships in and between the Board and with external bodies). It requires the seniority to engage at political level but also the understanding that the role is principally one which supports the Board and PMNCH as a whole. This requires alignment with agreed PMNCH principles and objectives.

Neither the Director nor other members of the Secretariat should be acting outside the agreed priorities and principles set by the Board. This does not currently seem to be clearly understood by all parties although it must be acknowledged that there is no Board level unanimity on principles, functions of PMNCH or priorities.

**Recommendation**

There is an urgent need to clarify the role, responsibilities and accountability of the Director and to provide a schedule of accountability / delegation (see above) and operating instructions within which the post holder should work. Given that the current post-holder does not come from a professional managerial background (i.e. with a management qualification and general management experience), consideration should be given to offering high level personal development in this field together with independent coaching and mentoring. This is a normal support mechanism for CEOs and Directors in both the public and private sector.

**26. Secretariat Senior Advisors**

Not all Senior Advisors posts are filled, and one has only been recruited recently. It will be necessary to review these in line with agreed functions and consider whether the posts are needed in the future. Again it is important to be clear whether these are support posts to working groups and partners or whether there is a legitimate role in activities including delivery of the work plan (as opposed to its co-ordination) The competences needed for these two roles are very different and, once clarification on the role has been agreed, personal development (including mentoring) should be offered.

**Recommendation**

As part of the PMNCH review, the current structure will need review. When appointing to/confirming staff in new posts there should be an assessment against the required competences and a personal development package agreed.

**27. Financial Arrangements**

PMNCH funds are recorded as trust funds in a special account in the Voluntary Fund for Health Promotion in WHO accounts and administered in accordance with WHO Financial Regulations and Financial Rules, financial procedures and practices, including those relating to internal and external audit and oversight. They are reported on in an Annex to WHO’s Financial Report and Audited Financial Statement as well the reports prepared by the Secretariat and approved by the Board.

As with other partnerships, WHO charge Programme Support Costs (PSC) on all PMNCH funds. They levy 13% on all Secretariat activities (which mainly consists of staff salaries), and 6% on all PMNCH ‘core activities’ such as Working Group activities, country level support, advocacy etc. All budgets are prepared by the Secretariat and approved by the Board. The PMNCH MOU requires six-monthly reports to be submitted to the Board on implementation of work plans and the budget.

In terms of spending PMNCH funds, the Director and Deputy Director have spending / signing authority up to an agreed limit (as WHO staff, according to WHO rules and regulations). The Director (or his deputy in his absence) approves all travel for Secretariat staff and non-staff. Travel for the director needs to be pre-approved by the ADG. If additional services are required (including technical support), the WHO Consultant Selection Committee will be used by the PMNCH. This committee requires evidence of fair tender process, adjudication reports, clear justifications etc.
Some concern has been raised by the Board and others about the extent of variance between planned expenditure on work plan activities and actual expenditure. Although these may well be justifiable, the Board requested in December 2007 that some rules / guidelines for approving expenditures which vary significantly from planned be established. The Governance Committee discussed this issue in February 2008 and agreed that variance from work plan budgets of up to 10% can be signed off by the Director, variance of 10-20% need Chair / Co-Chair approval, and over 20% variance from the approved work plan budgets need to be approved by the Board.

The MOU states that PMNCH operates “subject to funding availability and subject to and in accordance with WHO's financial and staff regulations and rules, manual provisions, procedures and policies.” WHO will therefore not release funds for any PMNCH activities unless there are funds available in the account. This includes appointing staff. WHO requires that at all times a six month funds should be in hand for fixed-term staff position.

Financial management by the Secretariat is certainly improving, however it is not happening as quickly as one might have hoped. The issue of adequate reporting has been raised since the beginning of PMNCH and, without this, it is very difficult to manage the funds appropriately. Budgeting for work plans needs to be addressed at the most senior level of the Secretariat, and attention paid to expenditure against these work plans. The issue of unbudgeted sections of the work plan also needs to be addressed – in a 2-5 year strategy this is useful, not in a one year plan.

Recommendation

Financial management needs to be taken more seriously within the PMNCH. This means ensuring adherence to a budgeting and monitoring process and ensuring accurate, timely information is received by the Board and individual funders. It is also essential that financial management is exercised to ensure that expenditure is in line with budget. This is essential to reassure current and future donors that their funds are being used in the most efficient and effective manner, and will encourage them to use PMNCH reporting cycles. It will also allow a much more effective management of the work programme, staff time, and expenditure against budgets. The new financial committee is vital, and a senior financial controller / officer should also be appointed with responsibility for managing and monitoring the use of all funds. PMNCH should establish strong internal processes as well as WHO ones.

28. Management of funding from the Bill and Melinda Gates Foundation

PMNCH funding from the Bill and Melinda Gates Foundation was received in December 2006, and is allocated towards three objectives:

- Objective 1 - implementation in jump-start countries (3 years)
- Objective 2 - external evaluation by Johns Hopkins team (4 years)
- Objective 3 - strengthening the Secretariat, advocacy and leveraging resources in the three large countries, DRC, Ethiopia and Nigeria as well as the Asia Framework (3 years)

Funding for objectives 1 and 2 ($25 million) is managed by a Committee chaired by Dr Liz Mason, Director of CAH/WHO. This reflects the fact that the grant holder is WHO, not PMNCH (because PMNCH is not a legal entity), although the "principle investigator" is the PMNCH Director. Funding for objective 3 ($10 million) is managed by the Secretariat, along with other PMNCH Director. The Secretariat organizes regular meetings, gathers information on implementation from Dr Liz Mason and prepares progress reports for the Management Committee on the entire grant ($25+$10 million), including financial analysis and projected spending.

The country support funded by the Bill and Melinda Gates Foundation (Objective 1) experienced problems at the early stages of implementation, largely as a result of inadequate consultation with countries during the design-phase. The April 2007 Board meeting recommended an immediate suspension of the $25 million portion of the grant for 3 months while options were examined about how to manage the grant most effectively, how to strengthen PMNCH constituencies at country level, how to engage effectively with the jump-start countries, and how to disburse the funds to
countries. A sub-group was established to review these issues, and the suspension was lifted in June 2007. A key learning point for PMNCH from this process was the need to consult extensively with countries when designing future interventions.

**Recommendation**

Lessons have clearly been learnt from the experience of the funding by the Bill and Melinda Gates Foundation. These include management of the grant between WHO (the grant-holders) and the PMNCH (applicants), how to liaise with countries to ensure proposed activities match requirements at country level, and how to disburse funds in the most appropriate fashion. It would be useful to review progress and record key lessons as information for future PMNCH activities.

**29. Risk Management**

There is no evidence of risk management in PMNCH and currently the information is not available to undertake this comprehensively. There are significant risks facing the PMNCH including loss of funding, loss of support from major players, reputational damage caused by lack of cohesion, “competition” from other bodies undertaking similar functions etc. These do not appear to be formally recognised, nor are they being managed or mitigated. It would appear to be the role of the Director to undertake this function and to initiate discussions both formally at Board level and informally with individual people and organisations in order to manage these.

**Recommendation**

This evaluation will highlight many of the risks facing PMNCH and some of the recommendations will suggest ways to mitigate risk. It is suggested that senior staff in the Secretariat undertake an exercise to identify risks across the full range of areas and prepare a paper identifying how these should be mitigated. This should be led by the Director who should take personal responsibility for assessing those risks which emanate externally. He will need to consult extensively in order to undertake this exercise.

**30. Conflict Management**

There is no evidence of outright conflict between partners in the PMNCH but there are clear differences of opinion and priorities. These need, as far as is possible, to be resolved. This will require both time and possibly some facilitation. It is clear that some partners will find it hard to accept the realities of the situation but pragmatism will need to be encouraged. If funding partners or the majority of Board members do not support a particular direction of travel, then there comes a point when further debate may not be worthwhile and, indeed, will be divisive. It will be important to allow views to be aired, to acknowledge these but then to move on. Total consensus cannot always be achieved and attempting to bring together the unreconcilable is a waste of valuable time and energy. The Board should not be frightened of having differences of opinion but difficult issues must be confronted.

It is recognised that the “one person / one vote” with a majority determining the outcome may not be functional under certain circumstances. For instance, in theory it would be possible for non-funding Board members to vote through a decision requiring funding. However this decision would be inoperable without the support of funders. Whilst this situation may not be to the satisfaction of some Board members, it is nevertheless a reality and cannot be changed. It is therefore suggested that, should this occur, it should be recorded factually but should not be made a barrier to working together.

**Recommendation**

There is much that can be undertaken in conflict management “behind the scenes” by the Director and the Chair/ co-Chairs. This requires excellent networking by the Director with all members and the exploration of options to establish the parameters for compromise.

**31. Audit and Evaluation**

As the PMNCH funds are stored held????? within a WHO account, their financial figures are included in an Annex to WHO’s Financial Report and Audited Financial Statement. The Secretariat
also prepares financial statements for review and approval by the Board. The MOU states that the Board should also review the audit report, and “monitor the use of all funds made available to PMNCH”. Internal audit review, if it occurs, is conducted by the Office of Internal Oversight Services of WHO. Audit reports will be addressed to the WHO Director-General with copies to the Director of PMNCH.

At the April 2007 Board meeting, following presentation of the 2007 Work plan and Financial Report, an audit was discussed. The minutes note that “The Secretariat would welcome an audit whenever this is convenient and timely for the Audit Department at WHO. However a special or external audit is not necessary because all PMNCH funds are held in a WHO Trust Account and finance reports are based on data generated by the WHO system.” At this time, the Board requested that the Secretariat clarify the auditing cycle at WHO and request a financial audit. A note on the audit cycle has since been supplied to the Governance Committee by the Secretariat.

A financial audit is both a useful tool for internal management of the PMNCH funds, and reassuring evidence for donors and potential donors about the PMNCH. It is suggested that senior members of the Secretariat request a financial audit at this time of establishing the Finance Committee.
Section VIII: Assessing Management

1. Managing the PMNCH Schedule
There is currently no single agreed annual schedule which identifies key events, deadlines for processes, submission dates required by third parties etc. This means that many events (such as Board meetings) are arranged/changed at short notice, that processes are not being completed in a timely manner and that key players are being disenfranchised because they cannot free up time to become involved.

Board meetings, working group meetings, finance and activity reporting dates, deadlines for submissions for the e-bulletin plus dates when papers will be sent out should all be scheduled in advance. This enables work to be undertaken in a timely manner, proper briefing material prepared, diaries to be synchronized etc. It will result in better attendance at meetings and both Secretariat staff and partners can schedule their time to give due consideration to discussions and activities. Likewise, ensuring that objective setting is synchronized with the approval of the annual work plan will mean all staff know what is expected of them and can align their efforts.

Different donors have different submission dates for funding/grant requests and these need to be taken into account in the planning process as does the need to meet WHO deadlines for plans and budgets.

Recommendation
A comprehensive annual schedule should be drawn up each year by November for the following year. It should be displayed on the website so that partners are also aware of the processes. In order to ensure that key tasks are completed adequately it may be beneficial to schedule “quiet weeks” where there is agreement that external contact is kept to a minimum to allow key players uninterrupted time to complete the task.

2. Planning processes
The planning processes for PMNCH have developed over time. The original intention was to create a ten year plan based on the strategy and then to produce annual Secretariat work plans. The first PMNCH work plan produced in 2006 was intended for a 2 and 5 year period and the subsequent work plans have been designed for a single calendar year. The 2007 work plan was not completed until April, and finalized in May however. This delay is acknowledged by all concerned as having been harmful. It should be acknowledged that there was little capacity in PMNCH at that time due to delays in recruitment.

The April 2007 Board confirmed support for a “value added” work plan which incorporated not only a “Secretariat” plan but also documented complementary initiatives by partners. This 2008 work plan was externally supported using a specialist consultant with funding from Norway. However, the process took approximately six months to complete and this clearly is not realistic for a routine annual activity.

The original work planning process would appear to have given the wrong messages. It reinforced the perception that the Secretariat was PMNCH and did not capitalize on the potential for funding, complementary work and additional initiatives which could have been leveraged from partners. The 2008 work plan appears much more collegiate and demonstrates better the added value of PMNCH through undertaking work which is complementary.

There remains a difference of opinion about what is included in the work plans. The early plans were basically extensive “wish lists” and only a proportion was funded. The view was that initiatives should be identified to facilitate advocating for funding. There was little prioritization. The 2008 is more on the model of a zero-based work plan as it applies to the Secretariat. In other words funding was identified before the activity was included. This makes for a more realistic and functional document which can be used for performance management. Whilst it is reasonable to
include “desirable but unfunded” initiatives in a three, five or ten year plan (whilst actively seeking funding) it is not acceptable in an annual work plan which should be realistic and achievable.

The work plan identifies the “umbrella effect” of PMNCH whilst still giving organizational attribution. It still gives the impression however that all work undertaken outside the remit of a single partner organization is delivered by the Secretariat. Many partners identified the need to involve individuals from a number of partner organizations in undertaking specific tasks. Whilst these might be facilitated by staff from within the Secretariat the actual work would be done by partners. Sometimes this might appropriately be attributed to a working group (such as drawing together partners to prioritise the agreed effective interventions), but equally there needs to be a convening mechanism relating to undertaking an activity which brings together a group for a time limited effort.

The work plan reports show that budgeting and expenditure are not aligned. Some of this may be related to poor management arrangements (lack of personal accountability, lack of control of spend) but equally it may be the result of poor costing. Either way it is unacceptable and needs to be addressed as partners will lose confidence in the process.

Because PMNCH is hosted by WHO it is necessary to align with their planning and budgeting processes. Although there is likely to be some change in the procedure, time alignment will still be essential. This needs to be scheduled in advance, together with ensuring all feeder information can be obtained in a timely manner and there can be meaningful discussion and sign off by the Board.

The added value work plan is for PMNCH as a whole. It is important therefore that all partners receive a personal copy. This is one way of keeping engagement with the 250+ organizations involved. Whilst it is available on the website it is not the same as receiving a targeted copy either by electronic or conventional mail. It was evident that this had not been customary.

3. Opportunistic Initiatives
Examination of the work plans shows that there have been a number of fairly major initiatives undertaken which do not feature in the work plan. Many interviewees have identified the desirability of the PMNCH being “light on its feet” and able to respond fast. It would be interesting to examine how many of these “last minute opportunities” were truly undertaken at such short notice or whether increased networking across a wider range of political and organizational stakeholders could have identified them earlier. There may be a small number of occasions where there is the need to reprioritize funding or staff time mid year but there needs to be a process for evaluating the opportunity costs versus the benefits.

4. Implementation processes
At the moment there appears to be a disconnect between the work plan and personal objectives agreed with staff. Staff objective setting needs to be synchronized with the planning process and staff members need to know what parts of the work plan they must personally achieve and what resources they have. There is a clear need for work plans to form the basis for performance management. The process within the Secretariat should be envisaged as follows:

Figure 1: Objective setting to achieve PMNCH goals

<table>
<thead>
<tr>
<th>Agreed Strategies</th>
<th>V</th>
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</thead>
<tbody>
<tr>
<td>Strategic Plan (5 year)</td>
<td>V</td>
</tr>
<tr>
<td>Annual value added work plan</td>
<td>V</td>
</tr>
<tr>
<td>Personal objectives</td>
<td></td>
</tr>
</tbody>
</table>
There appears to be some confusion about the approval mechanisms for implementation. Whilst the PMNCH budget has to be included in the WHO budgeting process, it is not voted on by the WHO assembly. WHO senior staff interviewed stated that the budget was the responsibility of the PMNCH Board, delegated to the Director. However, WHO could intervene if they felt it was inappropriate / illegal or might bring the organization into disrepute. Staff in the Secretariat reported however that they needed to gain WHO approval for implementing each activity under the work plan. This needs clarification.

5. Monitoring Processes
A monitoring report should be produced on a regular basis (scheduled, perhaps quarterly or 6 monthly to coincide with Board meetings). This should be the document which holds both individual staff members and partner organizations accountable for delivery. It must be recognized that there are no formal leverage mechanisms to encourage partner organization compliance but wide circulation of monitoring documents can prove efficacious.

Recommendation
The use of a value added work plan should be retained. There needs to be permanent capacity established in the Secretariat to undertake this (i.e. a member of staff with personal responsibility for ensuring it is completed with adequate input and consultation, that it includes robust performance indicators and that it is fully and accurately costed and delivered on time).

A decision needs to be made whether the work plan will include desirable initiatives which are seeking funding. It is strongly recommended that these should be produced at an earlier stage in the year and circulated to partners to attract financial support or to be “adopted” by individual partners for a value added complementary activity. Once support has been obtained they can be slotted into the work plan in the appropriate section.

Desirable initiatives need to be prioritized. This should be done using transparent criteria which are made public to ensure that stakeholders understand them. This will avoid the perception that currently exists that some initiatives or partners get “favoured”.

Opportunistic initiatives need to be rigorously evaluated before they supplant agreed work plan priorities. Every effort should be made to identify opportunities well in advance. The development of excellent personal networks will facilitate this. Clarification is needed relating to approval mechanisms for committing expenditure.

An explicit step should be taken to ensure that the work plan as a whole reflects appropriate weighting to activities in the three core areas – that efforts and resources are roughly equally invested in activities that advance maternal, newborn and child health.

The work plan should form the basis of personal objectives for all staff in the Secretariat on a cascade basis starting with the Director. They should be held personally accountable on the basis of objectives being defined by SMART (specific / measurable / achievable / realistic / time-bound).

Monitoring should be done on the basis of an agreed frequency. To avoid unnecessary transaction costs, the use of a traffic light reporting format is recommended. Each initiative would be marked green (progressing to plan including time and resources) orange (some slippage) or red (not progressing to plan). This would enable the Director and the Board to concentrate on those which were not performing well.

6. Resource mobilization
The nature of resource mobilization has changed fundamentally since PMNCH was established. At the start, there was a broad-brush approach to fundraising. Grants were sought and accepted for a number of earmarked projects (some very specific), which has caused subsequent problems with monies received not necessarily fitting the desired work plan of PMNCH. This strategy has
changed somewhat more recently, with unspecified grants and grants targeted towards work plan activities being sought from a number of partners.

Unspecified funding is important as it allows PMCNH more flexibility in responding to opportunistic initiatives, and helps fund core management functions. To date, PMNCH has only received totally unspecified funding from the Netherlands, WHO (through transfers) and more recently Italy, and the value of these funds remains unchanged from 2006 to 2007 (just under $1.8 million). As the value of specified funds has increased year-on-year, the proportion of unspecified funds available to the Secretariat has significantly diminished (from 25% in 2006 to 15% in 2007).

PMNCH does not have a formalized Resource Mobilization Strategy, however a Resource Mobilization Work plan is held by the Secretariat and updated every month. This plan indicates the status of existing grants, progress with targeting new donors and follow-up actions for Secretariat staff. Senior staff meetings are held regularly to discuss findings, developments and strategy. The PMNCH Memorandum of Understanding (MOU) states “the Role of the Director is to support the Secretariat to mobilize financial and other resources”. This is also included in the job description of the Director. It appears that more attention needs to be paid to this area.

To date, PMNCH has received funding from 12 organizations on their list of 27+ to target for resources. The number of funders increased from 7 in 2006 to 12 in 2007, with another recently identified to support the 2008 PMNCH work plan (AusAID). Of the current funders, 6 are bilaterals, 3 are UN organisations, and the others are the World Bank, the Bill and Melinda Gates Foundation and the MacArthur Foundation.

The status of current funding (as stated in the 11 June 2008 update) is outlined below:

- Germany – funds recently ran out
- USAID – no more expected at the current time
- Norway – time-limited funds (expire in 2008)
- Netherlands – unspecified funding into 2009
- UK – funding running out (Aug 2008)
- Italy – unspecified funds received 2007
- UNICEF – funds running out
- UNFPA – funds running out
- WHO – funds ran out Dec 2007
- World Bank – awaiting no-cost extension
- Bill and Melinda Gates Foundation – ongoing large grants
- MacArthur – time-limited funds (expire Nov 2009, with “hints of renewal”)

A number of funding sources have either run out recently, or are due to do so in the near future. It is therefore vital that PMNCH focus on maintaining relationships with existing or recent funders and continue to make contacts with new funding sources. Although small grants are useful, priority should be paid to identifying larger grants, over longer time periods that are not earmarked, but targeted towards agreed work plan activities. The 2008 value-added work plan is a significant step in moving PMNCH away from activities stipulated by available funding, towards a work plan based on identified priorities. So far, there is some evidence that PMNCH is seeking funding for priorities identified in the work plan, however it is not possible to measure the success of this as yet.

Annex XI summarises the financial position of PMNCH in 2006 and 2007, giving the income and expenditure by each donor, and by work area (showing expenditure against budget for activities). The total amount of funds available increased substantially from 2006 to 2007 (which is to be expected as the Secretariat increased in size and ability to seek resources), from $7,265,677 to $12,295,119 (69%). The ability to spend the resources also increased, with expenditure against available resources rising from 17% to 41%. The low figure in 2006 is skewed somewhat by the funding from the Bill and Melinda Gates Foundation arriving in December 2006. This picture is encouraging, although more needs to be done to ensure funds are utilised in a more timely fashion. There are also significant areas of the work plan that remain unfunded. The finance
committee should focus on this, however PMNCH also need to prioritise work plan activities, and agree where to scale back until resource mobilisation efforts reap substantially greater rewards.

It is interesting that written into the MOU, is an expectation that “all members of PMNCH will contribute to its activities, either financially or in kind”. This does not appear to have been enforced when recruiting new members of PMNCH, and the underlying obligation is unlikely to be understood by existing members. The MOU also states that “further details relating to support by the Members, including provision for the costs of operating the PMNCH Secretariat, will be set out in the PMNCH fundraising strategy”. As indicated above, there is a work plan, but no strategy in place as yet. It is recommended that this be developed and presented to the Board.

As one might expect, the issue of resource mobilization has been on the agenda since the beginning of PMNCH. Indeed, in the 2nd Interim Steering Committee Meeting, held in December 2005, Julian Lob-Levyt from GAVI was invited to talk about the new GAVI Health Systems Strengthening funding stream. In addition to describing the new initiative, he and Jacques Baudouy from the World Bank talked about other new funding sources aimed at tackling MDGs 4 and 5, highlighting the opportunities open to PMNCH. These included following-up the High-Level Forum, approaching GFATM and another new initiative Ending Child Hunger being supported by UNICEF, WFP and the World Bank. The conclusion at this meeting was that GAVI was the most concrete fund open to the PMNCH, and further collaboration should to be sought with the GFATM on health-systems strengthening. This does not appear to have been reflected in actions or funds, although there are opportunities for PMNCH, as countries have received GAVI funds for MNCH (Pakistan have received funds from GAVI), and PMNCH could work with other funds / partners.

**Recommendation**

Following a review of PMNCH objectives, the Secretariat need to develop a fundraising / resource mobilization strategy that sets out exactly what they need to collect to undertake the activities identified in the new plan / objectives, and the mechanisms for doing this. It may be necessary to engage the services of a skilled fundraiser to advise the Secretariat on the most effective mechanisms. There currently appears to be a lack of capacity to apply for grants and this must be addressed. PMNCH should also seek advice from other partnerships both on sources of funding and methods for obtaining it but also on potential finance which other GHPs could make available (particularly GFATM and GAVI).

### 7. Regulatory compliance

The PMNCH has no legal framework and operates under a hosting arrangement with WHO. The Secretariat is bound by the MOU to undertake its activities in accordance with WHO’s financial and staff regulations and rules, manual provisions, procedures, practices and policies. There is the opportunity to request adaptations and exceptions but these have to be justified. WHO is a large and bureaucratic organization and the regulations and rules are relatively complicated. It is unfortunate that there is no single point of contact that the Secretariat can access for advice on regulatory compliance.

There appear to have been incidences where PMNCH have not complied with WHO rules and procedures. Certainly in the past the planning and budgeting processes have not been fully synchronized. A further incident relates to the appointment of a goodwill ambassador which gave rise to political embarrassment due to the laid down processes not being followed.

There are likely to be changes to some regulations in the near future (particularly concerning budgeting) and this will affect the planning and budgeting process and provide greater clarity. It was reported that the current arrangements for management of the funds from the Bill and Melinda Gates Foundation do not technically comply with normal WHO regulations for budget allocations.

**Recommendation**

The lack of senior level managerial expertise and the absence of a point of contact on issues of compliance may have contributed to PMNCH not consistently following WHO regulations and procedures. This needs to be addressed but closer informal relations would
also help prevent reoccurrence. The use of an annual schedule would militate against missing key deadlines.

8. Reviewing and reporting

Both formal and informal reviewing and reporting arrangements appear to be inadequate. This relates both to PMNCH activities and funding as a whole but also to earmarked grants from individual donors. There is a danger that funding will be withheld unless there is an improvement.

The measures recommended under the section on planning will help mitigate this risk but consideration needs to be given to more adequate financial reports using a more meaningful cost coding. It is understood that this is available within WHO but time needs to be given to customize codes and agree frequency and formats.

It was reported by interviewees that financial reports were often received extremely late at Board meetings, and that the information presented was not comprehensive or clear enough. There is an issue that Secretariat staff are spending substantial amounts of time preparing reports on individual grants for individual donors at different times during the year and this is taking them away from concentrating on understanding and reporting on the overall PMNCH financial position adequately. Timely reports are an essential pre-requisite, and this needs to be given attention at a senior level.

During the existence of the interim Steering Committee the issue of how budgets, expenditures and the financial position of PMNCH were presented was raised several times. The most substantial outcome of this was the new Value-Added Work Plan 2008 and Budget, presented at the December 2007 Board meeting by Bo Stenson. A key point was made by Bo: “regarding budget, the work plan needs to be clearer about what can be achieved with funds in hand, and explicit about earmarked funds and the activities these support. The budget is insufficient to explore engagement with new countries.” This should be a concern for the Secretariat and the Board who are mandated with reviewing PMNCH direction and finances.

The financial reports appear to be presented without a substantial analysis, with no explanations for the large discrepancies between budgets and expenditures. The breakdowns give very little scope for probing by the Board, and shed little light on what the money has actually been used for, apart from at a very high level - total amounts spent for each Work Plan area; or by type (staff, travel, supplies etc) as shown below:

**Table 5: Example of financial Information presented to Board**

<table>
<thead>
<tr>
<th>Type of Expenditures (2007)</th>
<th>% Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff salaries and benefits</td>
<td>38%</td>
</tr>
<tr>
<td>Sub-contracts</td>
<td>29%</td>
</tr>
<tr>
<td>Non-staff travel</td>
<td>11%</td>
</tr>
<tr>
<td>Staff travel</td>
<td>9%</td>
</tr>
<tr>
<td>Programme support costs</td>
<td>7%</td>
</tr>
<tr>
<td>Transfer to WHO Regional Office</td>
<td>4%</td>
</tr>
<tr>
<td>Printing, shipping and purchase of admin and communications material</td>
<td>2%</td>
</tr>
<tr>
<td>Administration costs and miscellaneous</td>
<td>1%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

It is likely that the information is available in a more detailed form (as it has to be provided in reports to other donors), but it would be extremely useful to have it broken down in more detail for Board members.

The December 2007 Board discussed the issue of lack of clarity in the financial reports, concluding that “In future, finance reports will include analysis of financial sustainability, i.e. prospective
funding for a 3-5 year period. Also, finance reports should be reviewed by a Finance Committee which meets prior to the Board.” It is understood that this Committee is in the process of being established and will have it’s first meeting before the July 2008 Board meeting.

The Board also requested that financial reports include a) Duration of grants, b) How specified and non-specified funds are used and c) Explanation of any variances.

**Recommendation**

More detailed financial reports need to be provided to the Board, in a timely fashion well in advance of the Board meetings. These reports should provide the Board with enough detail to understand which monies have been used for what, and why any discrepancies have occurred between budgets and expenditures.

A section of the financial report should be dedicated to an analysis of financial sustainability, including the duration of grants, a summary of resource mobilisation plans and future requirements.

The establishment of the Finance Committee with responsibility for reporting to the Board on all financial matters is endorsed and is due to meet before the July 2008 Board meeting.

The Secretariat should negotiate strongly with funders to agree reporting schedules that fit better with PMNCH reporting schedules. Ideally, individual funders would agree to receive the PMNCH annual financial report instead of detailed individual project reports.

**9. Administrative efficiency**

It was not possible to examine routine administrative systems in detail but there was much anecdotal evidence that these lacked efficiency and effectiveness. There were reports that routine tasks were not completed satisfactorily and that agreed actions were not completed. Certainly some routine products such as monitoring reports and news bulletins do not appear regularly.

The evaluation team experienced personally the lack of information relating to partners and stakeholders. It was not possible to identify the cause of this but it is clear that administration and management are not given high priority by the senior staff. This may relate to there being primarily technical capacity at this level.

There does not appear to be adequate internal liaison on routine tasks such as diary scheduling. This may because of inadequate internal delegation or lack of communication.

Other partnerships and departments (some of whom had also experienced problems) within WHO identified the need to develop excellent relationships in order to facilitate routine tasks (booking flights / arranging meetings / ordering goods). The wish by the Director of PMNCH to remain relatively independent is not felt to support this. Reluctance to become involved with the introduction of and training for new administration systems might be a symptom of this.

**Recommendation**

Good administration is an essential pre-requisite for a successful organization. Whilst it may not contribute directly to institutional goals it underpins all activities. It is important that there is recognition of the need to retain excellent staff who have the opportunity to acquire appropriate competences and to develop productive internal and external working relations. Systems and accurate data bases are needed to underpin all work and to ensure excellent communication. These do not appear to exist and should be given priority.

**10. Stakeholder communication**

In order to be effective, PMNCH needs to communicate with a range of stakeholders including non members from the six constituencies and other global partnerships. Communication with partners is documented under the Section on Governance.
PMNCH is both its members and the Secretariat. Many of the partners and Board members have very wide networks of contacts and there is evidence that there is regular two way communication on matters relating to maternal, newborn and child health. This may not be specifically undertaken under the aegis of the PMNCH, however.

Whilst there is considerable potential synergy with the goals of several of the other global health partnerships, communication is patchier. Donors and multilateral agencies sit on the Boards of many of these partnerships but do not feel they have a remit to act as the spokesman for PMNCH when doing so. Informally there is, of course, much productive contact.

The role of the Secretariat in communication externally is very variable. Senior staff do not regularly attend other partnerships in an observer capacity even though it was reported that they would be welcomed.

When PMNCH was established there was attendance at Board meetings by at least one CEO of a similar partnership and perhaps others. This has discontinued and no regular top level communication channels were identified with any of the partnerships apart from the Health Workforce Alliance. It was reported that this was because the PMNCH was neither seen as having relevance nor to be working at the right level (for example G8 / IHP).

It was reported by several informants that the Director did not recognize the importance of participating in fora which involved all partnerships and thus lost out on networking, lesson learning and on potential funding opportunities.

It was reported that the Secretariat had been much involved in communication with some stakeholders at country level. However, it was not possible to identify why some stakeholders received regular communication and visits, whilst others did not and this was not necessarily aligned to work planning etc.

**Recommendation**

The need to engage with other global partnerships should be reviewed and key potential relationships should be identified where working together might have mutual benefit. As part of the planning process a stakeholder analysis should be carried out. It is recognized that both member and Secretariat time is limited and therefore priorities for stakeholder engagement should be agreed.

11. Learning

There is little evidence of PMNCH embracing a policy of reflective review and lesson learning. Although there has been an iterative process whereby some activities (such as work planning) have been modified in the light of experience, there does not appear to be a culture in place to learn lessons from both internal and external sources (such as other GHPs).

**Recommendation**

Both reflective learning and scanning externally for valuable experiences should be encouraged.

12. Hosting arrangements with WHO

The MOU with WHO is based on a standard hosting agreement used for a number of similar partnerships. It is necessary because the PMNCH is not a legal entity and does not possess the juridical personality. It therefore has limitations on its ability to contract, acquire goods and services and to take legal action. The current MOU is up for renewal in January 2009 and any intention to change or discontinue it, needs to be notified by mid July 2008.

It is clear that WHO are not prepared to make significant variations to individual MOUs (although there are some differences). This is due to the number they hold and their wish to standardise. Any variation seen by others as beneficial would trigger a mass renegotiation exercise. WHO attempts
to treat all partnerships equally but is not prepared to treat them more favourably than their own core business.

WHO is a large organisation and it is acknowledged that their systems are bureaucratic and somewhat cumbersome. However, hosting by a UN body brings many advantages including status, convening power and those relating to Swiss immigration and tax. One similar organisation (GAVI) has made the decision to establish itself as a Trust but this option would not be possible for PMNCH on the grounds of economies of scale and transaction costs.

Some delays in the delivery of functional tasks by WHO (e.g. staff recruitment) seem unacceptably long. It is reported that this currently may partially be due to the introduction of new internal systems but it has occurred throughout the lifetime of the PMNCH. Other partnerships have encountered similar problems but some have found ways round them by greater engagement with key WHO individuals and departments. If delivery of agreed services does not improve it needs to be the subject of formal discussions involving the Chair. There have been requests (initially in November 2007) made by a group of GHPs to discuss these issues with the Director General.

In most MOUs, it would be seen as desirable to agree standards and schedules of services so there is clarity of expectation on both parties. The standard WHO MOU does not contain such a specification but, although this is highly desirable, it seems most unlikely that a single hosted partnership could achieve this as, basically, there is no leverage.

There appear to have been a number of matters which relate to poor communication between PMNCH and WHO. These include matters relating to extension of personal contracts beyond the time-span of the MOU as well as collaboration on personal performance management. It is difficult to ascertain the reason for these but it needs to be clarified as quickly as possible.

There is a possibility that a different hosting arrangement could be made, perhaps joining a consortium of partnerships or requesting hosting from (say) GAVI in its new status but there is no indication that others would necessarily welcome the PMNCH in such a relationship and any change to hosting is probably a diversion that can be ill afforded at this critical time.

The Director of PMNCH has made a personal decision not to attend internal Divisional meetings in WHO. This seems to be due to a wish to keep the PMNCH “independent”. PMNCH is not a department of WHO but there would seem to be good reason to attend in order to share information etc. It needs to be acknowledged that PMNCH is not benefiting from this stance as co-operation on delivery of services is likely to be less and essential networking and information exchange opportunities are being lost. Attendance is not a matter of status but a manifestation of a mature relationship based on acknowledgement of mutual benefit.

**Recommendation**

The PMNCH should continue to be hosted by WHO but should seek to make the relationship more functional. This will require greater engagement by the Director. Other global partnerships have found that whilst processes may be cumbersome there is a way of solving most problems through excellent communication and nurturing the relationship. Ideally a more detailed MOU should be sought with agreed schedules of deliverables and standards (recognising this may not be achievable).

The Director should be encouraged to attend internal WHO meetings recognising the benefit to PMNCH.
## Section IX: Key Findings and Recommendations

The table below summarises the key recommendations of the evaluation team, identifying which are critical to the very existence of, and which are critical to the effective operation of PMNCH, and when the Board is likely to make decisions on each individual proposal.

### 1. Existence of PMNCH

<table>
<thead>
<tr>
<th>Decision should be taken at the next Board meeting</th>
<th>Critical</th>
<th>Not critical</th>
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<tbody>
<tr>
<td>1. Confirming the mandate of PMNCH</td>
<td>1. Fundraising / resource mobilisation</td>
<td>Section VI, Point 2</td>
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<tr>
<td>2. Identifying added value of PMNCH</td>
<td>Section VIII, Point 6</td>
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<tr>
<td>3. Role as ‘honest broker’ / facilitator</td>
<td>Section VI, Point 2</td>
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<td></td>
<td>Section VII, Point 8</td>
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<td>4. Global advocacy role</td>
<td>Section VI, Point 2</td>
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<tr>
<td>5. Develop corporate image and principles</td>
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<td>6. Standing and ad hoc working groups</td>
<td>Section VII, Point 16</td>
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<tr>
<td>7. Future of advocacy function</td>
<td>Section IV, Point 8</td>
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<tr>
<td>8. Future of country level support function</td>
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<td></td>
<td>Section VII, Point 15</td>
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<td>9. Future of monitoring &amp; evaluation function</td>
<td>Section IV, Point 10</td>
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<td>10. Future of effective interventions function</td>
<td>Section IV, Point 11</td>
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<td>11. Form and function of Secretariat</td>
<td>Section VII, Point 21</td>
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<td>Section VII, Point 22</td>
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<td>Section VII, Point 24</td>
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<td>12. Role and responsibilities of Director</td>
<td>Section VII, Point 25</td>
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<td>13. Impact of funding on goals of PMNCH</td>
<td>Section V, Point 5</td>
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<td>14. Future focus for funding</td>
<td>Section VI, Point 2</td>
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<td>15. Corporate cohesion at Board level</td>
<td>Section VII, Point 4</td>
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<tr>
<td>16. Achieving board alignment</td>
<td>Section VI, Point 5</td>
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2. Effectiveness of PMNCH

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<thead>
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<th>Critical</th>
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<td>Decision should be taken at the next Board meeting</td>
<td>Decision unlikely at next Board meeting</td>
</tr>
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<td>1. Modify structure of PMNCH</td>
<td>1. Expanding PMNCH scope to include RH Section IV, Point 12</td>
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<tr>
<td>Section VII, Point 2</td>
<td>1. Forum as lesson learning opportunity Section VII, Point 3</td>
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<tr>
<td>2. Radical review of working groups</td>
<td>1. Internal advocacy to increase alignment Section VI, Point 4</td>
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<tr>
<td>Section VII, Point 10</td>
<td>1. Obligations of membership Section VII, Point 18</td>
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<td>3. Role of advocacy working group</td>
<td>2. Role of Secretariat in Board cohesion Section VII, Point 4</td>
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<td>Section VII, Point 12</td>
<td>2. Communication with members (e-fora etc) Section VII, Point 19</td>
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<td>4. Board membership and attendance</td>
<td>3. Scheduling Board meetings Section VII, Point 7</td>
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<tr>
<td>Section VII, Point 6</td>
<td>3. Planning PMNCH forum Section VII, Point 3</td>
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<td>5. Role of Secretariat in country support</td>
<td>5. Review use of website and e-foras Section IV, Point 12</td>
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<tr>
<td>Section VII, point 15</td>
<td>5. Board accountability / monitoring schedule Section VII, Point 7</td>
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<td>6. Director: objectives and appraisal</td>
<td>6. Value added work plan Section VIII, Point 5</td>
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<td>Section VII, Point 23</td>
<td>7. Appointing staff to Secretariat Section VII, Point 26</td>
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<td>7. Appointing staff to Secretariat</td>
<td>7. Review of WHO hosted GHPs Section V, Point 5</td>
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<td>Section VII, Point 26</td>
<td>8. PMNCH transparency Section VII, Point 20</td>
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<td>8. PMNCH transparency</td>
<td>9. Stronger accountability framework Section VII, Point 23</td>
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<td>Section VII, Point 20</td>
<td>10. Managing PMNCH schedule Section VII, Point 1</td>
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<td>9. Stronger accountability framework</td>
<td>11. Financial reports to Board Section VIII, Point 8</td>
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<td>Section VII, Point 23</td>
<td>12. Hosting arrangements with WHO Section VIII, Point 12</td>
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<td>10. Managing PMNCH schedule</td>
<td>13. Stakeholder engagement Section VIII, Point 10</td>
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<tr>
<td>Section VII, Point 1</td>
<td>14. Strengthened partner communication Section VII, Point 8</td>
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<tr>
<td>11. Financial reports to Board</td>
<td>15. Review use of website and e-foras Section IV, Point 12</td>
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</tbody>
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| 4. Board agendas, papers and reports  
  Section VII, Point 7 | 4. Support provided to working groups  
  Section VII, Point 17 |
|------------------------|--------------------------|
| 5. Financial management  
  Section VII, Point 27 | 5. Role of ADG and Chair of Board  
  Section VII, Point 23 |
| 6. Finance Committee  
  Section VII, Point 7  
  Section VII, Point 27 | 6. Prioritisation / weighting of activities  
  Section VIII, Point 5 |
| 7. Conflict management  
  Section VII, Point 30 | 7. Secretariat support to the Board  
  Section VII, Point 19 |
| 8. Monitoring progress  
  Section VIII, Point 5 | 8. Secretariat accountability framework  
  Section VII, Point 23 |
| 9. Regulatory compliance  
  Section VIII, Point 7 | 9. Secretariat staff development plans  
  Section VII, Point 24 |
| 10. Administrative efficiency  
  Section VIII, Point 9 | 10. Grant management  
  Section VII, Point 28 |
| 11. Reporting schedules of funders  
  Section VIII, Point 8 | 11. Risk management  
  Section VII, Point 29 |
| 12. Links with other GHPs and alliances  
  Section V, Point 5 | 12. Workplan format: indicators and reporting  
  Section IV, Point 6 |
|                         | 13. Work plan led objectives for Secretariat  
  Section VIII, Point 5 |
|                         | 14. Secretariat learning  
  Section VIII, Point 11 |
|                         | 15. Secretariat involvement with WHO  
  Section VIII, Point 12 |
Annex I: Evaluation Team Members

**Liz Ollier: Team Leader - Governance and Management Lead**
Thirty eight years experience in health including fourteen in international health development. Specialist in governance, management and organisational development. Team leader for many evaluations including maternal, newborn and child health programmes and reproductive health programmes in China, Malawi, Kenya, Chile, Mozambique, Zimbabwe, Zambia, Botswana. Responsible for delivery of programmes with maternal, newborn and child health elements in Nigeria, South Africa and Kenya.

**Oona Campbell: MNCH Technical Lead - Pakistan and Cambodia visits**
Reproductive epidemiologist with degrees in demography, epidemiology and biology. Professor in Epidemiology and Reproductive Health at the London School of Hygiene and Tropical Medicine and is currently leading the Maternal health programme. Has led four large research programmes. Her specific areas of expertise include measurement of maternal morbidity and mortality, perinatal mortality, and evaluation of different modes of delivering maternal health and family planning services. She also provides training in research methods, epidemiology and current issues in maternal and perinatal health and family planning. Has worked in the Middle East (Lebanon, Egypt, Jordan, Turkey), in West Africa (Benin, Nigeria, and Ghana), and in the Philippines, Indonesia and Brazil. She has collaborated with a number of Ministries of Health and agencies (including Department for International Development, WHO, World Bank, UNICEF, USAID).

**Karen Newman: Advocacy and Communication Lead - Pakistan and Cambodia visits**
Worked in the field of maternal health for more than 20 years, serving in a number of professional capacities at regional and international levels for the International Planned Parenthood Federation, including as one of the three drafters of the document that became the IPPF Charter on Sexual and Reproductive Rights. Currently co-Chair of the World Health Organization (WHO) Gender and Rights Advisory Panel, within the United Kingdom she is a former Chair of Education for Choice – a small charity that supports young people’s right to informed choice - and has published widely on the connection between sexual and reproductive health and rights and human rights. Presently an evaluation consultant/trainer on these issues, her clients include DFID, Interact Worldwide, WHO, the United Nations Population Fund, IPPF Arab World and Western Hemisphere Regions, the Population Council, Women and Children First, Marie Stopes International Australia, the China National Population and Family Planning Commission, and Health Unlimited.

**Catharine Taylor: MNCH Specialist - Ethiopia visit**
A reproductive health, maternal, newborn and child health specialist with international experience in programme management, analysis, design and evaluation. Catharine has 15 years international experience working as an adviser on long term SRH projects and programmes, with long term assignments in South Africa, Seychelles, Nepal, Vietnam, Thailand and Turkey and short term assignments in Kenya, Malawi, Ghana, South Africa, Azerbaijan, Armenia, Nigeria, Pakistan, Laos, Cambodia and Philippines, Tanzania; experience working with bilateral/multilateral donors, including DFID, USAID and EU, ADB; experience working for public, for profit and non-government organizations; and experience in collaborating with multilateral organisations such as UNFPA, UNICEF and the Global Fund to fight AIDS, Tuberculosis and Malaria.

**Eva Tezcan: MNCH Specialist - Burkina Faso visit**
Degrees in obstetrics and gynaecology and business administration and expertise in reproductive health (specifically youth specific IEC/BCC for sexual and reproductive health; maternal health and family planning); project management including planning and evaluation, policy development, organisational development, and human systems. Eva has 18 years of international professional experience as a service provider, manager and consultant in health and education with experience in the USA and Europe, Sub-Saharan Africa (Chad, Namibia. Burkina Faso, Madagascar, Tanzania), Morocco, Yemen and Turkey. Eva has worked in collaboration with and coordination of Public Institutions, NGOs, Private Sector as well as bilateral and international agencies (German Development Agencies, USAID, Dutch Embassy, World Bank, UNICEF, UNFPA, WHO).
Emma Denton: Health Economist - VFM aspects and team coordination
A health economist with particular expertise in evaluating global health partnerships and initiatives. She worked on the five year evaluation design of the GAVI Alliance and GAVI Fund; was team leader for the GAVI Financial Sustainability Planning Process Evaluation; participated in an evaluation of the Global Stop TB Partnership; and has also worked on an evaluation of The International Union against Tuberculosis and Lung Disease, where she led on analysis of the financial aspects of the Union. She has experience of budget analyses and expenditure reviews, evaluating alternative financing options and cost recovery techniques, leading national health accounts exercises (including design, management, analysis of large scale household and specialist surveys), of SWAPs and PRSPs. Emma has undertaken consultancy projects in Sub-Saharan Africa, South East Asia, South America, the Balkans and in India.

Yasmin Hadi: Research Assistant - Review of other global health partnerships
A health specialist with medical training and a Masters degree in Public Health. She has experience of working with a variety of organisations including national and international NGOs such as Plan and the Population Council, a WHO Country Office, Johns Hopkins Hospital and Marie Stopes. She has also worked as a consultant for DFID, UNAIDS, WHO, the Bill and Melinda Gates Foundation, and the Health and Fragile States network. She has experience in reproductive health, maternal and neonatal health, knowledge management, research and literature reviews, M&E and strategy. Her international experience includes work in Pakistan, Australia, Armenia, the US and the UK.
Annex II: Evaluation Committee

PMNCH Evaluation Committee

Committee Chair:
Dan Kraushaar  Bill and Melinda Gates Foundation

Representing the Board Chair/Co-Chairs:
Ann Starrs  Family Care International

Other members:
Sadia Chowdhury  World Bank
Helga Fogstad  Norad
Jane Schaller  International Pediatrics Association
Anne Tinker  Save the Children
Pascal Villeneuve  UNICEF

WHO Support:
Daisy Mafubelu  Family and Community Health, WHO
Liz Mason  Department of Child and Adolescent Health and Development, WHO
## Annex III: Interview List

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<thead>
<tr>
<th>Contact Name</th>
<th>Name of Organisation</th>
<th>Constituency represented</th>
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<td><strong>Individual Interviews</strong></td>
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<tr>
<td>Abouzahr, Carla</td>
<td>Health Metrics Network</td>
<td>Other Partnership</td>
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<td>Aitken, Dennis</td>
<td>WHO</td>
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<td>Al-Islam, Monir</td>
<td>WHO (Effective Interventions WG)</td>
<td>WHO, Working Group Lead</td>
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<td>Araru, Trish</td>
<td>Ministry of Health, Malawi</td>
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<td>Bartlett, Al</td>
<td>USAID</td>
<td>Board Member Resigned, Donor, Working Group Lead</td>
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<td>Bhutta, Zulfiqar</td>
<td>IPA / Aga Khan University</td>
<td>Academic, Board Member, Working Group Lead</td>
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<td>John D and Catherine T MacArthur Foundation</td>
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<td>Bryce, Jennifer</td>
<td>John Hopkins University</td>
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<td>Calderon, Ruth</td>
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<td>Costello, Anthony</td>
<td>Institute of Child Health</td>
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<td>Fogstad, Helga</td>
<td>NORAD</td>
<td>Donor, Board Member?</td>
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<td>Gautam, Kul</td>
<td>Ex-UNICEF</td>
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<td>Graham, Wendy</td>
<td>IMMPACT, University of Aberdeen</td>
<td>Board Member, Academic, Working Group Lead</td>
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<td>Horton, Richard</td>
<td>The Lancet</td>
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<td>Paul, Vinod</td>
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<td>Board Deputy Chair, NGO</td>
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<td>Ten Hoope-Bender, Petra</td>
<td>formerly Partnership for Maternal and Newborn Health and Interim PMNCH</td>
<td>Observer of PMNCH, knows Global scene</td>
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<tr>
<td>Terreri, Nancy</td>
<td>UNICEF</td>
<td>Working Group Lead, UNICEF</td>
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<td>Tyson, Stewart</td>
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<td>Van Look, Paul</td>
<td>WHO Director of Reproductive Health and Research (RHR)</td>
<td>WHO, Observer of PMNCH, knows Global scene</td>
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<td>Villeneuve, Pascal</td>
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<td>Wainwright, Colleen</td>
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**Ethiopia Country Visit**

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<td>Abonesh, Haile</td>
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<td>Belay, Tesfanesh</td>
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<td>Gemechu, Ayele</td>
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<td>Pose, Barbara</td>
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**Burkina Faso Country Visit**

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<tr>
<td>Dr Bassané</td>
<td>Family Care international, Country Office</td>
<td>NGO</td>
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<tr>
<td>Conombo, Ghislaine</td>
<td>WHO BUF</td>
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<td>Diallo, Djenneba</td>
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<td>Mayouya, André</td>
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<td>Ouedrago, Laurent</td>
<td>MOH, Directorate of Family Health</td>
<td>Ministry of Health</td>
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<td>Peries, Hervé</td>
<td>UNICEF</td>
<td>In country UN Agency</td>
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<td>Romaric, Somé T.</td>
<td>MoH; Direction des Etudes et de la Planification</td>
<td>Ministry of Health</td>
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<td>Sankara, Tougma Téné</td>
<td>Enfants du Monde</td>
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<tr>
<td>Sibroago, Kientoré</td>
<td>SOG0B Association d'obstétriciens et de gynécologues</td>
<td>Healthcare Professional</td>
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<td>T Subayi</td>
<td>World Bank BUF</td>
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<td>Thombiano, Brigitte</td>
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<td>Zoungrana, Guy</td>
<td>GTZ/ Sexual Health and Rights Programme</td>
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**Cambodia Country Visit**

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<td>Chan, Theary</td>
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<td>Danielsson, Niklas</td>
<td>WHO Child and Adolescent Health</td>
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<td>Hong, Rathmony</td>
<td>MOH, Communicable Disease Department</td>
<td>Ministry of Health</td>
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<td>Jack, Susan</td>
<td>WHO Child Survival</td>
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<td>Koum, Prof. Kanal</td>
<td>National Maternal and Child Health Centre</td>
<td>Ministry of Health</td>
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<td>Moore, Judith</td>
<td>ACCESS Program, JHPIEGO</td>
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**Pakistan Country Visit**

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<td>Azfar, Shahida</td>
<td>CSP/Population Council</td>
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<td>Bhutta, Zulfiquar</td>
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<td>Hafiz, Rehan</td>
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<td>Sathar, Zeba</td>
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<tr>
<td>Shadoul, Ahmed</td>
<td>WHO MNCH</td>
<td>In country UN Agency</td>
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Annex IV: Semi-Structured Interview Proforma

Instructions to Interviewer
The interviewees cover a number of constituencies and some are being interviewed in more than one capacity. This document is a composite of questions and no single interviewee should be asked all questions. The questionnaire is broken up as follows:

- Board members questionnaire (section 1) acts as a base template
- Board members will be asked all questions
- Questions in **bold** will be used for all interviewees
- Constituency and working group members will in, addition, be asked the questions in section 2 where they have a “special” constituency (e.g. advocacy)
- Country level interviews will incorporate all the questions in section 3. Those in *italics* in this section will be asked of Board members and constituency members
- Section 4 is a section for donors
- Interviewers may need to use their judgment as to whether to continue with a particular section depending on the initial response received.

Prime and subsidiary questions
- If answers have covered subsidiary questions in any section, they should not be repeated

Preamble (to be clarified with each stakeholder interviewed):
- The evaluation report will, on completion, be a public document.
- There will be no personal attribution in the final document
- Individual responses will be shared within the evaluation team but will not be disclosed to any other parties
- Responses will be attributed by stakeholder constituency
- If a recording device is used this must be cleared with the interviewee in advance and the tape erased after transcription

Documentation - each interview record should include:
- Name of interviewer
- Name of interviewee
- Name of organisation
- Date and time of interview
- Capacity in which interviewee is being interviewed (may be more than one, in which case all relevant questions must be covered)

Once documentation has been completed please circulate the file to the team

Section 1: Board Members Questionnaire

Overview

Function
- Are the key functions as laid down at the establishment of PMNCH still valid? Has anything changed and if so why? Has this been positive?
- Do the same needs still exist in respect to: Advocacy; Country support; Identifying effective interventions; Monitoring and evaluation
- What do you think the most important 3 functions of PMNCH are?

Effectiveness
- What is the value-added of PMNCH? (globally, regionally and at country level) Is it the same as it was originally?
- Has PMNCH achieved its objectives as outlined in the Conceptual and Institutional Framework and the approved work plans?
• Were the original objectives of PMNCH realistic?
• Is there consensus on the objectives? Their priority? On strategies for action?
• Has the merger of the three partnerships resulted in greater achievements than were achieved separately?
• Has PMNCH successfully harnessed and harmonized the individual efforts of the partners to improve the survival outcomes of women, newborns and children (or to accelerate progress towards meeting MDGs 4 and 5) through better networking, advocacy, knowledge creation, technical assistance or investments? Can you give examples?
• How would you rate the Board's effectiveness?
• How would you rate the effectiveness of the WGs?
• How would you rate the effectiveness of the Secretariat?
• How effective is the contribution of the individual constituencies?
• Do you consider the partnership has done everything possible to maximise and diversify it's funding base?
• Do you think the establishment of PMNCH leveraged additional resources for MNCH at country and global level? Please give examples.
• Are funded work plans being achieved? If not, why not?
• What barriers have been encountered by PMNCH and how have they been surmounted?
• What positive results have been achieved from the merger of the three partnerships?
• Have there been any negative or unanticipated outcomes as a result of the merger of the three partnerships? If so, what?

Relevance
• Are there any major gaps in issues that the PMNCH should be addressing?
• Are PMNCH’s activities carried out at the most appropriate level — global, regional, national, or local — in terms of efficiency and responsiveness to the needs of beneficiaries?
• How does the work of PMNCH and its Secretariat complement, add to and enhance the work of individual partners?
• Does it compete or substitute activities that could better be done by individual donors, beneficiary countries/ other GPs?
• Subsidiary principle….Are there any activities that PMNCH is undertaking that could be more effectively done at country/ regional level? (demonstrate/ examples)
• Is the balance of activities appropriate in light of resources and agreed objectives?
• Is geographical coverage appropriate?

Alignment
• Has PMNCH complied with best practice principles for global health partnership activities at country level\textsuperscript{25}, including the broader principles of the Paris Declaration on harmonization and alignment?

Ownership
• Are the partners contributing to the success and effectiveness of PMNCH as outlined in the Conceptual and Institutional Framework and in the approved work plans?
• Is there a sense of ownership on the part of various constituencies, both those represented on the Board and those that are not?
• What indicators are there of beneficiary country ownership?
• Is the process for getting on the Board fair and transparent?
• What are the benefits of being a member of PMNCH?
• Do you plan continue your involvement with PMNCH in the future. Why? Why not?

Direction
- Is there a shared vision for PMNCH? (what is it there for, what does it aim to achieve)
- Who drives PMNCH? Why?

Legitimacy
- Do all key stakeholders have a communication channel? Is this known and utilised?
- How effective are the mechanisms for ensuring communication with partners?
- What about those not on the Board?

Linkages
- What is the relationship of PMNCH to other global initiatives?

Governance Issues

Accountability
- Is the role of the Board clear? What does it reserve to its self? What is devolved to the Secretariat?
- Are roles of Working Groups clear?
  - What are the pros and cons of the financial and governance sub-committees?
  - Are roles and responsibilities of individuals clear (accountable to PMNCH or constituency?)
  - Is accountability of Secretariat clear? What are they a/c to host (WHO) for?
  - Are there any resultant conflicts?
- Who is responsible for resource mobilisation?

Responsibility
- How does PMNCH safeguard interests of stakeholders not represented?
- Is there a policy of risk management? How would PMNCH deal with loss of major funding source?

Fairness
- Do you have equal opportunity to influence?
- Does any constituency have undue influence?
  - What mechanisms are there for conflict management at Board and WG level? Are they effective?

Transparency
- Is there adequate transparency?
  - What is made available to whom? Where can this information be found?
  - Is PMNCH subject to audit? (how often/ Who by/ who sees the reports etc)

Efficiency
- Does the size of the membership affect the efficiency of PMNCH? (inclusiveness v speed of response)
  - How does the infrastructure cost compare with other GPs?
  - How do costs compare with similar activities undertaken by other GPs
  - Does undertaking this activity through PMNCH outweigh doing it through individual donors / beneficiary countries?
  - Are there any obvious waste / inefficiency issues?
  - What are opportunity costs to your organisation? Are they justified by the benefits?

Probity
- Do you have any doubts about standards of ethics and professional conduct?
- Are you aware of any conflicts of interests? How are they handled?
Management Issues

Overarching
- To what extent have management responsibilities\(^{26}\) been effectively discharged by the Secretariat?

Planning
- Are the systems for work planning adequate, timely and transparent?
- Do they give equal opportunities for partners to benefit?
- Is budgeting realistic and rigorous? Have budgets been aligned with work plans?
- Does planning result in appropriate work plans?
- Have the work plans been delivered. If not, why not?

Implementation
- Who has responsibility for implementation of the work plan?
- Are the roles of the Director, Deputy Director, Secretariat, and partners clearly articulated and differentiated?
- Do they control the resources to do so?
- How are they held accountable?
- Are lines of accountability clear?

Staffing and Structures
- Is Secretariat structure effective and efficient?
- Do staff have appropriate competences?
- Are the numbers and qualifications of staff aligned to the work needing to be done as outlined in the work plans?

Performance management
- Are there adequate systems for individual performance management (objective setting and appraisal)?
- What problems result from the lack of synchronisation in planning, funding, reporting (to all relevant parties i.e individual funders. WHO/Board) and individual performance management (appraisal)?
- Is there a system for recording and reporting performance against work plan goals and objectives?
- Are lines of accountability clear? Are people/organizations being held accountability for results/commitments made?
- Is the Board in charge, does it monitor performance and does it hold partners, Director, DD and Secretariat members accountable for results?

Performance of the Host Organisation
- Does the current MOU safeguard the interests of PMNCH?
- Is there a clear demarcation of responsibilities between WHO and PMNCH?
- Is there clarity on reporting structures?
- Is there timely and effective recruitment and other functions?
- Are there alternative models for hosting that would facilitate the working of PMNCH better?

Financial Management
- Do you feel the financial management and reporting is adequate and timely?
- Has earmarking of funding been advantageous to ensure focus or disadvantageous?

\(^{26}\) Work planning and implementation, resource mobilisation, regulatory compliance, reviewing and reporting, administrative efficiency, stakeholder communication, learning, performance assessment
Focal Areas

M and E

- Is there a continuing need for the M and E infrastructure (Senior Advisor/working group etc) in the light of Countdown?
- Are M&E systems adequate? How is M&E work monitored? By whom? Are stakeholders involved?
- How was the M&E programme designed? Conceptual framework developed with goals and indicators identified in advance Proactive vs Reactive
- What M&E activities at the various levels (national, regional and international) do you feel have gone well and what do various stakeholders contribute to its success? What would you do differently?
- Is there some M&E work you would like to see PMNCH do more of? If so, what are the constraints?
- Are there systems for monitoring against work plan?
- M and E of Director and staff against work plan
- M and E of partners against work plan?
- If not, what is required
- Are progress indicators agreed and being monitored?
- Is there anything you would have liked me to ask you about the M&E work?

Country Level Activities (see section 3)

Effective interventions

- What gaps do you perceive in effective interventions evidence and in what areas could PMNCH bring added value? What are the constraints?
- How is the Effective interventions programme designed? Proactive vs Reactive
- Are there other bodies who are undertaking this function? How can linkages be achieved?
- How is the Effective interventions work monitored? By whom? Are stakeholders involved?
- What Effective interventions work at the various levels (national, regional and international) do you feel have gone well and what do various stakeholders contribute to its success?
- What would you do differently next time?
- Is there anything you would have liked me to ask you about the PMNCH effective interventions work?

Advocacy

- Who or what mechanism directs advocacy work at national, regional and international levels
- What is the role of the WG – supervisory, management, or what? Does the current operation of the WGs conform to their original remit and what are their current roles
- Who decides at regional and national level what the advocacy priorities are?
- Advocacy messages – what power do local stakeholders have to adapt messages?
- Who are the key advocacy targets at the various levels (national, regional and international)? And who decides who they are?
- Who decides at what level (national, regional and international) the PMNCH should focus its efforts?
- Is the advocacy implemented by PMNCH easily differentiated from the advocacy of the Partners? Is it complementary? Are the right skills in place?
Section 2: Constituency and Working Group members

Advocacy

- How is the most effective way of reaching the key advocacy targets determined, and how are the assumptions about this tested?
- How are the advocacy programmes designed? Is there a conceptual framework developed with goals and indicators identified in advance? Are opportunities identified and then activities adapted in line with these opportunities? Proactive vs Reactive
- How is advocacy work monitored? By whom? Are stakeholders involved? How is impact monitored?
- Where does responsibility lie for systematic data collection, data analysis and stakeholder involvement lie? Has any advocacy programme been amended as a result of this monitoring and analysis? Have lessons from previous alliances been brought into work of the PMNCH? How?
- Is there clarity within the PMNCH on the relative role of advocacy and it’s mission as a whole? What was it set up to be? What is it now? And what do you think it should be?
- What advocacy activities at the various levels (national, regional and international) do you feel have gone well and what do various stakeholders contribute to its success?
- Which advocacy activities do they feel could have gone better?
- What would you do differently next time?
- Is there some advocacy work you would like to see PMNCH do more of? If so, what are the constraints?
- Is there anything you would have liked me to ask you about the PMNCH advocacy work?

Section 3: Country Level Interviews

Country Level activities (for Board members and non country level partners ask the questions as they relate to all countries. For country level interviews make them specific to the specific country)

- What do you think have been the “added value” benefits of PMNCH (to your country?)
- Do you feel that PMNCH has encouraged countries to engage with them?
- Has PMNCH affected political commitment to the MNCH (in your country?)
- Has PMNCH had an impact on the funding (in your country?) How? or is there a risk that governments and donors will move money to other things?
- Do you think it would make any difference to your country if there were no PMNCH?
- Has the creation of a single partnership resulted in increased effectiveness (in your country? How?
- What do you believe PMNCHs strongest potential to achieve at country level is likely to be?
- Have there been any advantages through regional level activities (Asia, Health Care Professional Activities),
- Do benefits of PMNCH outweigh costs for the country (transaction costs/ drawing up proposals etc
- Is there alignment with (countries) priorities as expressed in national strategy documents/ PRSPs? And donors participatory frameworks (such as WB Country Assistance Strategy)?
- Has it resulted in greater donor harmonisation? (including process harmonisation)
- Has there been a greater recognition of the continuum of care (in your country) as a result of the work of PMNCH?
- What are the benefits of being a member of PMNCH?
- What do you feel are the major achievements of Deliver Now?
- Where does responsibility lie for systematic data collection, data analysis and stakeholder involvement lie? Has any advocacy programme been amended as a result of this monitoring and analysis? Have lessons from previous alliances been brought into work of the PMNCH? How?
- Is there clarity within the PMNCH on the role of country work within its mission as a whole? What was it set up to be? What is it now? And what do you think it should be?
- What national activities do you feel have gone well and what do various stakeholders contribute to its success? What would you do differently?
- Is there some Country work you would like to see PMNCH do more of? If so, what are the constraints?
- Is there anything you would have liked me to ask you about the PMNCH country work?

Section 4: Donor Questions

- Has an investment in PMNCH been perceived to be of good value to the donor agency?
- Did it result in what the donor wanted to be achieved?
- Was there an alignment between the interests of the donor and the Board/PMNCH partners?
- Were donor funds tied in a way that a) enhanced the functioning of the PMNCH, b) distracted attention from PMNCH goals and objectives or c) competed with PMNCH?
- Will the donor provide more funding in the future?
- Was the recipient receptive, responsive to the donor?
- What were the main issues, strengths and weaknesses of being a donor to PMNCH?
- Did the hosting of PMNCH by WHO in any way negatively or positively affect the amount, type or distribution of funding to PMNCH?
Annex V: Key Points and Recommendations from Cambodia

General MNCH issues in Cambodia

- MNCH is the top health priority in Cambodia, but, despite Paris Principles, etc donor funding is still overwhelmingly going into HIV/AIDS and Malaria. Alignment is dysfunctional. Even within the pooled funding that is likely to be available for the new health sector strategic plan, it is anticipated that funding will be earmarked for specific activities by the World Bank, UNFPA, the Global Fund, and there is still a big burden related to reporting. PMNCH may have a role at global level in advocating alignment in countries where the donor spend does not reflect national prioritization of MNCH.

- AIDS and Malaria have skewed government health systems, in that chronically low salaries leave health workers dependent on per diems that can be secured from externally funded training and other events. Areas that can offer higher per diem payments siphon off skilled workers into those areas, which do not reflect national health areas of greatest need, or priorities as seen by the government. Also, although programmes are vertical at the management level, they tend to be carried out in the field by the same people. Per diems levels dictate what gets prioritized/implemented. Those with money drive the agenda.

- In countries such as Cambodia, where the successful programmes are vertical, and co-ordination of separate activities, rather than integrated service delivery is the more realistic option, the importance of that co-ordination is critical. Successful advocacy can facilitate other programmes channeling funds to MNCH, because they can see the linkages - eg the continuum of care concept, or health systems funding of MNCH programmes.

- A recent UNICEF review indicated that they had had no “value added” impact, in that the government had pulled out of areas where they were working. The honesty of this review has been valuable.

- Government level MNCH activities were fragmented and led by many players / government departments. The national plan was in one document but was not really integrated. There was no one government person with over all responsibility for delivering in this area.

PMNCH specific issues in Cambodia

- The Cambodia DHS, which showed increased Child mortality, and in-country, action was credited to that, and not to the Child Survival Partnership, beyond the catalytic role of the high-level meeting in generating political will. Expectations were raised, but the funding never came.

- There is a lack of clarity about how to access PMNCH, and also about what they have to offer. Other perceptions included that they were very Africa-focused. No one knew about the regional Thailand Office.

- Continuum of care is a helpful concept, because it facilitates collaborative work where the services are in separate silos.

- A Civil Society representative valued the invitation their organization had received from PMNCH to the Countdown conference, and had had the Countdown final commitment/statement has been translated into Khmer. Follow-up from Countdown with Parliamentarians who attended could be useful, involving them was seen as being valuable.

- NGOs interviewed felt that membership of PMNCH as a country member was not meaningful.
Cambodia information on the PMNCH website is out-of-date. Concern was expressed that the Child Survival Partnership website\(^{27}\) has no link to the PMNCH website.

There was no awareness of Deliver Now materials on the part of anyone we interviewed, with the exception of one person, who had seen them as part of a web search in preparation for our meeting.

UN agency offices have very little information about/from PMNCH and had concerns about communication and organization around Countdown invitations.

**Key Requests and Recommendations** (apart from those arising from the above points)

- UN agencies could work more effectively in partnership and with governments, advocating best practices, etc.

- More learning from other countries would be useful; PMNCH could facilitate this.

- There may be a role for PMNCH in facilitating civil society and Ministry of Health linkages for fundraising.

- PMNCH could usefully promote the status of midwives, and midwifery skills.

- PMNCH may have a role in facilitating exchange of experience at Regional level. No-one knew of the existence of the Regional office in Bangkok. It was suggested that it could have been more usefully located in a country with higher levels of MNCH morbidity and mortality.

- It was suggested that PMNCH may have a role in global advocacy to get donors to stop earmarking funding for HIV/AIDS.

- It could also promote pre- and in-service training for provincial hospital and regional training centres.

\(^{27}\) [http://www.childsurvivalpartnership.org](http://www.childsurvivalpartnership.org)
Annex VI: Key Points and Recommendations from Ethiopia

Key Points raised by interviewees

- Ethiopia has been committed to the concept of the PMNCH from the beginning; Ethiopia attended the launch and has hosted meetings, including a Board meeting.

- Ethiopia is the co-chair for PMNCH and the Minister of Health is personally involved. However, Ethiopia is experiencing difficulty with a high turnover of focal persons within the MOH and so it is difficult to continue effective communication.

- Over recent years partner coordination within Ethiopia has been improving. The Government is committed to the Paris declaration principles. The UN agencies, including WHO, UNFPA and UNICEF are working together more, especially under the Making Pregnancy Safer Initiative, established in 2002.

- There has already been a lot of advocacy done in Ethiopia. The country has good policies and strategies for example for poverty reduction, Reproductive Health and a new adolescent and youth sexual and reproductive health strategy. However advocacy to ensure the MNCH is prioritised at a regional level and below remains an issue.

- There is no need for the PNMCH to focus on ‘best practices’ in Ethiopia, as Ethiopia has a best practice mechanism in place. This is being implemented with the UN and other organisations such as JHPIEGO and Engender health. While the policies and strategies are based on best practice, implementation is weak due to limited capacity.

- A number of interviewees commented that it is important for PMNCH to listen to countries and adapt its approach to country needs. Ethiopia was hoping for a $1,000,000 from PMNCH (from the grant received from the Bill and Melinda Gates Foundation). There has been a lot of discussion over the proposal. PMNCH wanted to bring in external people in to provide facilitation. Ethiopia’s priority is capacity building, and there is a need for instance $600,000 for the new MSc programme for RH. It is felt that PMNCH has its own mandate and agenda, and that it needs to be more aligned, with no parallel systems.

- The DHS is one of the only forms of reliable country wide information. The MoH is attempting to improve the Health Management Information System but there is a need for more support to improve monitoring and evaluation.

- Most interviewees had not heard of ‘Deliver Now’.

- On the whole the interviewees are positive that the PMNCH has a role in Ethiopia, but as yet it is unclear what that role will be and what added value the PMNCH could have.

Recommendations

- PMNCH should take on more of a coordination role. There is a plan for the PMNCH to be the umbrella for all the working groups and task forces around MNCH/RH, Although, these structures already exist and many of them work very well, there is little interaction between the different groups. Hopefully the PMNCH as an umbrella will help these groups to interact more.

- There is a need for region level advocacy and support for improved implementation. A plan of action is needed to support implementation, as community education is working but now services are lagging behind. The Making Pregnancy Safer Initiative is still only in 5 regions, it needs to be expanded to all the country.
• PMNCH should be more like GAVI, which has supported health systems strengthening not just immunisation in order to have an impact on the core goals (achieving MDG 4 and 5).

• PMNCH needs to focus on a number of priorities, mothers and newborns in particular. There is also a need to integrate initiatives and to look at issues around RH/HIV and Safe Motherhood.

• There is a need to bring more partners together, eg ILO, Transport unions etc. It is felt that PMNCH could assist in bringing together these partners and others.

• There is a new law governing NGO activity. PMNCH could support NGO involvement to ensure they are able to contribute fully to the Governments priorities and community needs.

• In general interviewees felt that there is a need for PMNCH to leverage resources and to bring money into the country.
Annex VII: Key Points and Recommendations from Burkina Faso

Key Points

- A road map to accelerate progress towards the MDGs related to MNCH, had been finalised by the MoH and its partners in October 2006. It was planned that interventions relating to MNCH would be carried out under the district support programme (PADS) which is financed through a common basket and is within the framework of the National Health Development Plan (PNDS).

- A PMNCH mission to initiate the process of development of the National Plan of Action for strengthening rapid scale-up of maternal, newborn and child interventions took place from 25 February - 04 March 2007. In order to plan for and coordinate the appropriate interventions, a workshop jointly organised by the MoH and partners was held during the visit. During this workshop it was decided to establish a coordination committee for MNCH and to start implementation of a plan from June 2007.

- A project to strengthen rapid scale-up of MNCH Interventions has been developed to be funded by the Bill and Melinda Gates Foundation. Key informants stated that the project had been initially conceptualised as being part of the common basket, and that this was later changed to administration by UNICEF via a special unit at the family health directorate (DSF). Key informants state that this change was made without acceptance from the national side. During an informal meeting between the Bill and Melinda Gates Foundation and the Burkina Faso delegation at the Lusaka IGP+ meeting the funding issue was discussed. On 21 March technical and financial partners of the MoH were informed about this informal meeting. The report of this meeting underlines a joint position of participants that integration of the grant into the common health basket would be the preferred way of proceeding.

- A subsequent meeting between the MoH, PMNCH, UN agencies and the Dutch (partner representative, PADS) took place. The Burkina mission to IHP+ recommended that the MoH establish a compact on the basis of the PNDS/PADS already in place to constitute a solid foundation for sector reform, with the Bill and Melinda Gates Foundation funds administered through the common basket. In order to communicate this wish, it was recommended an official letter be addressed to UNICEF and the PMNCH Director. In May 2008 a complete projected proposal was submitted to PMNCH insisting on the common basket as the fiduciary framework.

- No strong negative comments were expressed by interviewees in Burkina Faso, however they had seen few activities implemented by PMNCH, and even some representatives of UN Agencies only had a vague idea about PMNCHs set up and functioning. Generally interviewees felt that it was too early to evaluate, or, more positively, “if we had started those activities a year earlier, we would certainly be able to demonstrate very positive experiences”.

- To date the most visible activities are: the process of developing a request for funding from PMNCH over one and a half years; regional workshop on the development of professional associations, with a convention now being signed between the MoH and Associations.

- No-one felt that the absence of PMNCH would stop activities; instead aspects such as adding momentum and motivation would be at stake. Apart from the funds realised from PMNCH (from the Bill and Melinda Gates Foundation monies), the advantages of working with PMNCH were perceived to be more on a non-material level; motivation, courage, reassurance. The question about benefits outweighing costs was difficult.

- No interviewee considered that there is any danger that money will be moved to other areas, but two interviewees pointed out that there is a reverse competition for resources: in view of the scarcity of qualified service providers, projects compete for human resources to implement activities; in practical terms this means that the better funded (or otherwise more rewarding) elements of health care absorb more of the service providers work-time than others.

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28 Plan National du Développement Sanitaire ; Programme d’Appui au Développement Sanitaire
The creation of a single partnership was universally welcomed. Merging PMNCH with other alliances to further promote the continuum of care was considered as an option. However no-one was able to give an example of how to action this suggestion. Several interviewees stated that the integration of mother and child health services has been on the agenda for a long time and is a reality on a practical level because the same staff are involved and the structural setup is established. Combining partnerships may simplify the application for funds because the separation of mother and child in proposals, to meet donor requirements, is often artificial. One respondent reported: “While it makes sense to separate the different issues at higher advocacy (donor) level in order to increase commitment (“because some donors like nutrition...”), funds should be allocated to pay for a complete service package through a single mechanism.”

The regional approach to the work with professional associations was highly appreciated as a means to tap resources (experience and knowledge), and for benchmarking own performance.

A core issue of critique focussed on an apparent discrepancy between PMNCH’s procedures and behaviour in relation to the process for disbursing funds made available by the Bill and Melinda Gates Foundation, and ideas of alignment with national strategies and procedures. This was a major concern of all who were involved in the process. “It is bizarre that on one side they encourage “compacts” and on the other side they want such project oriented approaches”.

However it seems that the process has led to greater ‘Donor Harmonisation’ because ALL interview partners subscribed to the principle of using funds for MNCH through the common basket; however there is insufficient evidence to confirm previous attitudes towards this.

The continuum of care is a longstanding concept, however disillusionment has set in due to: ups and downs in the use of community based services and activities resulting in ambiguity towards community health workers; unavailability of complete packages of care almost ubiquitous due to lack of personnel and commodities; and continuously low utilisation rates.

Deliver Now is almost unknown with the exception of the local branch of FCI.

Data collection is a difficult topic. Everyone realizes it needs to be done, but no-one feels the benefit. Repeatedly it was emphasized that M&E is a national responsibility, but even those really involved in Planning and M&E are unaware of international initiatives (e.g. Countdown 2015); even WHO suggested that PMNCH should help in finding FEASIBLE indicators.

Interviews did not provide any evidence on advocacy being reshaped due to monitoring results. Learning from experience with other partnerships is anecdotal (GAVI, common basket HIV/AIDS), but not related to any systematic support to do so through PMNCH.

Recommendations

All interviewees felt encouraged to engage further with PMNCH; but also suggested that it should do much more do make itself known, to establish regular communication and to provide concrete support - both financial and technical. All interviewees emphasized, more or less strongly, that the country had their own plans and priorities in place and would like reassurance that these would be honoured. “We don’t want our processes to be swallowed by crocodiles”

Most interviewees felt that political commitment within the MoH is already strong, but several interviewees emphasized that other Ministries (Finance, Human Rights, etc) and Government needs to be encouraged to make the necessary shift in resource (and prestige) allocation.

Dissemination of effective interventions and advocacy could play important roles in the establishment of trust and the improvement of availability of resources.

The role of country work is apparently unclear to all interviewees. Direct technical support is requested; as well, a permanent and reliable communication channel is urgently requested. One interviewee raised the language problem (domination of English). NGOs and Professional associations emphasize a need for more active involvement and do not want to remain in a position where “people call upon us when they need us”.
Annex VIII: Key Points and Recommendations from Pakistan

Key Points

- MNCH was coming together around the same time as the PMNCH. Ideas and structures influenced each other.

- MNCH is an important health priority in Pakistan, with many of the right pieces in place for action and success, including strong partners. There is now one national MNCH plan, with a PC1, which is essential for action. It is not totally integrated (the newborn is once again seen as part of maternal and child health separately), but it is moving in the right direction.

- There is sufficient donor and government money available for MNCH. The big challenge is implementation. Politicians are needed to take actions to overcome bottlenecks. Some degree of verticality of programmes was felt necessary to drive change and because government level MNCH activities are fragmented and led by many players / government departments.

- Provincial level engagement is essential however devolved implementation requires time and capacity development.

- A National MNCH coordinator (a former Head of EPI) has been appointed and has overall responsibility. He has experience getting GAVI funds for health systems strengthening.

- The large maternal mortality DHS survey is ready to be released (scheduled for July 12 but postponed because of the Lawyers Long March.

- There is a lack of clarity about how to access PMNCH, and also about what they have to offer.

- UN agency offices have very little information about / from the Partnership. They worked well together but more because of being a pilot One UN country than because of any directive to work in / with PMNCH.

- PMNCH may have a role at supporting advocacy for implementation and putting pressure on politicians to overcome implementation bottlenecks.

- Continuum of care is a helpful concept, because it facilitates collaborative work where the services are in separate silos.

- There was no awareness of Deliver Now materials.

- Parliamentarians had not been engaged with this Countdown although they had been in the first one in London. Countdown data were felt to be accurate and materials used in county, including by UNICEF.

Recommendations (apart from those arising from the above points)

- PMNCH has an opportunity to link to the newly appointed NMNCH coordinator. Given all the pieces are in place, Pakistan may be a country in which to make some concrete gains (with the caveat of the unstable political situations).

- Regional activities (sharing of best practices) were judged to be very desirable. A strong delegation had attended the USAID supported regional meeting in Bangkok in Nov 2007. This was felt to be of great benefit. PMNCH may have a role in facilitating exchange of experience at regional level, although all interviewees were unaware of the existence of the Regional office in Bangkok.
Annex IX: Review of Global Health Partnerships

GHPs reviewed
A sample of global health partnerships that could potentially duplicate, overlap with or have complementarities with PMNCH are described in a series of tables below. They include:

Table 6: GHPs reviewed

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Main Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Global Campaign for MDGs 4 and 5\textsuperscript{29},</td>
<td>Advocacy</td>
</tr>
<tr>
<td>International Health Partnership (IHP)</td>
<td>Advocacy / Financing</td>
</tr>
<tr>
<td>The Catalytic Initiative to Save a Million Lives Support</td>
<td>TA / Service Support</td>
</tr>
<tr>
<td>Providing for Health Initiative (P4H)</td>
<td>TA / Service Support</td>
</tr>
<tr>
<td>Innovative Results-Based Financing</td>
<td>Financing</td>
</tr>
<tr>
<td>2. Countdown to 2015\textsuperscript{30}</td>
<td>Advocacy / R&amp;D</td>
</tr>
<tr>
<td>3. White Ribbon Alliance</td>
<td>Advocacy</td>
</tr>
<tr>
<td>4. Global Fund to Fight AIDS, TB and Malaria (GFATM)</td>
<td>Financing</td>
</tr>
<tr>
<td>5. Global Alliance for Vaccines and Immunisation (GAVI)</td>
<td>Financing</td>
</tr>
<tr>
<td>7. Global Health Workforce Alliance Support</td>
<td>TA / Service Support</td>
</tr>
<tr>
<td>8. Health Metrics Network Support</td>
<td>TA / Service Support</td>
</tr>
<tr>
<td>9. Implementing Best Practices in Reproductive Health (IBP)\textsuperscript{31}</td>
<td>Advocacy / R&amp;D</td>
</tr>
<tr>
<td>10. Roll-Back Malaria Initiative (RBM)</td>
<td>Advocacy</td>
</tr>
<tr>
<td>11. Stop TB</td>
<td>Advocacy / Financing</td>
</tr>
</tbody>
</table>

Comparisons
1. Vision/mission
2. Objectives
3. Major members
4. Funding source and amount
5. Hosting arrangements/ legal status
6. Where they are working

“Most studies comment on GHPs’ inability to specify their partners’ roles and responsibilities clearly. This makes it difficult to monitor individual GHP’s performance because it is not clear what the partnership is expected to achieve\textsuperscript{33}.”

1. Vision and Mission

<table>
<thead>
<tr>
<th>PMNCH (est Sept 2005)</th>
<th>Vision: A world where all women and children receive the care they need to live healthy, productive lives.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Goal: To invest in, deliver and advance maternal, newborn and child health, and thereby put 50% of the 60 high-burden countries &quot;on track&quot; to achieve MDGs 4 and 5 in 5 years.</td>
</tr>
<tr>
<td>Countdown to 2015 (est 2005)</td>
<td>Mission: To track progress made towards the achievement of the United Nations Millennium Development Goals 1, 4 and 5 and promote evidence-based information for better health investments and decisions by policy-makers regarding health needs at the country level.</td>
</tr>
<tr>
<td>White Ribbon Alliance (launched August 1999)</td>
<td>Mission: The WRA is a grassroots movement for safe motherhood that builds alliances, strengthens capacity, influences policies, harnesses resources and inspires action to save women's and newborns lives worldwide.</td>
</tr>
<tr>
<td></td>
<td>Vision: The WRA works to create a world where:</td>
</tr>
<tr>
<td></td>
<td>• It is a woman’s’ basic human right to achieve optimal health throughout pregnancy and</td>
</tr>
</tbody>
</table>

\textsuperscript{29} Includes the advocacy drive Deliver Now and The Network of Global Leaders for MDGs 4 and 5.
\textsuperscript{30} The Partnership for Maternal, Newborn and Child Health (PMNCH) has been collaborating with the Countdown to 2015 efforts since its inception (in September 2005), and the PMNCH Secretariat has been asked to facilitate the planning and execution of events in 2008.
\textsuperscript{31} Established another GHP in the shape of the Global Alliance for Nursing and Midwives.
childbirth for themselves and their newborns.

- Women are empowered to demand respectful, quality safe motherhood services and help other women to do the same.
- Women and newborns have access to essential and life saving safe motherhood services and information.
- Women and men are active members in the safe motherhood movement, are knowledgeable, and make decisions together that promote safe motherhood within their own families and their communities.
- Communities work together to address the effects of poverty, HIV/AIDS, armed conflict, violence against women and children, and gender inequities on safe motherhood.
- Governments set policies in collaboration with women, their communities, and other stakeholders and implement programs in support of safe motherhood.

*This includes all women of childbearing age.*

| GFATM (est 2001) | **Mission:** To dramatically increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need. |
| GAVI | **Vision:** Make a major contribution to the 2/3 reduction in U5MR targeted by the international community in the MDGs. It will do this by making advanced vaccine products available in the world’s poorest countries and strengthening delivery systems to ensure that their children derive full benefit. **Mission:** To save children’s lives and protect people’s health by increasing access to immunisation in poor countries |
| GAIN | **Vision:** All people, everywhere, have the nutrition they need to live healthy and productive lives. **Mission:** To reduce malnutrition through the use of food fortification and other strategies aimed at improving the health and nutrition of populations at risk. |
| Global Health Workforce Alliance | **Vision:** The Alliance will, through the coordinated actions of its members, support the development of evidence-based, comprehensive and coherent country-level approaches and the significant scaling up of country, regional, and global actions necessary to ensure universal access to motivated and skilled health workers. **Mission:** To advocate for health workers to be trained, supported and retained in sufficient numbers to ensure accelerated progress towards the health MDGs, to enable everyone, particularly poor, marginalized and remote populations, to benefit from essential prevention, treatment, and care services. |
| Health Metrics Network | **Strategic Goal:** to increase the availability and use of timely and accurate health information by catalysing the joint funding and development of core country health information systems |
| Implementing Best Practices in Reproductive Health | **Vision:** The IBP initiative will strengthen and maintain networks of international organizations and establish new networks committed to working together at the global, national and local levels, to ensure that practical, cost-effective best practices are shared and utilized within reproductive health programs worldwide. **Mission:** Support countries to fulfill their reproductive health agendas by strengthening international and country co-operation to share experiences aimed at improving the introduction, adaptation, utilization and scaling-up of evidence-based and/or proven effective practices in reproductive health. |
| Roll-Back Malaria (launched in 1998) | **Vision:** By 2015 the malaria-related MDGs are achieved. Malaria is no longer a major cause of mortality and no longer a barrier to social and economic development and growth anywhere in the world. **Mission:** To work together to enable sustained delivery and use of the most effective prevention and treatment for those affected most by malaria by promoting increased investment in health systems and incorporation of malaria control into all relevant multi-sector activities. |
| Stop TB (est 2000) | **Vision:** A TB-free world: the first children born this millennium will see TB eliminated in their lifetime. **Mission:** To ensure that every TB patient has access to effective diagnosis, treatment and cure. To stop transmission of TB. To reduce the inequitable social and economic toll of TB. To develop and implement new preventive, diagnostic and therapeutic tools and strategies to stop TB. |
**Global Campaign for Health MDGs (Sept 07)**

**Aim:** To respond to the MDG challenges by calling for all signatories to accelerate action to scale-up coverage and use of health services, and deliver improved outcomes against the health-related MDGs and universal access commitments.

**Catalytic Initiative (Nov 07)**

**Aim:** To save lives by identifying and scaling up services, initiatives and projects that have proved effective. It will support and develop the capacity of a country’s health system to provide services that are demonstrably high-impact and cost effective.

**Innovative Results-Based Funding**

**Aim:** To help governments to achieve their national health goals by organising their health systems in different ways. The goal is to shift the emphasis away from distributing and using resources and move it to results.

**Providing for Health**

**Principal objective:*** To strengthen health systems—their organisation, governance and financing—by putting appropriate social health protection mechanisms in place with a view to achieving universal coverage.

* May 5, 2008

## 2. Objectives

**PMNCH**

1. Include MNCH as a core component of national development plans and investment plans.
2. Mobilize resources and advocate for increased commitment to maternal, newborn and child health.
3. Align PMNCH resources and action.
4. Catalyze implementation at scale of national MNCH plans and essential packages of interventions.
5. Strengthen national health systems, including human resources, to support MNCH.
6. Improve equity in coverage of essential MNCH services.
7. Increase demand for essential MNCH services.
8. Monitor and evaluate progress towards PMNCH and country level results and promote stakeholder accountability.

**Countdown to 2015**

1. To summarize, synthesize and disseminate the best and most recent information on country-level progress in achieving high, sustained and equitable health coverage with interventions effective in reducing mortality among mothers, newborns and older children less than five years of age;
2. To promote media visibility for the Countdown to 2015 Report by projecting its key messages, selected country profiles and the human face behind the data and trend analysis;
3. To raise the awareness of key national and international decision-makers regarding the conclusions of the Countdown to 2015 Report in a manner which will stimulate discussion and motivate their commitment and investment;
4. To provide a forum for the development of coordinated institutional commitments to maternal, newborn and child survival efforts.

**White Ribbon Alliance**

These are determined at a country level in response to the membership priorities.

**GFATM**

1. Operate as a financial instrument, not an implementing entity.
2. Make available and leverage additional financial resources.
3. Support programs that reflect national ownership.
4. Operate in a balanced manner in terms of different regions, diseases and interventions.
5. Pursue an integrated and balanced approach to prevention and treatment.
6. Evaluate proposals through independent review processes.
7. Establish a simplified, rapid and innovative grant-making process and operate transparently, with accountability.

**GAVI (targets)**

1. 66% reduction in child mortality rates in 36 designated countries by 2015.
2. Introduction of hepatitis B vaccine in 72 countries by 2010.
3. Raising an additional US$4.5 billion to support immunisation programmes by 2010.

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32 Facilitated by the **Health 8** agencies which are an informal group of 8 health-related organisations including the WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, The Bill and Melinda Gates Foundation and the World Bank (created in mid-2007). Also facilitated by the **Network of Global Leaders for MDGs 4 and 5** which include PM Jens Stoltenberg (Norway), PM Michelle Bachelet (Chile), PM Gordon Brown (UK), Pres. Armando Guebuza (Mozambique), Pres. Jakaya Kikwete (Tanzania), Pres. Luiz Inácio Lula da Silva (Brazil), Pres. Ellen Johnson Sirleaf (Liberia), Pres. Abdoulaye Wade (Senegal), Pres. Susilo Bambang Yudhoyono (Indonesia), and Graça Machel, recipient of the UN’s Nansen medal for her humanitarian work.
| **GAIN (goals)** | 1. To improve the nutritional status of 1 billion people to save lives and reduce disease; improve individual wellbeing, enjoyment and productivity; and thereby reduce poverty and stimulate economic growth.  
2. To reach the MDGs, the virtual elimination of iodine deficiency by 2005; of vitamin A deficiency by 2010; and a reduction of at least 30% in the global prevalence of iron deficiency by 2010. |
| **Global Health Workforce Alliance** | 1. **Accelerating country actions** by strengthening national planning and management through the development and application of information, tools, knowledge, technical excellence, building sustainable local and regional capacity.  
2. **Solving global problems** by bringing together stakeholders backed by data and analyses to tackle trans-national problems such as grossly insufficient resources, fiscal restraints on health sector spending, migration, priority research and cooperation among actors. |
| **Health Metrics Network** | 1. Create a harmonized framework for country HIS development (the HMN Framework) which describes standards for health information systems  
2. Strengthen country HIS by providing technical and catalytic financial support to apply the HMN Framework  
3. Ensure access and use of information by local, regional and global constituencies |
| **IBP** | 1. To promote a multi-sector approach to the provision of reproductive health care to strengthen programmatic and technical linkages.  
2. To create and sustain an effective network of collaborating international and national reproductive health organizations and institutes willing to maximize resources, avoid duplication of services and support the use of best practices to improve reproductive health.  
3. Expand resource base to support innovative activities related to knowledge sharing, coordination and utilization of best practices.  
4. To identify, study and adapt new and existing models for knowledge sharing while supporting a system of collaborative learning and information sharing between partners in and among countries.  
5. To identify, recommend and provide evidence-based tools and proven effective approaches that will help support countries in implementing and/or scaling-up best practices in reproductive health.  
6. To work with countries to build on existing management and leadership skills to foster the effective management of change to either scale-up or implement best practices.  
7. To develop a transferable process that fosters innovation, shared learning and information exchange for the management and application of new and existing effective practices in reproductive health. |
| **Roll Back Malaria Priorities:** | 1. To ensure that costs are not a barrier for the poor and vulnerable, the RBM Partnership supports free or highly subsidized access to curative and preventive interventions for these groups;  
2. To support countries to implement effective malaria control interventions nationwide;  
3. To make significant investment in monitoring activities, especially to enable tracking of equitable coverage and access;  
4. To actively seek out and engage private sector and civil society groups, including them in all phases of scaled-up malaria control efforts;  
5. To greatly expand investment in research to obtain the strong evidence base needed to put into place the most effective and appropriate national policies and practices; and  
6. To give greater emphasis to community-based advocacy and social mobilization as a vital process in increasing demand for, and use of, interventions. |
| **Stop TB** | 1. **Promote wider and wiser use of existing strategies to interrupt TB transmission,** by:  
   - Increasing access to accurate diagnosis and effective treatments by accelerating expansion of DOTS to achieve the global target for TB control; and  
   - Increasing the availability, affordability, and quality of TB drugs.  
2. **Adapt existing strategies to address the challenges posed by emerging threats,** by:  
   - Developing an effective strategy to prevent and manage multi-drug resistant TB; and  
   - Developing an effective strategy to reduce the impact of HIV -related TB.  
3. **Accelerate elimination of TB,** by:  
   - Promoting research to develop new and improved diagnostic tests, drugs and vaccines; and  
   - Promoting adoption of new and improved tools by ensuring appropriate use, access and affordability. |
<table>
<thead>
<tr>
<th>Global Campaign for Health MDGs</th>
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<tbody>
<tr>
<td><strong>International Health Partnership</strong></td>
</tr>
<tr>
<td>1. Develop <em>country compacts</em> that commit development partners to provide sustained and predictable funding and increase harmonization and alignment in support of results orientated national plans and strategies that also tackle health system constraints.</td>
</tr>
<tr>
<td>2. Generate and disseminate knowledge, guidance, and tools in specific technical areas related to strengthening health systems and services.</td>
</tr>
<tr>
<td>3. Enhance coordination and efficiency as well as leverage predictable and sustained aid delivery for health.</td>
</tr>
<tr>
<td>4. Ensure mutual accountability and monitoring of performance.</td>
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<tr>
<td><strong>Catalytic Initiative</strong></td>
</tr>
<tr>
<td>? to catalyse 500 million Canadian dollars over 5 years</td>
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<tr>
<td><strong>Innovative RBF</strong></td>
</tr>
<tr>
<td>2. To design, implement and sustain successful results-based financing pilots targeting MDGs 4 and 5 and through these pilots</td>
</tr>
<tr>
<td>3. Generate new knowledge about how to governments and partners can most effectively design and use Results-Based Financing (RBF) mechanisms in health</td>
</tr>
<tr>
<td><strong>Providing for Health</strong></td>
</tr>
<tr>
<td>1. To enhance harmonization of external and domestic funds for expanding social health protection</td>
</tr>
<tr>
<td>2. To increase and improve utilization of domestic and international resources (e.g. vertical funds, SWAps) for the development of equitable and sustainable social health protection structures</td>
</tr>
<tr>
<td>3. To provide timely coordinated support for the formulation of pertinent policy options and the implementation of national strategies;</td>
</tr>
<tr>
<td>4. To facilitate sharing of experiences on social protection in health and learning across countries.</td>
</tr>
</tbody>
</table>

*N.B. 16 objectives in all: the 2 above for Strategic Partnership, but also 3 objectives for Supportive R&D, 3 for Vaccine Evaluation and 8 for Vaccine Access (http://www.pdvi.org/about-us/default.htm)*

### 3. Partners and Members

<table>
<thead>
<tr>
<th>PMNCH</th>
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<tbody>
<tr>
<td>240 country, organisational and honorary members including current Board members: Bangladesh Rural Advancement Commission, Bill &amp; Melinda Gates Foundation, CIDA, Care, DFID, Family Care International, Bolivia, Ethiopia, India, Mali, Norway, International Confederation of Midwives, FIGO, International Paediatric Association Save the Children USA, UNICEF, UNFPA, USAID, World Bank, WHO.</td>
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<table>
<thead>
<tr>
<th>Countdown to 2015</th>
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<table>
<thead>
<tr>
<th>White Ribbon Alliance</th>
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<tbody>
<tr>
<td>188 member organisations from 88 countries with 14 national alliances</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>GFATM</th>
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<tbody>
<tr>
<td>Board members (19): Private Sector, Developing Country NGO, Communities (NGOs representative of the Communities Living with the Diseases), Developed Country NGO, Eastern Europe, Eastern Mediterranean Region, Eastern and Southern Africa, European Commission, France and Spain, Germany, Italy, Japan, Latin America and Caribbean, Point Seven, Private Foundations, South East Asia, United Kingdom and Australia, USA, West and Central Africa, Western Pacific Region.</td>
</tr>
<tr>
<td>Ex Officio Members without voting rights (5): UNAIDS, WHO, World Bank, Board Designated non voting Swiss Member.</td>
</tr>
<tr>
<td>TA, support etc.: WHO, SIDA, UNAIDS, ILO, UNICEF, the World Bank, GAVI, Stop TB, CIDA, NORAD, UNDP, DFID, European Union, GTZ, France, OGAC/PEPFAR/USA.</td>
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<tr>
<th>GAVI</th>
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<tbody>
<tr>
<td>UN agencies and institutions (UNICEF, WHO, the World Bank), civil society organisations (International Paediatric Association), public health institutes (The Johns Hopkins Bloomberg School of Public Health), donor and implementing country governments, the Bill &amp; Melinda Gates Foundation, other private philanthropists, vaccine industry representatives, the financial community and others.</td>
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<tr>
<th>GAIN</th>
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<tr>
<td>10 partners including Danone, Helen Keller International, Micronutrient Initiative, National Fortification Alliance, Tetra Pak, UNICEF, Unilever, World Bank Institute, WFP, WHO.</td>
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<table>
<thead>
<tr>
<th>GHWA</th>
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<tbody>
<tr>
<td>109 partners including Board members NEPAD / African Platform, Gates Foundation, Brazil, USA, Physicians for Human Rights, CIDA, Cameroon, China, Norway, WHO, GHWA Executive Director, ICN, World Bank, France, AMREF, Thai Government /AAAHT.</td>
</tr>
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<tr>
<td>IBP in RH</td>
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<tr>
<td>Roll Back Malaria</td>
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<tr>
<td>Stop TB</td>
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<tr>
<td>Global Campaign for Health MDGs</td>
</tr>
<tr>
<td>Innovative RBF</td>
</tr>
<tr>
<td>P4H</td>
</tr>
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</table>

### 4. Funding: Key Sources and Amounts

<table>
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<tr>
<th>PMNCH</th>
<th>Bill and Melinda Gates Foundation, Norway, DFID (all 3 earmarked for specific activities), The Netherlands: US$1.2million to &gt;US$3 million; UNICEF, USA, WHO: US$400,000 to US$30,000; World Bank, UNFPA, MacArthur: US$350,000 to US$390,000; Germany, Italy &lt;US$150,000; Plus in-kind: USA and Save the Children.</th>
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<tbody>
<tr>
<td>Countdown to 2015</td>
<td>Not found</td>
</tr>
<tr>
<td>White Ribbon Alliance</td>
<td>Bill and Melinda Gates Foundation, USAID, ACCESS Program, UNFPA, PMNCH, DFID, the World Bank. Launched in independent financial operations in May 2006 with donations from individuals, Constella Group, DFID, USAID, JP Morgan, Ebay Foundation of US$ 236, 979</td>
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<tr>
<td>GFATM</td>
<td>US$11.4 billion from 2001 – 2007 from 43+ countries, Bill and Melinda Gates Foundation etc.</td>
</tr>
<tr>
<td>GAVI</td>
<td>US$3.2 billion received 2000-2007 from: Private and institutions (Bill and Melinda Gates Foundation, World Bank, Other Private), Government Donors (Australia, Canada, Denmark, France, Germany, Ireland, Luxembourg, Netherlands, Norway, Sweden, United Kingdom and United States), IFFIm (since 2006), European Commission (EC). N.B. Just under 1/3 from BMFG.</td>
</tr>
<tr>
<td>GAIN</td>
<td>Bill and Melinda Gates Foundation, CIDA, USAID (amount not available)</td>
</tr>
<tr>
<td>GHWA</td>
<td>Not found</td>
</tr>
<tr>
<td>IBP</td>
<td>US$4.06 million for 2006 and 2007 from USAID, WHO and UNFPA.</td>
</tr>
<tr>
<td>Roll Back Malaria</td>
<td>US$35.4 million from WHO, bilaterals and multilaterals</td>
</tr>
<tr>
<td></td>
<td><strong>Secretariat:</strong> US$32.96 million between 2003-2006 from governments and their agencies including Canada (CIDA), USA (CDC/USAID), UK (DFID), The Netherlands, The Bill and Melinda Gates Foundation, and voluntary contributions in kind.</td>
</tr>
<tr>
<td></td>
<td><strong>Global Drug Facility:</strong> US$1.369 billion between 2003-2006 from governments (CIDA, USAID, Norway, DFID), direct procurement, in-kind contribution of drugs (Novartis), in-kind contribution of staff.</td>
</tr>
</tbody>
</table>
### Global Campaign for the Health MDGs

<table>
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<tr>
<th>Initiative</th>
<th>Funding Details</th>
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<tbody>
<tr>
<td>P4H:</td>
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<tr>
<td>IHP</td>
<td>IHP+ Scaling Up for Better Health Budget Plan in February 2008: US$14 million</td>
</tr>
<tr>
<td>Catalytic Initiative</td>
<td>Canada: US$105 million over 5 years</td>
</tr>
<tr>
<td>Innovative RBF</td>
<td>Norway 6-year grant (FY 2007-2013) US$105 million</td>
</tr>
</tbody>
</table>

N.B. According to one study, GHPs have an average 60% deficit in funding [33].

By November 2007, 75 countries had successfully applied to GAVI for support and the organisation had approved support totalling US $3.5 billion for the period 2000 to 2015 [34].

5. Hosting Arrangements / Legal Status

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Details</th>
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<tbody>
<tr>
<td>PMNCH</td>
<td>Secretariat hosted and administered by the WHO.</td>
</tr>
<tr>
<td>Countdown to 2015</td>
<td>Hosted by PMNCH, c/o WHO</td>
</tr>
<tr>
<td>White Ribbon Alliance</td>
<td>Global Secretariat based in Washington Dc</td>
</tr>
<tr>
<td>GFATM</td>
<td>Independent office in Geneva.</td>
</tr>
<tr>
<td>GAVI</td>
<td>An unincorporated public-private partnership with a Secretariat hosted by UNICEF in Geneva and four affiliated charitable entities: The GAVI Fund, IFFIm Company, The GAVI Fund Affiliate and The GAVI Foundation. The Secretariat and Fund operate under the Executive Secretary and CEO.</td>
</tr>
<tr>
<td>GAIN</td>
<td>Founded in 2002 at a special session for children at the UN. HQ in Geneva.</td>
</tr>
<tr>
<td>Global Health Workforce Alliance</td>
<td>Secretariat located at WHO headquarters in Geneva. Secretariat staff members are either recruited through WHO procedures or seconded by GHWA partners.</td>
</tr>
<tr>
<td>HMN</td>
<td>Hosted by WHO.</td>
</tr>
<tr>
<td>IBP</td>
<td>WHO Department of Reproductive Health and Research, Geneva (first two years)</td>
</tr>
<tr>
<td>Stop TB</td>
<td>Secretariat is hosted by WHO.</td>
</tr>
<tr>
<td>Roll Back Malaria</td>
<td>Secretariat hosted by WHO.</td>
</tr>
<tr>
<td>Global Campaign for MDGs 4&amp;5</td>
<td>Managed by a core team based at WHO in Geneva, World Bank in Washington and WHO Brazzaville.</td>
</tr>
<tr>
<td>IHP</td>
<td>Managed by World Bank</td>
</tr>
<tr>
<td>P4H</td>
<td>? One German secondment to WHO where plan is being worked out.</td>
</tr>
<tr>
<td>Innovative RBF</td>
<td>Managed by World Bank</td>
</tr>
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</table>

6. Countries [35]

GAWI, RBM, Stop TB and GFATM work in too many countries to list [36]. Also not included overleaf:

- Countdown 68 countries.
- White Ribbon Alliance: 88 countries
- Innovative RBF: to fund 6 pilot countries in 2 rounds in 2008/2009
- Health Metrics Network: 65 countries over 2 rounds so far
- GHWA: 8 Pathfinder countries

---


34 Of the 72 countries currently eligible only Timor-Leste had not yet requested support.

35 Table Adapted from Global Campaign for the Health Millennium Development Goals Progress Report: April 2008 www.norad.no/globalcampaign

* Providing for Health Initiative not yet begun.

36 To date, the Global Fund has committed US$ 10.7 billion in 136 countries, GAVI – 75 countries
<table>
<thead>
<tr>
<th>Country/G</th>
<th>PMNCH</th>
<th>White Ribbon Alliance</th>
<th>HP</th>
<th>Providing for Health</th>
<th>Network of Global Leaders</th>
<th>Deliver Now</th>
<th>Norwegian MDG 4 &amp; 5 bilateral</th>
<th>Catalytic Initiative</th>
<th>Results-based Financing</th>
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Annex X: PMNCH Secretariat Organogram

Partnership for Maternal, Newborn and Child Health (PMNCH)
Update at December 2006 - To include Gates and other funding

### 2006

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<tr>
<td>Gates</td>
<td>$1,015,131</td>
<td>$3,345,407</td>
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<td>$4,360,538</td>
<td>$389,780</td>
<td>9%</td>
<td>$3,970,758</td>
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<td>USAID</td>
<td>-$58,768</td>
<td>$766,369</td>
<td>$8,569</td>
<td>$736,170</td>
<td>$255,542</td>
<td>35%</td>
<td>$480,626</td>
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<td>$5,901</td>
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<td>$228,004</td>
<td>93%</td>
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<td>UNFPA</td>
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<tr>
<td>Total</td>
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<td>$8,569</td>
<td>$5,484,015 ($79%)</td>
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<td>$1,200,000</td>
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<td>$18,946</td>
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<td>$586,885</td>
<td>$1,781,662 (25%)</td>
<td>$253,565</td>
<td>14%</td>
<td>$1,528,097</td>
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<td>Grand Total</td>
<td>$1,154,717</td>
<td>$5,515,506</td>
<td>$595,454</td>
<td>$7,265,677 ($75%)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gates</td>
<td>$3,970,758</td>
<td></td>
<td>-$41,614</td>
<td>$3,929,144</td>
<td>$1,966,484</td>
<td>50%</td>
<td>$1,962,660</td>
</tr>
<tr>
<td>USAID</td>
<td>$480,628</td>
<td></td>
<td></td>
<td>$480,628</td>
<td>$359,210</td>
<td>75%</td>
<td>$121,418</td>
</tr>
<tr>
<td>World Bank</td>
<td>$17,897</td>
<td>$150,000</td>
<td></td>
<td>$167,897</td>
<td>$11,447</td>
<td>7%</td>
<td>$156,450</td>
</tr>
<tr>
<td>UNICEF</td>
<td>$485,000</td>
<td></td>
<td></td>
<td>$485,000</td>
<td>$386,643</td>
<td>80%</td>
<td>$98,357</td>
</tr>
<tr>
<td>UNFPA</td>
<td>$4,575</td>
<td>$330,000</td>
<td></td>
<td>$334,575</td>
<td>$316,120</td>
<td>94%</td>
<td>$18,455</td>
</tr>
<tr>
<td>DFID</td>
<td>$1,045</td>
<td>$2,064,838</td>
<td>-$658,156</td>
<td>$1,407,727</td>
<td>$292,665</td>
<td>21%</td>
<td>$1,115,062</td>
</tr>
<tr>
<td>Germany</td>
<td>$47,327</td>
<td></td>
<td></td>
<td>$47,327</td>
<td>$37,537</td>
<td>79%</td>
<td>$9,790</td>
</tr>
<tr>
<td>Mc Arthur</td>
<td>$225,000</td>
<td></td>
<td></td>
<td>$225,000</td>
<td>$208,100</td>
<td>92%</td>
<td>$16,900</td>
</tr>
<tr>
<td>Norway</td>
<td>$3,418,803</td>
<td></td>
<td></td>
<td>$3,418,803</td>
<td>$624,830</td>
<td>18%</td>
<td>$2,794,173</td>
</tr>
<tr>
<td>Total</td>
<td>$4,474,903</td>
<td>$6,720,968 ($96%)</td>
<td>-$699,770</td>
<td>$10,496,101 (85%)</td>
<td>$4,202,837</td>
<td>40%</td>
<td>$6,293,264</td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>$1,137,620</td>
<td></td>
<td></td>
<td>$1,137,620</td>
<td>$363,740</td>
<td>32%</td>
<td>$773,880</td>
</tr>
<tr>
<td>Italy</td>
<td></td>
<td>$133,333</td>
<td></td>
<td>$133,333</td>
<td>$41,542</td>
<td>31%</td>
<td>$91,791</td>
</tr>
<tr>
<td>Other</td>
<td>$32,101</td>
<td></td>
<td></td>
<td>$32,101</td>
<td>$7,972</td>
<td>25%</td>
<td>$24,129</td>
</tr>
<tr>
<td>Transfer WHO</td>
<td>$358,376</td>
<td>$122,816</td>
<td>$14,772</td>
<td>$495,964</td>
<td>$377,299</td>
<td>76%</td>
<td>$118,665</td>
</tr>
<tr>
<td>Total</td>
<td>$1,528,097</td>
<td>$256,149 (4%)</td>
<td>$14,772</td>
<td>$1,799,018 (15%)</td>
<td>$790,553</td>
<td>44%</td>
<td>$1,008,465</td>
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<tr>
<td>Grand Total</td>
<td>$6,003,000</td>
<td>$6,977,117</td>
<td>-$684,998</td>
<td>$12,295,119</td>
<td>$4,993,390</td>
<td>41%</td>
<td>$7,301,729</td>
</tr>
</tbody>
</table>

Note: Minus correspond to either transfers of obligations or decrease / cancellation of un-liquidated obligations.
Source of Income (2006)

- Gates: 60%
- Netherlands: 17%
- DFID: 1%
- UNFPA: 1%
- World Bank: 3%
- USAID: 10%
- Transfer WHO: 7%
- Other: 1%
- Other: 1% (Other source)

Source of Income (2007)

- Gates: 33%
- Norway: 28%
- Mc Arthur: 2%
- DFID: 11%
- UNICEF: 4%
- USAID: 4%
- World Bank: 1%
- UNFPA: 3%
- Italy: 1%
- Transfer WHO: 4%
- Netherlands: 9%
2007 Budget Implementation by Work Area

- Work Area 1: Country Support
- Work Area 2: Global Political Advocacy
- Work Area 3: Aligning partners and increasing aid effectiveness
- Work Area 4: Monitoring and Evaluation
- Work Area 5: Governance

Programme support cost

2007 Expenditure against Budget for Work Plan Areas (excluding staff costs), US$

- Work Area 1: Country Support
- Work Area 2: Global Political Advocacy
- Work Area 3: Aligning partners and increasing aid effectiveness
- Work Area 4: Monitoring and Evaluation
- Work Area 5: Governance