

ANALYSING COMMITMENTS TO ADVANCE
THE GLOBAL STRATEGY
FOR WOMEN'S AND CHILDREN'S HEALTH



THE PMNCH 2011 REPORT



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On behalf of the board and secretariat of The Partnership for Maternal, Newborn & Child Health (PMNCH), we are pleased to introduce this 2011 report, *Analysing Commitments to Advance the Global Strategy for Women's and Children's Health*.

This report seeks to further our collective understanding of the current Global Strategy commitments, facilitating more effective advocacy to advance the Every Woman, Every Child effort, as well as greater accountability in line with the recommendations of the Commission on Information and Accountability for Women's and Children's Health.

This 2011 report is based on structured interviews with those who made commitments, supplemented by reviews of related documentation. This report analyses the specific nature of each commitment recorded through May 2011 to produce a preliminary picture of the achievements of the Global Strategy commitments to date, as well as to identify opportunities and challenges for advancement.

It has been only a year since the Global Strategy was launched and the first commitments were made. This report does not attempt to present a comprehensive picture of progress, nor is it mandated to do so. Rather, our goal is to spark discussion to inform future reporting and analysis, taking the view that accountability cannot start too early.

Topics of analysis for this report include:

- the number of stakeholders, from different constituency groups, who have made commitments to advance the Global Strategy;
- the estimated value of the financial contributions made, including the extent of new and additional resources and projected government health spending on reproductive, maternal, newborn and child health (RMNCH) through 2015 in 16 low-income countries;
- the focus and scope of policy and service-delivery commitments made to date, including the use of innovation to catalyse progress;
- the geographic distribution of commitments, mapped against current progress on Millennium Development Goals (MDGs) 4 and 5 in low- and middle-income countries;
- the alignment of commitments with identified gaps in human resources for health, the coverage of essential RMNCH interventions, and integration with other MDGs; and
- the extent to which commitments relate to promoting human rights, equity and empowerment, addressing structural and political barriers that impede progress.

As stated in the Delhi Declaration (2010), PMNCH members are firmly committed to working together across all stakeholder groups to “turn pledges into action” and to hold ourselves accountable. We hope this report contributes to these goals, and to even greater progress in saving the lives of 16 million women and children by 2015. ■■■■



Dr Julio Frenk
Chair, PMNCH
Dean of Harvard School of Public Health



Dr Carole Presern
Director, PMNCH

EXECUTIVE SUMMARY

In September 2010, the United Nations Secretary-General Ban Ki-moon launched the Global Strategy for Women's and Children's Health, aiming to save 16 million lives in the world's 49 poorest countries by 2015. The Global Strategy sets out six key areas where action is urgently required to enhance financing, strengthen policy and improve service-delivery:

1. Support to country-led health plans, supported by increased, predictable and sustainable investment.
2. Integrated delivery of health services and life-saving interventions – so women and their children can access prevention, treatment and care when and where they need them.
3. Stronger health systems, with sufficient skilled health workers at their core.
4. Innovative approaches to financing, product development and the efficient delivery of health services.
5. Promoting human rights, equity and gender empowerment.
6. Improved monitoring and evaluation to ensure the accountability of all actors for resources and results.

The Global Strategy put women's and children's health at the top of the political agenda. Almost 130 stakeholders from a variety of constituency groups made financial, policy and service-delivery commitments. Commitments addressed areas ranging from human rights, technical guidelines and gender and economic empowerment, to citizen participation, accountability and governance.

Stakeholders reported a wide variety of reasons for engaging with the Global Strategy. They wanted to be part of an unprecedented global movement for women's and children's health, and many wanted to make fresh commitments to help fill the gaps in global funding and resources. Others were keen to showcase their existing work, and found that a commitment gave it visibility. And others recognized an opportunity to link with partners who could provide technical and financial support. Finally, they wanted to ensure that their work for women's and children's health was prioritized by their own organizations and national leaders.

This report's objective

The overall objective of this report is to present an introductory analysis of the commitments to inform discussion and action on the following topics:

1. Accomplishments of the Global Strategy and the Every Woman, Every Child effort, in terms of the commitments to date;
2. Opportunities and challenges in advancing Global Strategy commitments;
3. Stakeholders' perceptions about the added value of the Global Strategy; and
4. Next steps to strengthen advocacy, action and accountability, taking forward the recommendations of the Commission on Information and Accountability for Women's and Children's Health.

Unprecedented commitments

The Global Strategy resulted in a remarkable set of commitments.

- 127 stakeholders made commitments to advance the Global Strategy, collectively worth more than US\$40 billion. This only includes monetized commitments, and therefore underestimate the total value, as extensive policy and service-delivery commitments were also made.
- Low-income countries made the highest number of commitments overall, including financial commitments valued at US\$10 billion. In addition, 24 governments committed to expand access to family planning, 18 to expand access to skilled birth attendance and 23 to reduce financial barriers to health-care.
- More than 100 stakeholders made policy commitments, including removing user fees, improving access to high-quality health-care and promoting gender empowerment.
- Of the 127 stakeholders, 99 (78%) made commitments to strengthening health systems and service-delivery. These included specific pledges to improve health services and incorporate innovative approaches to expand utilization, for example by using

mobile phones to raise awareness and promote healthy behaviours.

- Of the 127 stakeholders, 66 (52%) made commitments to building human resource capacities for health. These included pledges to increase the number of health workers (by more than 45 000), with 35% of these commitments focused on skilled birth attendants and 23% on midwives.
- Of the 127 stakeholders, 87 (69%) made commitments that promote some dimensions of human rights. For example, to address equity by using mobile clinics to reach remote areas and women and children in greatest need, to reduce the costs of medicines by negotiating royalty-free licences from pharmaceutical companies, and to address accountability by working with local communities to establish maternal death audits.
- Of the 477 references to countries in commitments and interviews, 70% focused on the 49 low-income countries, ensuring that women's and children's health in these countries is now a joint global responsibility.

Opportunities and challenges in advancing Global Strategy commitments

The analysis in this report indicated a number of opportunities to further advance the Global Strategy.

- Stakeholders identified funding shortfalls as the most important constraint to implementation, and many also pointed out that there is insufficient clarity on how and when the funds already committed can be accessed.

“Based on our experience, the Global Strategy has helped in raising awareness of the needs of women's and children's health, and has helped identify where organizations like ours can have the greatest impact.”

– Private sector respondent,
PMNCH 2011 Report

- More than 95% of commitments are from stakeholders in the health sector. However, improving the health of women and children also requires the involvement of many other sectors, including education, nutrition, water and sanitation, agriculture and infrastructure.
- Of the 127 stakeholders making commitments, only 14 are from the business community and five from middle-income countries – both these groups can play a much more significant role, including in the lowest-income countries.
- The Commission on Information and Accountability recommends the use of innovation, particularly in the field of information and communication technologies, to strengthen vital registration and health information systems that underpin accountability for women's and children's health.

Next steps for stakeholders

Stakeholders can build on their existing work to achieve more in six focus areas of the Global Strategy. In particular, they can:

- Prioritize implementation, guided by how their commitments contribute to the ultimate goal of saving 16 million lives by 2015. The Commission follow-up will focus on what is actually being done to achieve the desired impact. Its 11 indicators will allow stakeholders to know whether or not they are on track, and how to either consolidate successes or change course if needed.
- Focus on all low-income countries. Korea PDR attracted no commitments, and seven countries attracted only one. By contrast, 15 countries attracted more than 10 commitments each.
- Link commitments to needs, addressing gaps in the coverage of key life-saving interventions. Along the continuum of care, some interventions received fewer commitments, such as postnatal care for mothers, insecticide-treated bed nets and nutrition.
- Invest in innovation to speed up progress. Although 50 stakeholders expressed an interest in innovation, only nine commitments refer to using it to catalyse progress in areas such as leadership and policy, product development and financing.



- Develop a common understanding of what a “commitment” is. For example, some stakeholders have based their commitments on new and additional activities, policies and/or financing. Others chose to package a selection of their existing and ongoing RMNCH-related efforts to emphasize their support for the campaign. Some also viewed the commitment-making process as an opportunity to set out intended activities and policies, should future support be available for implementation. Developing a common approach to commitment-making will facilitate better targeting of priorities identified by the Global Strategy.
- Harmonize efforts to avoid duplication and facilitate more efficient use of resources. This will also help address issues that are beyond the capacities of any single country or partner, such as cross-border health emergencies and human rights violations.
- Address structural barriers to, and social determinants of, women’s and children’s health, focusing on gender equality and empowerment. This requires the engagement of many players across sectors working to achieve the Millennium Development Goals and to realize human rights.
- Ensure that future commitments promote health and human rights literacy and health-seeking behaviour. Less than 10% of

the commitments have addressed the need to promote health and human rights literacy, and education, so that individuals and communities can have the information they need to make decisions about their health, claim their rights and demand accountability.

- Do more to strengthen community systems and participation, recognizing the essential role communities play in providing health-care, facilitating access to health services, promoting citizen participation and empowerment, advocating for essential interventions and addressing structural barriers to health. Women and children, and their families and communities, cannot be viewed as passive recipients of services. They must be active participants in the realization of their rights.

This report is a first step towards unpacking the commitments made to advance the Global Strategy. While the approach and methods need to be discussed and improved, it is hoped that the report’s findings, and the challenges it identifies, will inform the accountability process, as well as more targeted action and advocacy. It should also help identify areas that can be addressed by the independent Expert Review Group set up to take forward the recommendations of the Commission on Information and Accountability. ■■■■

THE MILLENNIUM DEVELOPMENT GOALS AND THE GLOBAL STRATEGY FOR WOMEN'S AND CHILDREN'S HEALTH



In September 2010, the Global Strategy for Women's and Children's Health was launched as a high-level roadmap for action and accountability to improve the health of women and children in the poorest countries of the world. This was a game-changing moment in the run-up to 2015 and the deadline for the achievement of the Millennium Development Goals (MDGs).

For the first time, women's and children's health moved to the top of the political agenda. This is a credit to the leadership of United Nations Secretary-General Ban Ki-moon, under whose auspices the Global Strategy was developed. It is also the result of an unprecedented joint effort engaging hundreds of stakeholders, from community members to technical experts, and donors to political leaders.

Facilitated in its development by The Partnership for Maternal, Newborn & Child Health (PMNCH), the Global Strategy aims to save 16 million lives in the world's 49 poorest countries by 2015. To do so, it sets out the key areas where action is urgently required to enhance financing, strengthen policy and improve service-delivery. These include:

- Support to country-led health plans, supported by increased, predictable and sustainable investment.
- Integrated delivery of health services and life-saving interventions – so women and their children can access prevention, treatment and care when and where they need them.
- Stronger health systems, with sufficient skilled health workers at their core.
- Innovative approaches to financing, product development and the efficient delivery of health services.
- Promoting human rights, equity and gender empowerment.
- Improved monitoring and evaluation to ensure the accountability of all actors for resources and results.

Following extensive consultation, the Global Strategy was launched during the MDG Summit in New York in September 2010. The launch was welcomed by

more than 90 financial, policy and service-delivery commitments by a wide range of stakeholders, including governments, international organizations, the business community, academia, foundations, health professional organizations and NGOs.

Financial commitments amounted to an estimated \$40 billion, one of the largest sums ever raised in the shortest amount of time for global health. The figure triggered headlines around the world and instant attention from the world's political leaders.

The launch of the Global Strategy followed closely on the heels of several important regional and economic initiatives in 2010 to accelerate progress towards the health MDGs. These events included the African Union Summit in July 2010 focusing on maternal and child health and development in Africa. The AU Summit saw the launch of the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) and a commitment to a new task force to review progress through 2015. At a global level, the G8's Muskoka Initiative highlighted the unprecedented global commitment to women's and children's health, committing US\$ 5 billion to improving maternal, child and newborn health.

Figure 1.1 summarizes key milestones related to the Global Strategy, from the high-level retreat in April 2010 that launched this effort to the first meeting on the implementation of the Global Strategy at the UN General Assembly in September 2011.

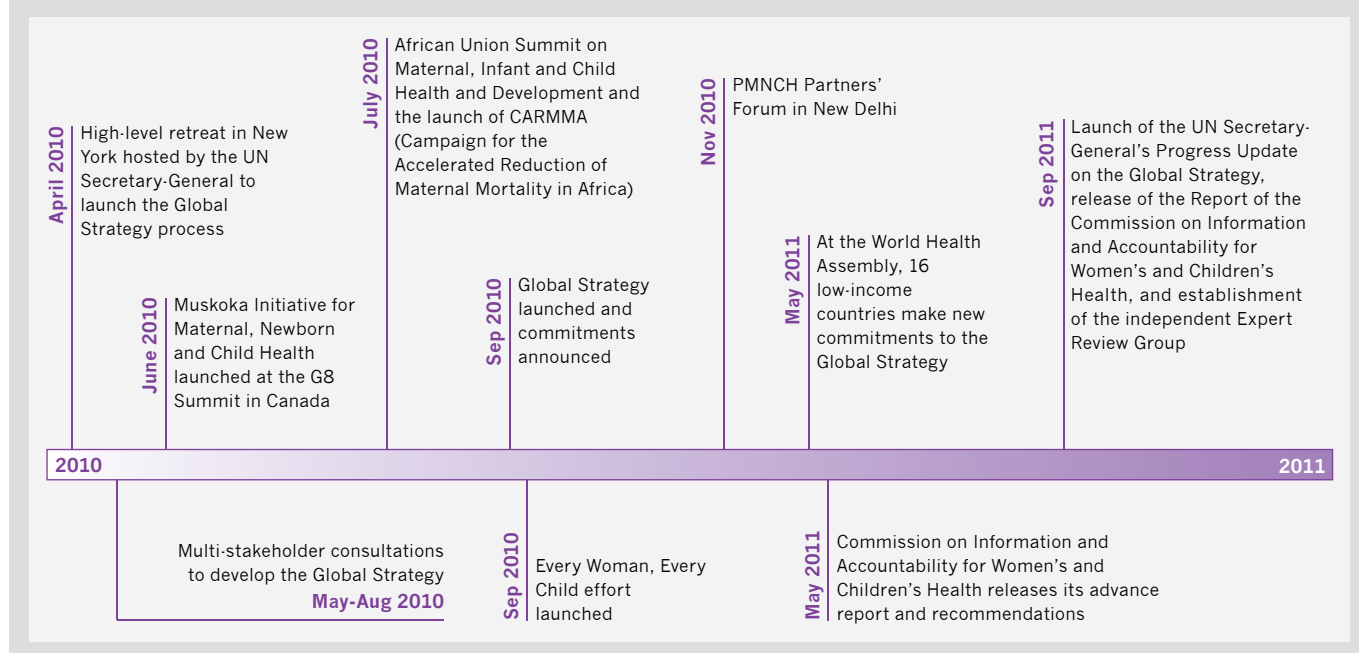
Every Woman, Every Child

The global effort that brought together leaders and stakeholders from around the world to develop the Global Strategy for Women's and Children's Health was launched as "Every Woman, Every Child" by Secretary-General Ban Ki-moon at the time of the MDG Summit in September 2010. The Office of the Secretary-General spearheads work to advance Every Woman, Every Child and to ensure continued support for the Global Strategy at the highest levels. This work is supported through the active involvement of partners such as the H4+ working group, the United Nations Foundation, PMNCH, the Secretary-General's MDG Advocacy Group, the "H8" health-related agencies and others, to galvanize ongoing action and commitment.

Commission on Information and Accountability for Women's and Children's Health

The Commission on Information and Accountability for Women's and Children's Health was convened by the World Health Organization in 2011 as an urgent, time-limited effort. Its formation was a response to the United Nations Secretary-General's call to identify the most effective international institutional arrangements for reporting, oversight and accountability. The aim was to produce a coherent set of recommendations to facilitate national leadership and ownership of results.

FIGURE 1.1: Key events related to the Global Strategy



The Commission's final report, issued in September 2011, focuses on better information for better results, better tracking of resources for women's and children's health, and better oversight of results and resources, nationally and globally (see Annex 1).¹ Going forward, an independent Expert Review Group, reporting to the United Nations Secretary-General and supported by the WHO, will assess whether Global Strategy commitments have been fulfilled and the required results achieved.

Every Woman, Every Child Innovation Working Group

The Every Woman, Every Child Innovation Working Group promotes cost-effective innovation and partnerships to enhance the implementation of the Global Strategy. Its role is to drive innovations delivered through sustainable business models. Forging partnerships between public and private organizations, the Innovation Working Group encourages new and complementary approaches to address a wide range of health issues.

New commitments at the 2011 World Health Assembly and United Nations General Assembly

These efforts have helped the Global Strategy grow into a broad-based movement with an expanding list of public and private contributors and a robust plan for enhanced accountability. Additional commitments continue to be made to advance the Global Strategy, including those of 16 low-income countries at the World Health Assembly in May 2011. A significant number of new commitments will be announced at the time of the September 2011 United Nations General Assembly.

PMNCH 2011 report on commitments to advance the Global Strategy

This 2011 PMNCH report aims to support greater action and accountability. It recognizes and highlights stakeholders' commitment to collective action as represented by the Global Strategy process. At the same time, this report responds to the interest of the international development community, media and wider public in taking a closer look at the basis of the commitments made to date. It is less than a year since the Global Strategy was launched, and there are many limitations with respect to getting detailed data on the commitments and progress made. Nevertheless, there is an urgent need for action and accountability. The PMNCH Partners' Forum in New Delhi in November 2010 committed all constituencies to a process of mutual accountability. This report puts that pledge into action.

This document presents an introductory analysis of the financial, policy and service-delivery commitments to the Global Strategy in order to inform discussion and to support further advocacy, action and accountability. In doing so, PMNCH seeks to catalyse further commitments by identifying opportunities for greater action, as well as promote the implementation of existing commitments. Through greater understanding and discussion of the commitments made to date, PMNCH hopes to contribute to greater accountability and enhanced collective action, optimizing the impact of this historic global effort for women and children. ■■■■



“With the right policies, adequate and fairly distributed funding, and a relentless resolve to deliver to those who need it most – we can and will make a life-changing difference for current and future generations.”

– United Nations Secretary-General
Ban Ki-moon

CHAPTER 2

HOW THIS REPORT WAS DEVELOPED

This report was developed by The Partnership for Maternal, Newborn & Child Health (PMNCH) to complement the work of the Commission on Information and Accountability for Women's and Children's Health by analysing commitments to the Global Strategy to date. The Acknowledgements section provides a list of contributors to this report.

Objective

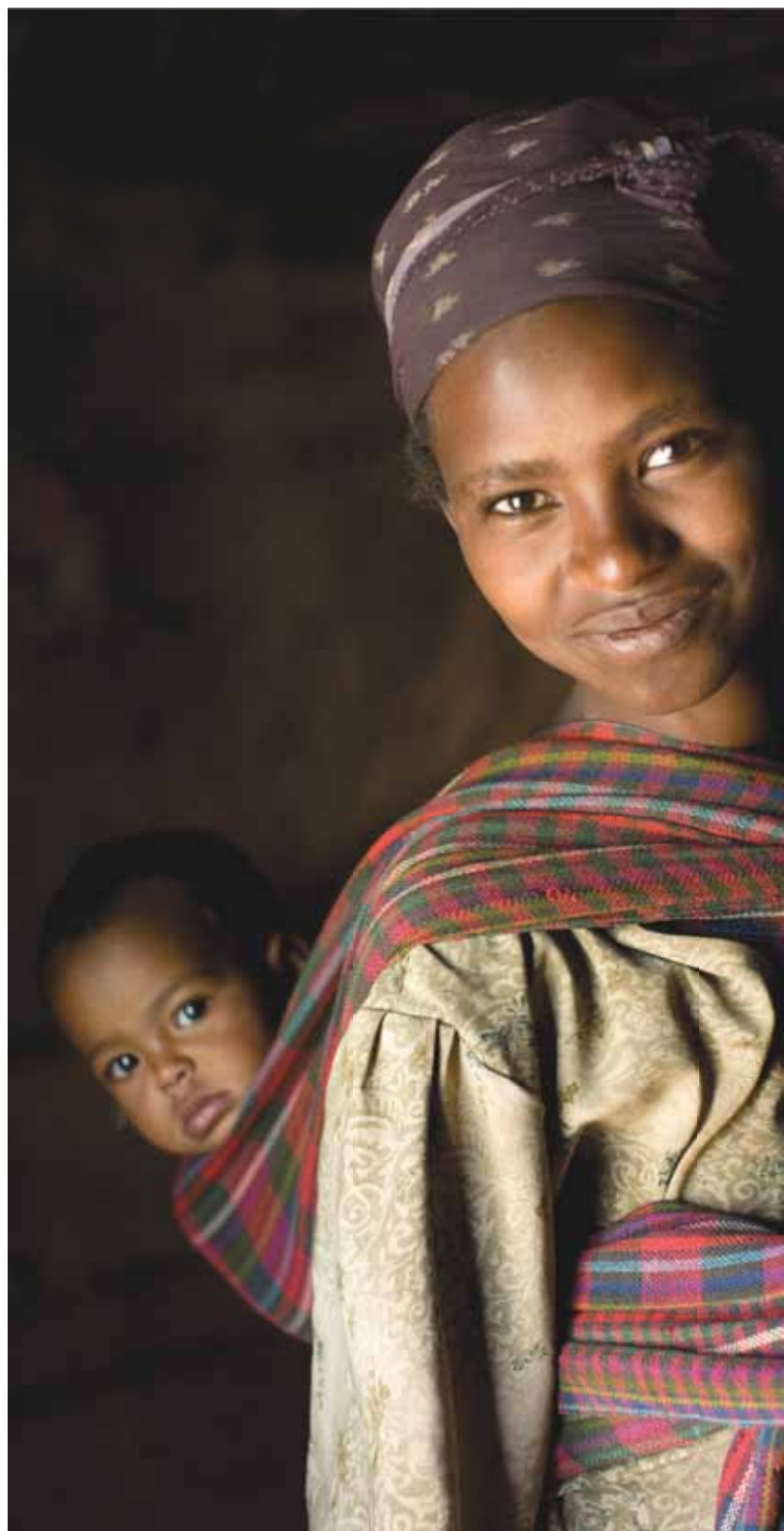
The main objective of the report is to present an introductory analysis of the financial, policy and service-delivery commitments to advance the Global Strategy in order to inform discussion and action on the following topics:

1. Accomplishments of the Global Strategy and the Every Woman, Every Child effort, in terms of the commitments to date;
2. Opportunities and challenges in advancing Global Strategy commitments;
3. Stakeholders' perceptions about the added value of the Global Strategy; and
4. Next steps to strengthen advocacy, action and accountability, taking forward the recommendations of the Commission on Information and Accountability.

At time of writing this report, it has been less than a year since the Global Strategy was launched and the first commitments were made. Relatively little information is available on implementation or impact of these commitments. Nevertheless, the need for action is urgent – 2015 is approaching rapidly. This report aims to generate discussion on what is required in the future to report on the implementation and impact of the commitments.

Scope

The analysis is not a comprehensive stock-taking of all financing, policies and programmes related to reproductive, maternal, newborn and child health (RMNCH). The report recognizes that there are significant ongoing investments and efforts of stakeholders to improve women's and children's health. However, this report analyses commitments



that were specifically made in the context of the Global Strategy. This means, for example, that the analysis of the financial commitments presented in Chapter 4 does not capture the full extent of stakeholders' ongoing investment in women's and children's health, but rather what was specifically committed to the Global Strategy.

Methods

When this report was conceptualized in early 2011, just a few months had passed since the first commitments to the Global Strategy were made in September 2010, and there was limited independent data available in the public domain. After an assessment of possible methods, it was decided to conduct structured interviews with those who had made commitments, guided by a questionnaire (see Annex 2). The questionnaire was peer-reviewed and pilot tested with representatives of the different constituency groups that had made commitments to the Global Strategy.

Questionnaires were sent to the 111 stakeholders who had made commitments to the Global Strategy in September 2010. Seventy-eight (70%) questionnaires were completed; 63 of which were completed through interviews with representatives of all the stakeholders that made commitments, and 15 of which were completed in writing (see Annex 3). The questionnaire and an accompanying guide were sent in advance of the interview. Most interviews were conducted in May-July 2011. The interviews were conducted by phone by a team that was kept intentionally small to support comparability of the collected information. The interviewers received initial training and had technical support and supervision by PMNCH throughout the process.



The interviewers wrote up the questionnaire responses and shared this information with the key informants for review and confirmation. Most respondents agreed that the completed questionnaires could be made publically available on the PMNCH website that contains the report and related documentation and links: www.who.int/pmnch/topics/part_publications/2011_pmnch_report/en/index.html

To supplement each interview, the team consulted additional documentation from respondents and related information in the public domain as available. These included details of the new commitments by 16 low-income countries announced at the World Health Assembly in May 2011, and institutional plans and budgets related to other commitments.

A database was compiled to record the commitments statements and additional information collected during the interviews and document reviews. A content analysis was conducted to produce broad, descriptive statistics that informed the development of each chapter in this report. Qualitative analysis highlighted additional analytical themes and illustrative examples.

A multi-stakeholder Advisory Panel, with expertise on different dimensions of accountability, was established to review the report and to contribute to the development of its recommendations (see Acknowledgements for a list of panel members).

Limitations and lessons learned

The interviews generated rich and diverse information. Many respondents noted that the interview process stimulated reflection on the implementation of, and reporting on, their commitments – and more broadly on accountability for women's and children's health. By the same token, a limitation of the report is that it relies on self-reported information. The analysis of commitments was also somewhat constrained by the fact that there was no commonly agreed format or guidance for making commitments to the Global Strategy in September 2010. That was a deliberate decision in order not to limit potential commitments. However, guidance on the parameters of future commitments to the Global Strategy would be helpful for future assessment of the implementation of commitments.

As noted above, the response rate was 70%. While no respondents declined to complete the questionnaire, the lack of response from the remaining 30% meant that not all questionnaires were completed. The response rate might have increased if options had included a web-based or mailed questionnaire or face-to-face interviews.

Both approaches could be complemented by a phone call to clarify any questions and probe for additional information.

Many of the interviewees said that they are still getting their budgets and programme activities approved, as the commitments were made less than a year before the interview. Detailed and independent analysis of disbursements of commitments was not possible at this early stage, since few stakeholders were able to report on actual or planned disbursements. Financial analysis of the implementation of commitments should become increasingly possible as more information on disbursements becomes available, for example, as donors report to the OECD Development Assistance Committee. However, and as recognized by the Commission on Information and Accountability, it should be noted that the OECD database on development assistance is currently not set up to provide disaggregated data on spending for RMNCH. In addition, not all donors currently report to the OECD.

To inform future reporting and analysis, additional questions and themes could be added to the questionnaire, for example on reasons and process for making a commitment, and priority actions and needs identified in the Global Strategy.

This report is a first step towards unpacking the commitments. While the approach and methods need to be discussed and improved, it is hoped that the report's findings, and the challenges it identifies, will help to inform the accountability process. It should also help identify areas that can be addressed by the independent Expert Review Group set up following the recommendations of the Commission on Information and Accountability.

The next chapter provides an overview of the commitments to the Global Strategy, and presents an initial analysis of the extent to which commitments appear to focus on the low-income and high-burden countries in greatest need of policy support and investment. ■■■■



OVERVIEW OF COMMITMENTS TO ADVANCE THE GLOBAL STRATEGY

Mobilizing global collective action for women's and children's health

The Global Strategy for Women's and Children's Health was developed by a wide range of stakeholders, and emphasizes that all partners have an important role to play to improve the health of women and children. Since the launch of the Global Strategy in September 2010, at the Every Woman, Every Child special event during the MDGs Summit, many partners have made ambitious financing, policy and service-delivery commitments. Governments and policymakers, donor agencies and philanthropic institutions, the United Nations and other multilateral organizations, non-governmental and civil society organizations, the business community, health workers and their professional associations, and academic and research institutions have all made commitments to advance this global effort (see Figure 3.1).

It is of particular importance that countries with the lowest incomes, which bear the highest burden of maternal, newborn and child ill health and deaths, have made the most (39) commitments (see Figure 3.1). These commitments to advance the Global Strategy are important because they build on countries' existing commitments, under international law, to the progressive realization of human rights.

The primary responsibility lies with countries to ensure that all citizens have the right to the highest attainable standard of health. However, progressive realization is an important concept in this context, because "the international code of human rights recognizes that many human rights will be realized progressively and are subject to the availability of resources".³

Even if resources are limited, there is nevertheless an immediate, ongoing obligation to use all appropriate means and maximum available resources, in a non-retrogressive manner, to ensure the realization of rights. This involves applying the appropriate priorities when it comes to resource allocation, domestically and internationally, because 'maximum resources' are defined not only by reference to the state's resources, but also by reference to resources available through international assistance and collective action.⁴



Global collective action is also required to address issues that are beyond the capacities of any single country or partner to address. For example, collective action is needed to share technical knowledge and provide additional resources required for development efforts. It is also necessary to deal with cross-border health emergencies, to combat inequities, discrimination and human rights violations, to address structural and economic barriers to health, and to promote access to global public goods and essential interventions.⁵

The shift towards global collective action in framing and addressing problems is illustrated by the approach chosen by the constituencies of The Partnership for Maternal, Newborn & Child Health (PMNCH) to align and accelerate action on MDGs 4 and 5. Its key constituencies are: governments; multilateral organizations; donors and foundations; NGOs; health-care professional associations; academic, research and training institutes; and the private sector – comprising over 400 members from around the world.

While PMNCH provides a platform on which to align strategies and build on synergies between the many stakeholders, the Global Strategy for Women's and Children's Health has provided 'a clear roadmap' for how to move forward. This unique combination has generated pledges from public and private institutions – including unprecedented total financial commitments – and policy and service-delivery commitments by multiple constituencies. It highlights where action is urgently required to enhance financing, strengthen policy and improve service-delivery, and thus opens the potential for very different types of involvement.

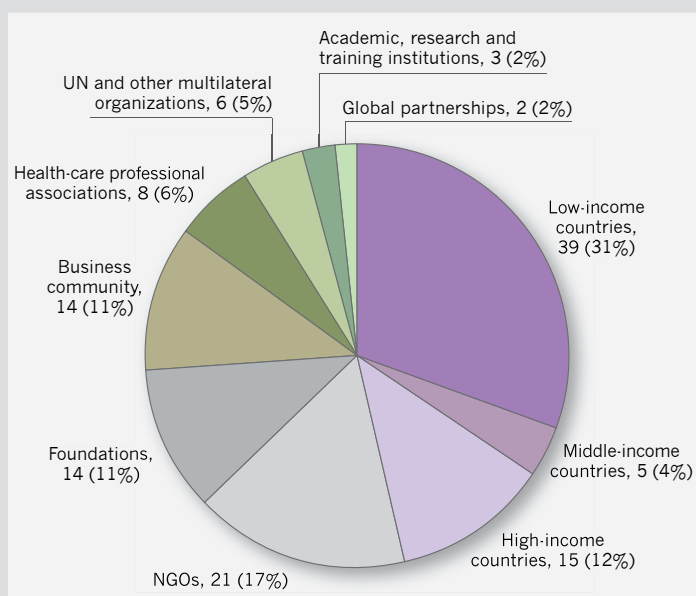
Wide-ranging commitments to strengthen policy, financing and service-delivery

The Global Strategy spells out what is required to accelerate progress to improve women's and children's health, and to achieve the MDGs:

It calls for a bold, coordinated effort, building on what has been achieved so far – locally, nationally, regionally and globally. It calls for all partners to unite and take action – through enhanced financing, strengthened policy and improved service-delivery.⁶

The variety, ambition and innovative nature of the policy, financing and service-delivery commitments are striking. Figure 3.2 summarizes the breadth and scope of these commitments.

FIGURE 3.1: Number of stakeholders, by constituency group, who have made commitments to advance the Global Strategy (total = 127)

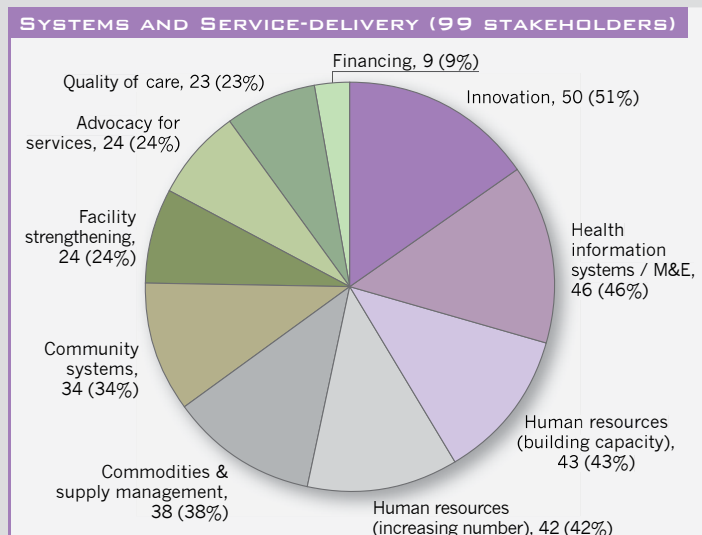
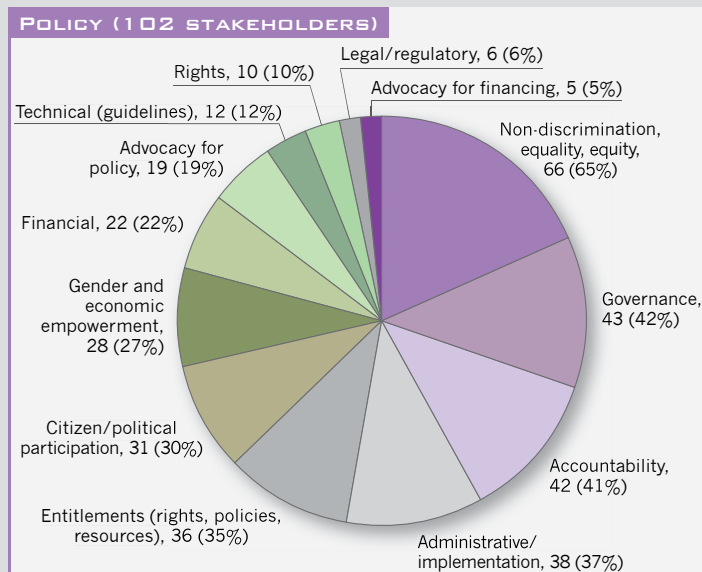


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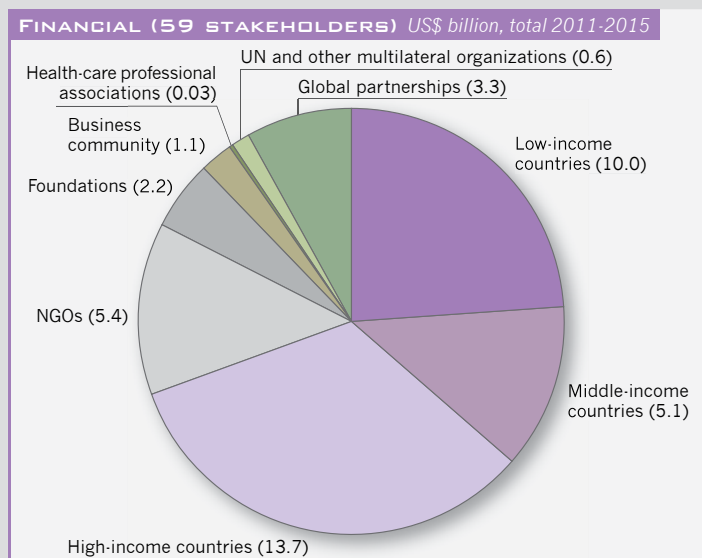
1. Percentages add to 101% due to rounding.
2. In addition to the 93 commitments made in conjunction with the launch of the Global Strategy in September 2010, this report includes an assessment of commitments by additional low-income countries made at the World Health Assembly in May 2011, partner countries of the G8 Muskoka Initiative (joint commitment in Sep 2010), the H4+ agencies UNFPA, UNICEF, WHO, World Bank and UNAIDS (joint commitment in Sept 2010) and the different health-care professional associations (joint commitment in Sep 2010);
3. Income-categories according to World Bank classifications;²
4. Global partnerships refer to the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria.



FIGURE 3.2: Summary of policy, service-delivery and financial commitments



Note: In their commitment statements and interviews, stakeholders often specified more than one area of focus, which is why the percentages indicated in the above two figures add up to more than 100%.



Web Annex 1 sets out the details of all the commitments made to date to advance the Global Strategy:
www.who.int/pmnch/topics/part_publications/2011_pmnch_report/en/index.html

The following discussion illustrates this finding, beginning with the commitments made by governments in developing countries.

These policy, financing and health systems and service-delivery commitments will be examined in further detail in Chapters 4 to 8 of this report. In this chapter, a quick 'snapshot' serves to provide an overarching picture of the nature and variety of the commitments made by multiple stakeholders to advance the Global Strategy.

Many of the low-income governments committed to expanding access to essential health services, with 24 governments explicitly committing to expand access to family planning, and 18 to expanding access to skilled birth attendance (some committed to both). Twenty-three governments made commitments to reduce financial barriers to health-care. Nine countries made some form of specific commitment with respect to expanding and/or strengthening the health workforce. Mongolia included in its commitment a policy to increase the salaries of obstetricians, gynaecologists and paediatricians by 50%. Some governments made service commitments targeted at specific groups: Vietnam included in its commitment that it would increase the percentage of people with disabilities who had access to reproductive health-care services from 20% to 50%.

This breadth of variety, ambition and innovation is also clearly present in the commitments made by the other stakeholder groups. The following examples among the many that could be chosen are illustrative of the range of commitments made to advance the Global Strategy. BRAC, the Bangladesh-based NGO, committed to support community-level RMNCH interventions in other countries, including Afghanistan, Haiti, Liberia, Pakistan, Sierra Leone, Southern Sudan, Tanzania and Uganda. The White Ribbon Alliance for Safe Motherhood, Family Care International, and International Budget Partnership included in their commitments that they would focus on ensuring accountability, including of governments and donors, for commitments made.

It needs to be understood that many of these activities were being planned, or were already in operation, prior to the launch of the Global Strategy. However, what is valuable is that they have since been brought under the umbrella of the Global Strategy, where commitments are clearer and more public, and therefore more accountable.

Strategic alignment of commitments to priority needs

Every commitment to advance the Global Strategy is important and embodies the spirit of global collective action. However, it is also important to assess whether the commitments are targeted strategically and to the areas of greatest need, as prioritized in the Global Strategy. It is critical to ensure that interventions are targeted to reach those women and children in greatest need, so that the poorest and most vulnerable do not miss out. The Global Strategy focuses on the 49 low-income countries where the burden of maternal and child deaths is the highest, and the financing, policy and service-delivery needs are most acute.

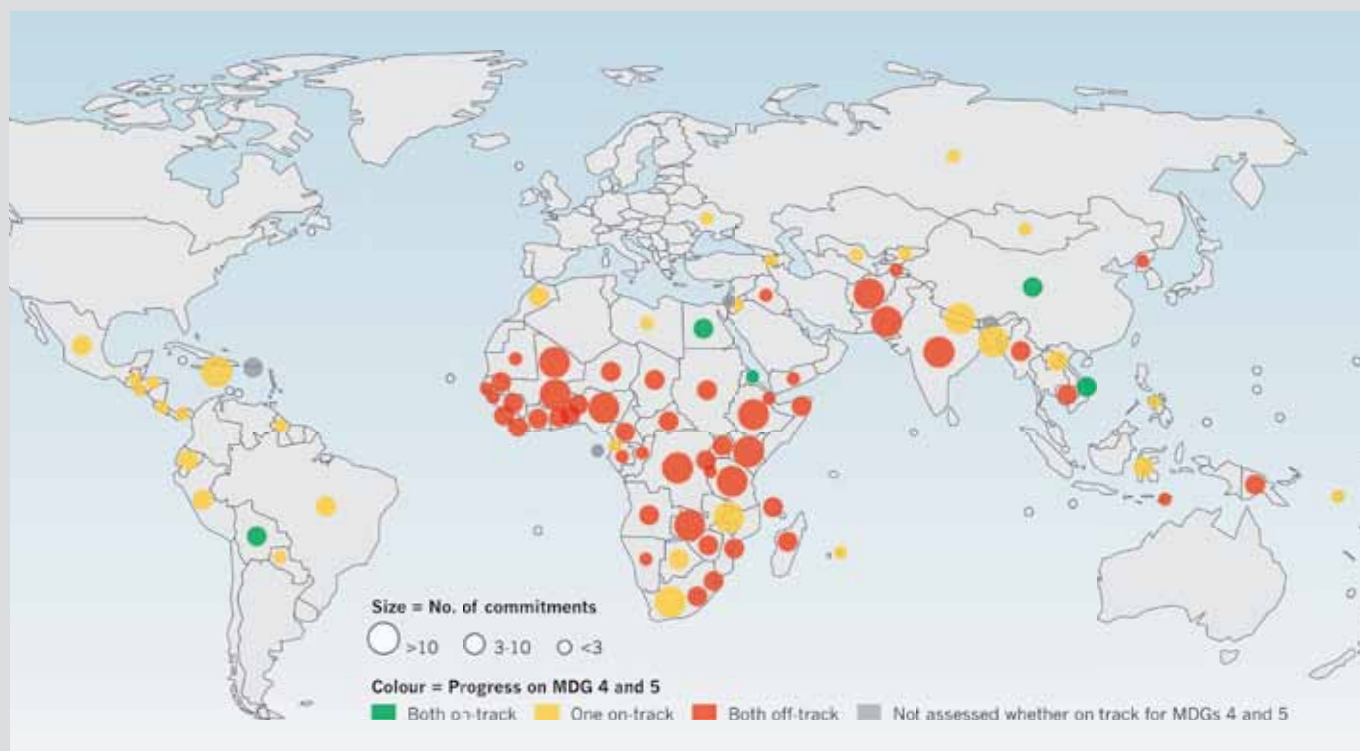
Annex 4 sets out the number of commitments made to countries through the Global Strategy; their main causes and rates of maternal and child mortality; maps related to progress on MDG 4 to reduce child mortality and MDG 5a to reduce maternal mortality; and their child nutrition status. Figure 3.3 synthesizes the level of alignment of Global Strategy commitments to need in 49 low-income and middle-income countries by linking the number of commitments with information on whether or not these countries are 'on track' to

achieve MDGs 4 to reduce under-five mortality by two thirds by 2015 and 5a to reduce the maternal mortality by three quarters by 2015.

The different sizes of circles in Figure 3.3 represent the relative number of commitments, while the colour of the circle indicates the degree of progress towards MDGs 4 and 5a. It should be emphasized that the figure is based on a count of commitments and does not provide information on the scope and content of the commitments. However, it shows that some countries in particular (for example, the small red circles) are in need of additional support and commitments.

The distribution of commitments varies widely between countries (see Annex 4). India received the largest number of specific references (24). This is understandable given that India alone contributes over 20% of all deaths among the under-fives, and accounts for more maternal deaths (63 000) than any other country in the world. On the other hand, India is a middle-income country and has significantly increased its own support for women's and children's health in recent years. Fifteen countries attracted more than 10 commitments, including Nigeria (22), Kenya (18), Ethiopia (17) and Bangladesh (16).

FIGURE 3.3: Geographical distribution of commitments to advance the Global Strategy with respect to progress on MDGs 4 and 5a in low- and middle-income countries



Thirteen (27%) of the 49 low-income countries that are the focus of the Global Strategy received fewer than three commitments (Annex 4). Eight (16%) of the 49 low-income high-burden countries, including Congo, Gambia, Uzbekistan and Yemen attracted just one commitment. Korea PDR attracted no commitments.

Special consideration may need to be given to the best ways of engaging with fragile and post-conflict countries, which typically have high mortality, poor infrastructure, weak governance and poor service-delivery. The UK and Australia demonstrate particular interest in, and experience of, engaging with such countries. With the exception of support through France's commitment to the Global Strategy, there appears to be relatively little support for some Francophone countries in Africa. Burundi was the focus of only two commitments, while the Central African Republic and Togo were the focus of only three.

Conclusion

An overall conclusion of this chapter is that the Global Strategy has been a catalyst for more focused efforts for women's and children's health. Stakeholders demonstrated strong commitment to mobilizing around the issues of the health and survival of women, newborns and children. By bringing previously made commitments under the 'umbrella' of the Global Strategy, stakeholders committed themselves to a global, and public, level of accountability that otherwise would not necessarily exist.

Respondents to the interview process frequently said the Global Strategy had provided an additional focus and source of momentum for their efforts. Several respondents said the Global Strategy alerted them to others working in the same field that they had not hitherto been aware of, and to the opportunities for new partnerships. Some said it had helped elevate, and then institutionalize, their financial and other commitments with the political leadership of their country or their institution. Those making commitments either implicitly or explicitly endorsed the RMNCH continuum of care, and key interventions within that continuum defined in the Global Strategy.

It has become apparent that improving the health of women and children is a health challenge that (like many others) cannot be resolved by the health sector and health organizations alone. Rather, it needs to become part of a much larger intersectoral and political agenda. It has also become obvious that wanting to 'do good' is no longer sufficient. Accountable global action requires a lucid and transparent strategic intent and an excellent evidence base from which to plan interventions. Above all, it requires structures and mechanisms that enable collaboration, facilitate the continuous exchange of knowledge and expertise, and ensure accountability. ■■■■

“The Global Strategy has served as an internal instrument for raising awareness of the work we do to support women's and children's health and for mobilizing political commitment from the leadership of our organization.”

– Media respondent, PMNCH 2011 Report



CHAPTER 4

COMMITMENTS TO SUPPORT COUNTRY-LED HEALTH PLANS AND FINANCING

Country-led health plans

The previous chapter identified opportunities for strengthening alignment and targeting of investments to reach women and children with essential services and an integrated package of interventions. The Global Strategy emphasizes the critical role of country-led health plans as a basis for strengthening alignment and coordination of the efforts by all stakeholders:

The Global Strategy builds on country-led health plans. Partners must support existing, costed national health plans to improve access to services. Such plans cover human resources, financing, and delivery and monitoring of an integrated package of interventions.⁷

The interviews informing this report yielded information on how some countries and partners are taking action to strengthen planning, coordination and alignment of funding and programmes. They also highlighted the need to gather better information on whether support is provided through national budgets or other mechanisms. For example, Cambodia has an inter-agency Task Force, headed by a senior official within the Ministry of Health, which is specifically responsible for providing a roadmap and coordinating inputs to maternal and child-health initiatives. The Ministry of Health in Nigeria has established a Core Technical Committee, which meets regularly to coordinate partners' support to women's and children's health. Other mechanisms that support coordination in countries include IHP+ compacts and the H4+, which coordinates support to countries by UNFPA, UNICEF, WHO, World Bank and UNAIDS.

Some interviewees called for clearer guidance on where and how stakeholders could engage and coordinate their efforts to support the implementation of national health plans. For example, health-care professional associations explained that they would like to contribute to the design and implementation of national plans. Academic institutions suggested that they could play more of a role in monitoring and evaluation of the implementation of national health plans.



The interview process found that particular challenges were faced by those countries that operated decentralized health systems. Even if there was leadership and a roadmap for implementing the Global Strategy at the national level, it was not always clear how this then linked through to the provincial and district levels.

The implementation of national health plans and delivery of essential services and interventions depends partly on the availability and use of financial resources. This is discussed in the remaining part of this chapter.

More money for health

The Global Strategy recognizes that increased and sustained investment in health systems is needed to deliver basic services and essential interventions to women and children, where they need them and when they need them. A lack of financial resources severely constrains the capacity of countries to reach MDGs 4 and 5 and improve women's and children's health. This was confirmed in all interviews with officials from low-income countries. Building on the work of the Taskforce on Innovative International Financing for Health Systems⁸, the Global Strategy estimated that the total additional funding required in 2011-2015 in

49 low-income, high-burden countries to substantially improve access to essential interventions is US\$88 billion, which consists of the direct and the health systems costs of programmes targeting women and children (Figure 4.1).

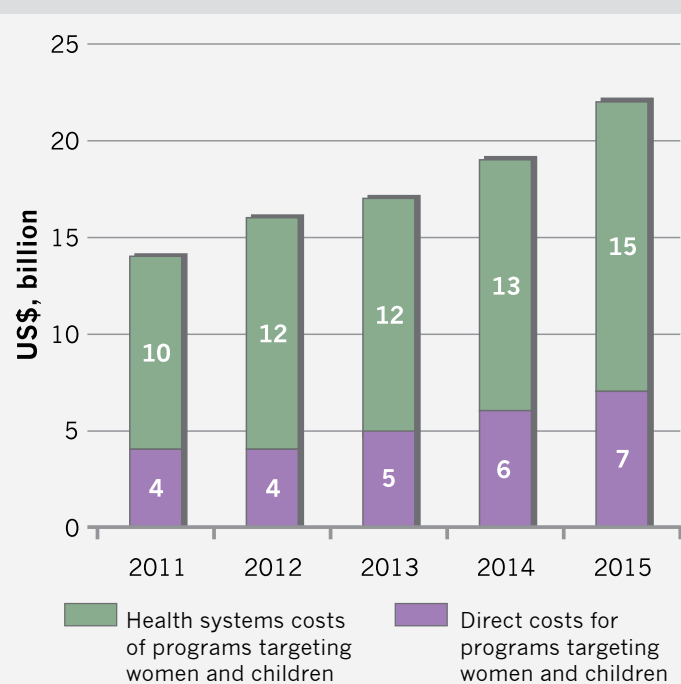
Commitments to advancing the Global Strategy can make a large difference in narrowing the financing gap for women's and children's health. At the launch of the Global Strategy in September 2010, unprecedented financial commitments of US\$40 billion were announced. However, it should be emphasized that the many substantial policy and service-delivery commitments made in September 2010 were not monetized – the US\$40 billion figure therefore significantly underestimated the total financial value of all the commitments to advancing the Global Strategy.

Financial commitments included both existing and new activities and resources that were brought under the Global Strategy's umbrella at its launch in September 2010. Making these resources and activities public has been extremely valuable in identifying gaps, catalysing collective action, tracking global progress and promoting mutual accountability. As noted in Chapter 2, it should be emphasized that there are significant ongoing investments and efforts of stakeholders to improve women's and children's health that may not be reflected in the commitments to the Global Strategy. For example, it was estimated that in 2008 between US\$ 3.2-5.4 billion of international development assistance for health benefitted maternal, newborn and child health.^{9, 10}

However, it did make the process of estimating financial commitments more complex, and led to some double-counting due to external financial support that could legitimately be claimed by both the source and recipient of the funds. After eliminating some instances of double-counting and making other adjustments based on the completed questionnaires and review of supporting documentation, this report estimates that about US\$41.4 billion has been committed to advancing the Global Strategy. Figure 3.2 in Chapter 3 provides a breakdown of the US\$41.4 billion figure by constituency group.

Web-Annex 1 on the PMNCH web site (www.who.int/pmnch/topics/part_publications/2011_pmnch_report/en/index.html) contains a list of all – financial, policy, service-delivery and advocacy – commitments made to advance the Global Strategy, as well as explanations of any adjusted estimates of the financial commitments.

FIGURE 4.1: Estimated annual funding gap for women's and children's health in 49 low-income, high-burden countries (2011-2015): US\$88 billion



Source: Global Strategy for Women's and Children's Health (2010)



The picture will become clearer in the coming months as countries and institutions disburse their financial commitments. As emphasized throughout this report, the monetary value of the substantial policy commitments (e.g. abolishing user fees) and systems and service-delivery commitments (e.g. training additional health workers and expanding and refurbishing health clinics) is not yet determined and, more importantly, the impact of these policies on saving lives and reducing mortality needs to be ascertained.

As discussed in Chapter 3, commitments included ongoing activities and investments as well as new activities and investments specifically targeting the funding gap identified in the Global Strategy. Determining the extent to which the different financial commitments address this funding gap is a complex exercise and methods and assumptions vary between different stakeholders.

For example, the G8 members of the Muskoka Initiative equated new and additional funding with MNCH-related investments above baseline spending of 2008. This assessment resulted in a financial commitment of US\$5 billion of new and additional funding from the G8 members for the Muskoka Initiative (see Web-Annex 1).

To estimate the new and additional funding committed by 10 low-income countries in September 2010, and by six low-income countries at the World Health Assembly in May 2011, different methods and assumptions were used as described below:

1. Unless otherwise specified, and following the method used by Countdown to 2015, it was

assumed that 25% of government health spending will benefit RMNCH. Where a specific proportion was specified in the commitment, this figure was used instead; for example, 30% for the Central African Republic.

2. Based on trends of annual government health spending in 2006-2009, total government health spending on RMNCH in US\$ in 2011-2015, if the commitment to the Global Strategy had not been made, was estimated ("X" – purple area in Figure 4.2). This means that spending would increase at the current rate until 2015.
3. Total government health spending on RMNCH in 2011-2015, if spending would increase to meet the government health spending target in the Global Strategy commitment, was estimated (both X-purple and Y-green areas in Figure 4.2). Unless another target year was specified in the commitment, a linear rate of increase in government health spending until 2015 was assumed.
4. The total additional government health spending on RMNCH in 2011-2015 ("Y", green area in Figure 4.2) is the estimated value of governments' financial commitments.

This process resulted in a figure of US\$10 billion as new and additional from the 16 low-income countries' financial commitments. While some of the US\$10 billion would need to be financed from external sources, it is clear that the Global Strategy has catalysed important commitments. If they are met, a substantial amount of increased resources will be channelled to women's and children's health in low-income, high-burden countries. Again, it should be emphasized that

the US\$10 billion figure only includes commitments that were expressed in financial terms, and does not include the financial value of the substantial policy and service-delivery commitments made by low-income countries.

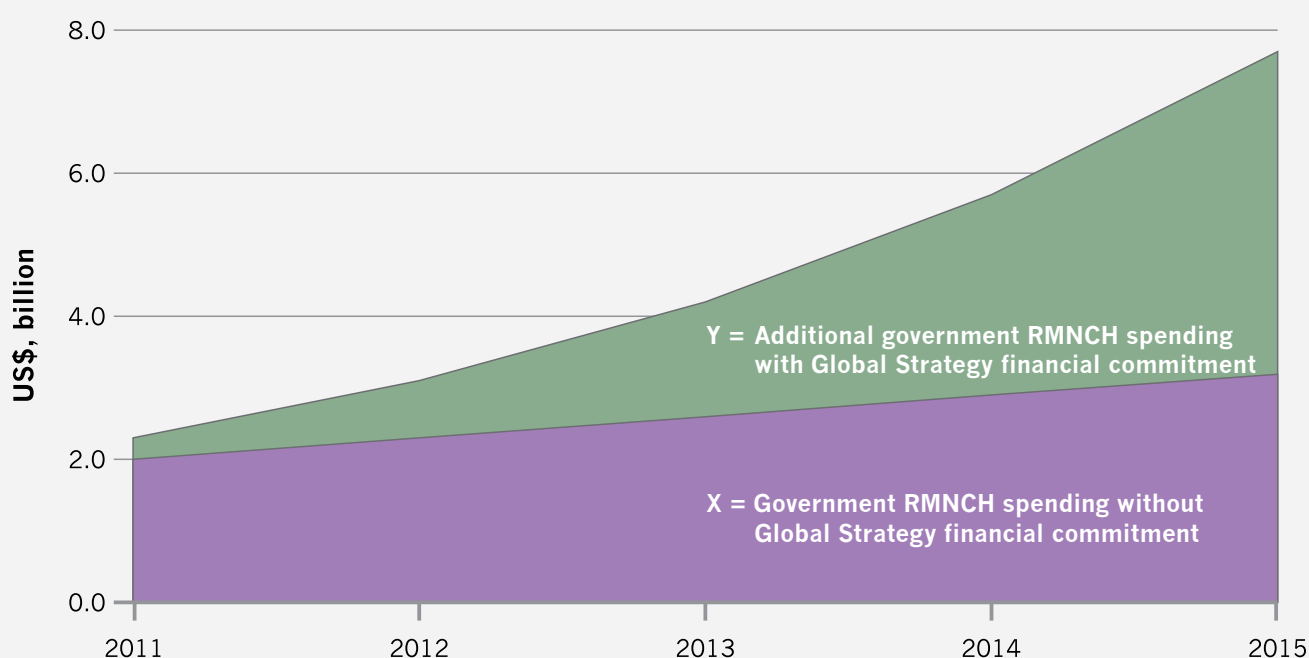
Similar processes would need to be undertaken to determine new and additional funding from other stakeholders' financial commitments. This is beyond the scope of this report, but is something that is within the mandate of the independent Expert Review Group to address in collaboration with other expert groups, such as the OECD, as follow-up to the Commission on Information and Accountability. This would require disaggregated data on RMNCH expenditures from domestic and external resources, and related efforts are underway.

With few exceptions, it is difficult to say with any certainty how much of the US\$41.4 billion has been spent or disbursed. The interview process identified progress in the implementation of commitments made by several stakeholders. However, most respondents stated that it is too early to provide figures on expenditures or plans for disbursements. For example, five of the 10 bilateral donors interviewed provided information on expenditures or plans for disbursements.

The most common constraint to implementation that emerged through the interview process was lack of available financing. While it is clear that the Global Strategy is not a new global financing mechanism for MDGs 4 and 5, many of those interviewed called for guidance on how to access funding committed to advancing the Global Strategy. An important recommendation of the Commission on Information and Accountability is that stakeholders should have the ability to publicly share "information on commitments, resources provided and results achieved annually, at both national and international levels".¹¹

The calculations referred to above are limited to commitments that included explicit financial figures (less than half of all commitments) and do not include the financial value of many of the substantial policy and service-delivery commitments made, for example, by low-income countries and United Nations organizations. The remaining institutions that made a policy, service-delivery or advocacy commitment to advancing the Global Strategy did not make any explicit references to financial amounts. Yet many of those commitments – including abolition of user fees, building new or rehabilitating existing health facilities, or expanding access to family planning and skilled birth attendance – clearly have

FIGURE 4.2: Government health spending on reproductive, maternal, newborn and child health in 16 low-income countries with and without financial commitments to the Global Strategy, 2011-2015



substantial financial implications. As just one example among many, Bangladesh stated as part of its commitment that it would “double the percentage of births attended by a health worker by 2015 through training an additional 3000 midwives, staffing all 427 sub-district health centres to provide round-the-clock midwifery services, and upgrading all 59 district hospitals and 70 Mother and Child Welfare Centres as centres of excellence for emergency obstetric care services”.¹²

It is beyond the scope of this report to estimate the monetary value of the many commitments to policy, service-delivery and advocacy, especially due to incomplete cost data. Further, it is difficult to monetize the value of a change in policy from a developing country, such as prioritizing RMNCH programmes. Nevertheless, an example from one country offers an order of magnitude of possible costs for scaling up policy and service-delivery in specific circumstances.

Niger was able to provide a costed breakdown of some of the components in its commitment. Its commitment to create 2120 new contraception distribution sites will cost around US\$157 500, while its commitment to equip 2700 health centres to support reproductive health and HIV/AIDS education will cost US\$1.2 million. Its plan to improve female literacy from 28.9% in 2002 to 88% in 2013 will cost a further US\$6.4 million. While this provides an illustration of monetization, it should be emphasized that cost estimates of this nature are best made within the context of country planning and budgeting processes.

More health for the money

While mobilizing additional funding is critical, there are opportunities to improve the use of existing resources. The Global Strategy recognizes this by emphasizing not only the need for more money for health, but also the need to get more health for the money by using existing and future resources more efficiently. Country-led health plans are very important in this context as well, as they should be a fundamental tool to help inform prioritization and allocation of scarce resources. The interview process revealed that some stakeholders are contributing to prioritization by supporting an ‘investment case’ approach to strengthening planning and budgeting to implement national health plans and service and interventions for women and children. This approach identifies key gaps and barriers on the demand and supply side of essential care, as well as the ‘best buys’ for governments and their development partners.^{13, 14} Efficiency can also be increased by national coordination mechanisms, such as those in Cambodia and Nigeria mentioned above, supported by the principles of the Paris Declaration of Aid Effectiveness and the Accra Agenda for Action.¹⁵

There are other ways to increase efficiency. For example, by maximizing the impact of investment by integrating efforts across diseases and sectors, by using innovative approaches to delivering cost-effective interventions and services, and by making financing channels more effective. The role of innovation in increasing the efficiency of investments is discussed in Chapter 6, while the role of integration in increasing value for money is discussed in the next chapter on health systems and service-delivery. ■■■■



“Inadequate funding has been the main limitation to expand services rapidly. Inadequate funding also limits incentives to health workers for their retention in the remote and rural areas.”

– Government respondent, PMNCH 2011 Report

COMMITMENTS MADE TO PROMOTE ESSENTIAL INTERVENTIONS, STRENGTHEN SYSTEMS, AND IMPROVE INTEGRATION ACROSS THE MDGs



More than 80% of stakeholders, in their commitments to advance the Global Strategy, focused on improving the coverage of interventions in relation to the reproductive, maternal, newborn and child health (RMNCH) continuum of care (Figure 5.1): from adolescence and pre-pregnancy through to birth, infancy and then to childhood.

Thirty-nine stakeholders also refer in their commitments to improving women's health more generally. The phrase 'women's health' usually applies to all women, and encompasses not only an absence of illness but also complete physical, mental and social wellbeing. The primary objective of the Global Strategy is to accelerate progress towards MDGs 4 and 5 – to reduce child and maternal mortality and to ensure universal access to reproductive health. In this context, a specific focus of stakeholders' commitments is on those women who face particular risks related to reproductive health, pregnancy and childbirth. Nonetheless, it is well recognized that improving and sustaining health and development requires addressing structural barriers and social determinants. Thus, some stakeholders explicitly address the need for a holistic focus on women's health, gender equality and empowerment, which are not only essential for health and development, but are also fundamental human rights.

Addressing coverage gaps for essential RMNCH interventions

As emphasized in the Global Strategy, and documented by the Countdown to 2015, there are evidence-based, cost-effective interventions that can save women's and children's lives. There are, however, significant gaps in the coverage of these interventions (see Figure 5.2).

Particular gaps include having skilled birth attendants, providing postnatal care for mothers and newborns, and specific interventions for the management of childhood illnesses, such as treatment for diarrhoea and pneumonia. Figure 5.2 summarizes the commitments with respect to the coverage gaps in key interventions across the RMNCH continuum of care.

FIGURE 5.1: The RMNCH continuum of care



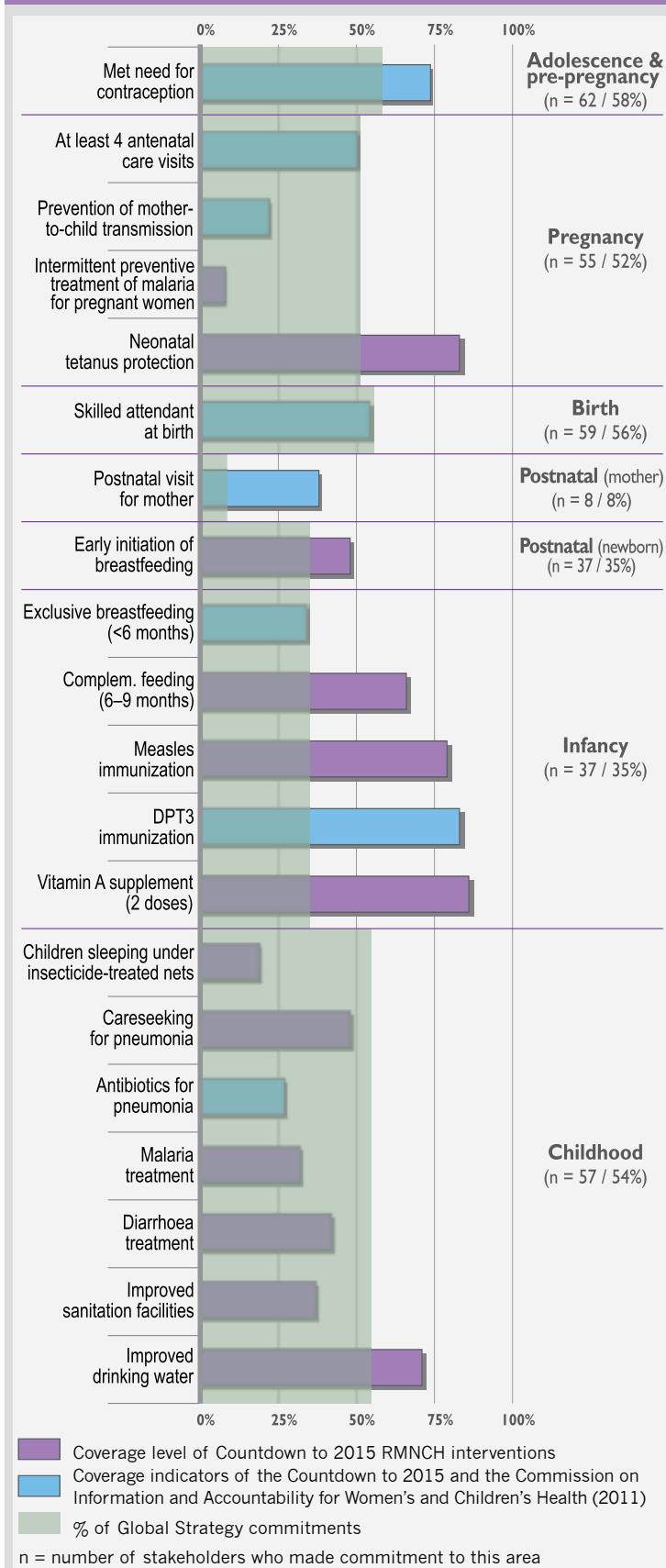
This analysis is largely descriptive and based on a content analysis of the commitments. It does not take into account the projected increase in coverage as a result of the commitments, nor does it necessarily correlate well with the financial gaps needed to scale up coverage of essential RMNCH interventions. Many stakeholders may, for example, refer to comprehensive emergency obstetric care in their commitment, but this may not necessarily be accompanied by the required investments, financial or otherwise. However, with such significant caveats in mind, it is possible to see the areas of focus for the commitments to date to the Global Strategy.

There appears to be a concentration of commitments around certain interventions. For example, reproductive health is specifically referred to by 25 governments, eight donors, seven foundations, two multilateral agencies, 12 NGOs, two stakeholders from the business community, two health-care professional associations and two academic institutions. Some of the commitments around reproductive health are particularly ambitious. Afghanistan's included the goal of increasing contraception use from 15% to 60%, and Bangladesh will halve the unmet need for family planning. There is also concentration of references around increasing skilled birth attendance: 18 governments explicitly referred to this intervention in their commitments or subsequent interviews. Again, there are ambitious commitments, with Ethiopia committing to increase the proportion of births attended by skilled birth attendants from 18% to 60%.

All constituency groups included in their commitments interventions for infants and children, with 37 specific references to infancy and 57 to childhood. Some countries (Afghanistan, Bangladesh, Kyrgyzstan, Mali, Nepal) specifically referred to the Integrated Management of Childhood Illness programme (IMCI).

However, gaps remain with respect to commitments to other parts of the continuum of care. There were only three specific references to postnatal care for mothers. There also seems to be a relatively limited focus on breastfeeding. Only seven references to exclusive breastfeeding were made in the commitments or in follow-up interviews. There were also relatively few references to nutrition-related interventions. This is somewhat surprising bearing in mind the strategic and high-impact value of proven interventions. Under-nutrition is an underlying cause of one third of child deaths, and maternal nutritional status is increasingly recognized as an underlying determinant of not just newborn health but also subsequent adult health.

FIGURE 5.2: Commitments related to the mean coverage of essential RMNCH interventions in Countdown to 2015 countries (106 stakeholders)



Adapted from: Countdown to 2015 (2010), Guttmacher Institute and IPPF (2010)



Strengthening health systems and improving quality of care

Strong health systems, with sufficient skilled health workers, are a core component of the Global Strategy. In Chapter 3, the range of commitments related to strengthening health systems and improving quality of care is depicted in Figure 3.2. The following discussion broadly highlights commitments made to key building blocks of health system strengthening – health workers, health financing, facilities and drugs, information systems and planning.

To address the worldwide shortage of 2.5-3.5 million health workers identified in the Global Strategy, almost half of the commitments focused on increasing the numbers, and strengthening the capacities, of health workers in general, and skilled birth attendants and midwives in particular (Figure 5.3).

The State of the World Midwifery Report, launched in June 2011, identified a shortage of some 350 000 skilled midwives in 58 developing countries.¹⁶ Sixteen countries in their Global Strategy commitments specifically referred to increasing the number of midwives/skilled birth attendants. As Table 5.1 shows, if those countries met their commitments, there would be an additional 24 000 midwives/skilled birth attendants by 2015.

FIGURE 5.3: Strengthening human resources for health

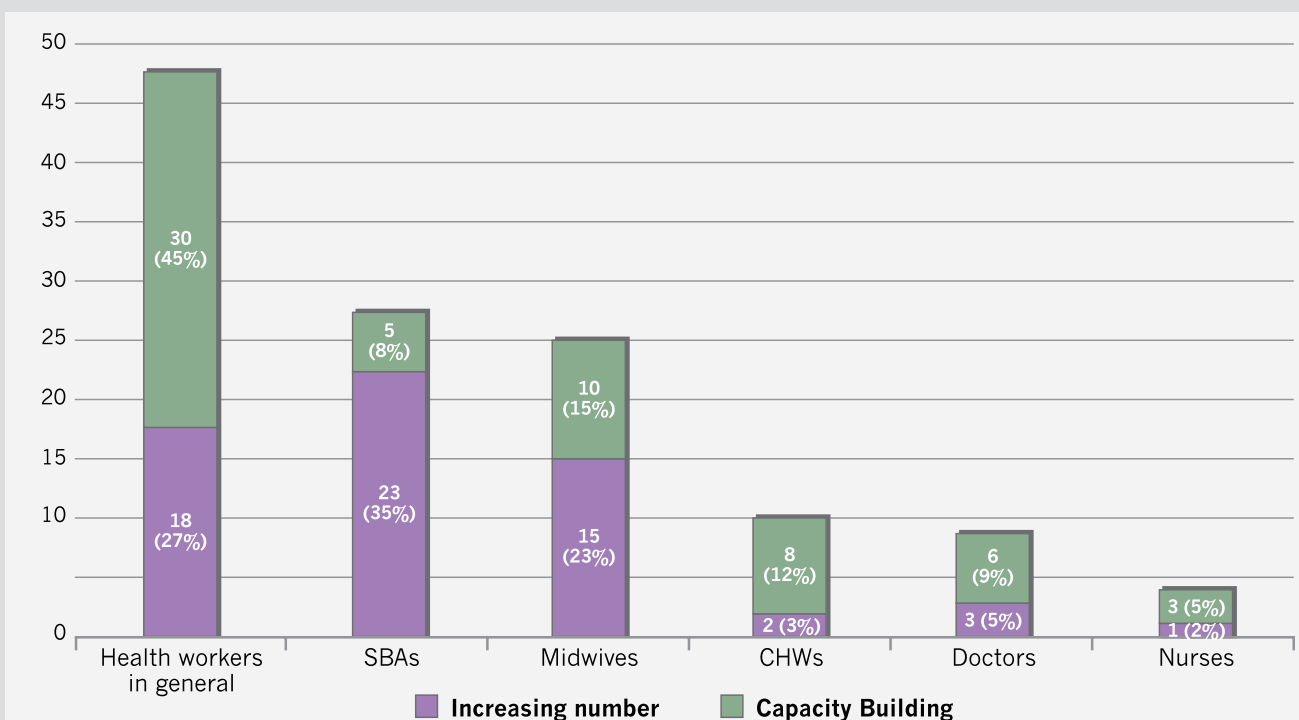


TABLE 5.1: Commitments to increase the number of midwives/skilled birth attendants and other health workers

COUNTRY	INCREASE IN NUMBER OF MIDWIVES / SKILLED BIRTH ATTENDANTS	INCREASE IN NUMBER OF OTHER HEALTH WORKERS
Afghanistan	2 156 midwives	
Bangladesh	3 000 midwives	
Burundi*	211 midwives	
Chad*	160 midwives	
Ethiopia	6 585 midwives	
Kenya		20 000 primary-care health workers
Lao PDR*	1 500 midwives	
Liberia	Double the number of midwives trained and deployed than were in the health sector in 2006	
Myanmar*	Improve ratio of midwives to population from 1/5000 to 1/4000	
Nepal	10 000 skilled birth attendants	
Niger		1 000 providers to handle adolescent reproductive health issues, and to address domestic violence and female genital mutilation
Nigeria		Unspecified increase in number of providers of core services
Papua New Guinea*	500 midwives	23 obstetricians
Rwanda	5 times more midwives	
Senegal*	Increase recruitment of midwives and nurses	
Tanzania		Increase annual enrolment in health training institutions from 5 000 to 10 000 and graduate output from 3 000 to 7 000
<i>Sub-total</i>	<i>24 112 skilled birth attendants</i>	<i>21 023 other health workers</i>
TOTAL		45 135 HEALTH WORKERS

* Commitments made at the World Health Assembly in May 2011 (all others made at the launch of the Global Strategy in September 2010)

Skilled birth attendance is one intervention that can have a high impact on reducing maternal and neonatal mortality and morbidity. It can also help to prevent stillbirths, which affect at least 2.6 million families every year.^{17, 18}

There were also references in the commitments to reforms of health-systems financing – another key ‘building block’ of a well-functioning health system. Twenty-three countries made commitments to abolish user fees or provide some new form of income protection for targeted, poorer and vulnerable groups – especially women and children.

Several stakeholders made commitments to improving health facilities, and some in very specific ways. For example, Rwanda committed to providing 100% coverage of water and electricity to health facilities.

Commitments were also made to improve medical equipment and commodities and supply management. The United States is also developing tools that are simpler, more cost-effective and easily deployable, such as a device to address asphyxia that was rolled out in 30 countries as a result of a public-private partnership. John Snow, Inc. (JSI) – through the HAND to HAND Campaign – aims to “support the availability of contraceptives in low-income countries through the provision of supply chain management, technical assistance and training for national, regional, and global programs; to [collect] accurate, timely information about the status of supplies, programme requirements, and supply chain operations in over 20 countries, and [share] that information widely with stakeholders to raise awareness and improve decision-making”.

The Global Strategy emphasizes the importance of quality care to improving women's and children's health, and urges partners to support efforts to strengthen health systems to deliver integrated, high-quality services. Twenty-three stakeholders focused specifically on support to improve quality of care. For example, the health-care professional associations of PMNCH committed to working with policy and implementing agencies to improve quality and to extend coverage of the key 22 Countdown-supported interventions in 25 high-burden countries across Africa, Asia and Latin America. Family Health International committed to focus on the quality assurance of contraceptive commodities and improve the safe use of contraceptive methods.

Strengthening community systems

Communities play a critical role in providing health-care, facilitating access to health services, promoting citizen participation and empowerment, advocating for essential interventions and addressing structural barriers for health.¹⁹ Taken together, the Global Strategy commitments that directly addressed community systems span the spectrum of functions community systems can play. For example, Afghanistan committed to strengthening community outreach and establishing mobile health teams and local health facilities to improve access to health services. World Vision committed to a primary focus on empowering communities to raise their voices about their right to quality health-care and to hold their

governments accountable for delivery. It also committed to working with empowered communities to advocate for more effective responses to RMNCH at the local, provincial and national levels. The Global Alliance to Prevent Prematurity and Stillbirth committed to work collaboratively with the local community to develop innovative approaches to engagement in research.

A few Global Strategy commitments directly addressed strengthening community systems, and nearly 25 stakeholders referenced activities that were relevant to it. For example, the Women's Funding Network committed to providing "investments and grants in women-led solutions that address health and wellness as a part of a holistic approach to fostering communities, countries and nations that thrive." This commitment emphasises the importance of women and their networks investing in their own health, and not just waiting to be beneficiaries and recipients of programmes. Commitments from foundations, such as The Bill & Melinda Gates Foundation, Grand Challenges Canada, and the David and Lucile Packard Foundation, discussed efforts aimed at generating demand for health services. Noting the recent shift towards prioritizing demand-side generation as well as the supply-side, the David and Lucile Packard Foundation commented that, "On the service-delivery side, what is different in our new strategy for this period is the shift from focusing most of our funding on the supply-side of family planning and reproductive health to prioritizing funding to demand-side generation".



While there is an increasing recognition of the importance of demand for high quality health services, the 'supply side' of service-delivery has received more attention and emphasis from Global Strategy stakeholders to date.

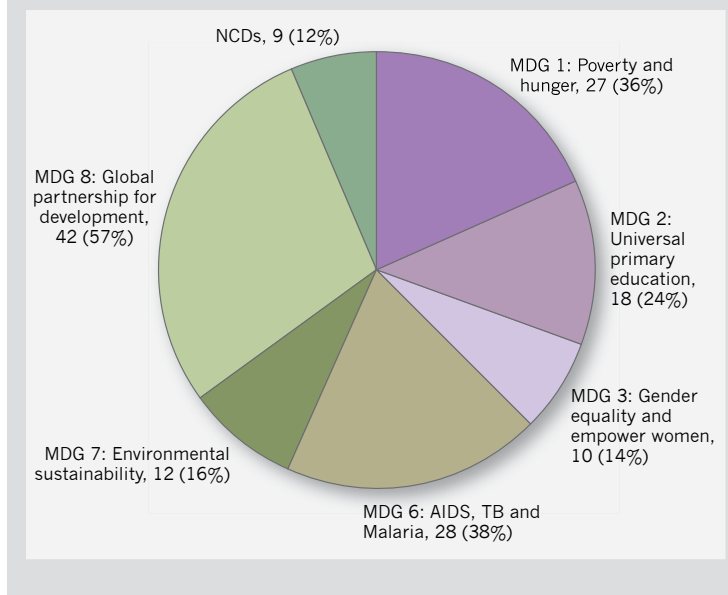
Improving integration across the MDGs

The Global Strategy recognizes that the health of women and children depends on progress made towards achieving all the other MDGs, and that the other MDGs depend on progress made towards improving women's and children's health. As such, an integrated approach to achieving the MDGs is a critical component of the Global Strategy. Several stakeholders recognized the importance of strengthening these linkages across the MDGs and made related commitments (see Figure 5.4). The strongest areas of focus for MDGs-related commitments to the Global Strategy are MDG 8 (developing global partnerships), MDG 1 (eradicating extreme poverty and hunger) and MDG 6 (combating AIDS, malaria and other diseases).

Recognizing the clear links between the 'health MDGs' – MDGs 4, 5 and 6 – many stakeholders made explicit links in their commitments to reduce the burden of AIDS, tuberculosis and malaria. These commitments concentrated around prevention of mother-to-child transmission (PMTCT), with 12 governments referring to this intervention. Burundi committed to increasing PMTCT service coverage from 15% in 2010 to 85% by 2015; Chad committed to increasing coverage from 7% to 80%; Myanmar to reaching 80%; and Vietnam to increasing coverage from 20% to 50%. UNAIDS noted in its commitment, and its follow-up interview, that it also supports the "Global Plan to eliminate new HIV infections among children by 2015 and to keep their mothers alive".²⁰ Investment needs for this AIDS-related Global Plan are US\$5 billion between now and 2015.

The business community was particularly active in explicitly linking its commitments to women's and children's health to MDG 6 and other health-related issues. Merck, for example, commits an estimated US\$840 million over the next five years through its HIV prevention and treatment, childhood asthma programmes, and donations of HPV vaccines. Overall, the business community committed an estimated US\$1 billion to expand access to free or subsidized drugs, treatment and screening. This addresses the needs of women and children for interventions such as deworming, PMTCT of HIV and AIDS, infant immunization, extending vaccinations for

FIGURE 5.4: Integrative commitments across the MDGs (74 stakeholders)



human papilloma virus, and research to develop a new drug for treating tuberculosis.

Addressing non-communicable diseases (NCDs), while not a formal part of the MDGs or the RMNCH continuum of care, is a global priority and the focus of the United Nations General Assembly high-level meeting in September 2011. Women and children in low- and middle-income countries often bear a triple burden of ill-health related to pregnancy and childbirth, to communicable diseases and to non-communicable diseases (NCDs). The latter are mainly cardiovascular disease, cancer, chronic respiratory disease and diabetes. Increasing exposure to NCD risk factors affects not only women's and children's health, but also increases the vulnerability of future generations to ill-health.²¹

The Global Strategy for Women's and Children's Health recommends that health-care for NCDs be provided as part of an integrated approach to promote women's and children's health. The RMNCH continuum of care provides many opportunities to integrate NCD services. Global Strategy commitments related to NCDs address cancers, including cervical cancer, and also diabetes. During the interviews, Cambodia highlighted the attention it is giving to NCDs, which often disproportionately affect the poor and vulnerable. Medtronic Foundation, Merck, Novo Nordisk, and Susan G Komen for the Cure Health Alliance also specifically mentioned commitments addressing NCDs.

In addition to commitments focusing on the health MDGs and NCDs, stakeholders made commitments across sectors to address the full spectrum of MDG priorities. Some illustrative examples of these commitments are listed below.

As part of the Global Strategy, Comoros addressed MDG 1 on reducing poverty and addressing nutrition by making a commitment to reduce the percentage of underweight children under-five from 25% to 10%. To contribute to progress towards achieving MDG 1, the United States made a commitment to reduce child under-nutrition by 30% across assisted food-insecure countries, in conjunction with President Obama's Feed the Future Initiative. Through a partnership with the World Food Programme's Partnership of Hope – Africa, LG Electronics made a commitment to poverty alleviation and reducing hunger through sustainable development in communities in Kenya and Ethiopia. As part of the Early Origins of Health Initiative, Novo Nordisk commits to supporting women during pregnancy and advocating for a gender-based, life-course approach to NCDs that emphasizes clinical and community-based interventions for adolescent girls and women. This is focused in the areas of nutrition, physical activity and health literacy, as well as screenings for risk factors and disease management.

Addressing MDG 2 on education in addition to MDG 4 and 5, Burkina Faso made a commitment to provide free schooling for all primary school girls by 2015.

Including a focus on MDG 3 on gender in its Global Strategy commitment, Niger committed to introduce legislation to increase the legal age of marriage to 18 and to improve female literacy from 28.9% in 2002 to 88% in 2013. Congo committed to support women's empowerment by passing a law to ensure equal representation of Congolese women in political, elected and administrative positions.

“We are investing in the integration of maternal, newborn and child health services to move away from vertical delivery of interventions. We will collaborate with other sectors that have an important impact on women's and children's health.”

– Government respondent, PMNCH 2011 Report

In the spirit of MDG 8, which aspires to building global partnerships for development, some commitments address multiple MDGs simultaneously. For example, UNFPA, UNICEF, the World Bank and UNAIDS have committed to promoting the critical engagement of other sectors such as nutrition, education, gender, water and sanitation, culture and human rights. The Global Leaders Council for Reproductive Health committed to broaden the range of stakeholders engaged in maternal and child health by targeting new sectors. By linking reproductive health with issues such as population and environment, the Global Leaders Council for Reproductive Health aims to increase the interest of stakeholders from other sectors in reproductive health.

More than 95% of the commitments to advance the Global Strategy have to date been made by stakeholders traditionally operating in the health sector. As the Global Strategy emphasizes, there is a need to engage other sectors, such as education, nutrition, water and sanitation, business and infrastructure. The aim is to provide resources and to address the structural barriers and social determinants of women's and children's health. ■■■■



CHAPTER 6

COMMITMENTS MADE TO INNOVATIVE APPROACHES TO FINANCING, PRODUCT DEVELOPMENT AND THE EFFICIENT DELIVERY OF HEALTH SERVICES

The Global Strategy recognizes that innovation can help countries build on the already significant reductions in maternal and child mortality and improvements in women's and children's health:

Innovative approaches can achieve even more, eliminating barriers to health and producing better outcomes. These approaches need to be applied to all activities: leadership, financing (including incentives to achieve better performance and results), tools and interventions, service-delivery, monitoring and evaluation.

Innovation can enable Global Strategy partners to 'do things better' and 'do better things', increasing efficiency and impact. As such, the Global Strategy gives emphasis to innovative approaches to policy, service-delivery and financing that play a key role in speeding up progress towards achieving MDGs 4 and 5. It also highlights the importance of involving both the public and the private sectors through public-private partnerships.

Only nine stakeholders explicitly made commitments to innovative approaches. However, in the interviews about their commitments, 46 stakeholders across the constituency groups emphasized the need for innovation, and reported a variety of innovations related to the implementation of commitments. Only 12% (five out of 41) of low-income countries reported any innovative activities, either in their commitments or in the interviews, demonstrating that there are opportunities to expand innovation within national government plans and actions. The main areas in which commitments related to innovation were: leadership and policy, product development and service-delivery, financing, and health literacy and community participation.

Innovative approaches to leadership and policy

To promote innovation in the area of leadership and policy, the David and Lucile Packard Foundation partnered with the Bill & Melinda Gates Foundation to support political and financial commitments in nine countries through African women leaders and their networks.



While few interviewees had made explicit commitments related to innovation in policy and leadership, they made nearly 36 references to the need for innovation in this area, and to how related innovations have been employed. For example, India has enacted a policy to implement the Mother and Child Tracking System. This tracks every pregnant woman by name for provision of timely antenatal care, institutional delivery and postnatal care, along with immunization of newborns. The Body Shop is carrying out innovative approaches to policy advocacy, which include encouraging customers to write to governments to raise their concerns about women's and children's health. This has already resulted in stronger laws on commercial sexual exploitation in Malta and Malaysia.

Innovation in product development and health services delivery

A few commitments highlighted innovative approaches to provide, improve and integrate service-delivery. For example, Rwanda committed to taking forward an initiative that provides multi-sectoral services under the same roof: legal, medical, housing, and psycho-social services.

Investing in innovation is important to ensure that creative solutions are developed and deployed to promote women's and children's health, in conjunction with solutions that are already known to be cost-effective. Progress towards this goal is demonstrated by the commitment of the US, Norway, the Bill & Melinda Gates Foundation, Grand Challenges Canada and the World Bank in launching Saving Lives at Birth: A Grand Challenge for Development.²² This initiative aims to promote and support innovations that can improve maternal and child health in rural and low-income areas during the first 10 days after birth, when women and children are at greatest risk of dying. The call for proposals reached out to entrepreneurs across sectors to come up with innovative technologies, innovative uses of existing technologies and innovative approaches to strengthen the supply and demand-side of health services. In 2011 there were over 600 applicants to Saving Lives at Birth, with 75 finalists selected and 22 projects identified for funding.

Other commitments focused on product development. For example, GE Healthcare developed the Lullaby Warmer, which is a highly versatile infant warmer, priced 70% lower than current baby warmers of the same class. Mobile devices and diagnostics were also identified by stakeholders as an important area for innovation in health. In Indonesia, GE Healthcare is working with midwives to provide access to ultrasound imaging in pregnancy care. This innovation aims

to increase access to state-of-the-art diagnostics, and improve health outcomes by empowering midwives with portable ultrasound systems to help visualize complications in pregnancy and refer mothers for further care accordingly.

Stakeholders also emphasized the potential of information and communication technologies (ICT) to help strengthen health-services delivery and address practical challenges of health-care workers at different levels. BRAC will provide mobile phones to community health workers in Bangladesh so that they can offer health services to patients in real time, with the support of supervisors through this mobile phone service. IntraHealth International is committed to using a range of mobile technology tools, including the mobile technology learning method, to support the training of health workers and reinforce information post-training. It also has a web-based meeting tool to fully engage and build capacity of country-based colleagues.

Innovations to promote health literacy and community participation

Commitments to the Global Strategy also include innovative approaches to strengthen the demand-side of women's and children's health, including health literacy. Similarly, India is promoting demand through Janani Suraksha Yojana, a national conditional cash-transfer scheme to incentivize women of low socio-economic status to give birth in a health facility. The David and Lucile Packard Foundation supports efforts to work closely with communities to stimulate demand and use of family planning and reproductive health services by women and girls. The Foundation also supports civil society efforts, especially by women leaders and women-centred networks, to redefine community priorities, guide resources and advance policies related to reproductive health.

The potential of mobile phones to promote health literacy is highlighted in the Global Strategy, and related commitments have been made.²³ The United States Government, through the Mobile Alliance for Maternal Action (MAMA), uses cell-phone technology to raise awareness in low-income countries and promote healthy behaviours that help to ensure healthy mothers and healthy pregnancies. The initiative provides health information (e.g. when to get antenatal care visits, healthy foods and tips on healthy pregnancy) to mothers via text messages or voicemails. Similarly, Johnson & Johnson committed to providing more than 15 million expectant and new mothers with free mobile phone messages about prenatal health, reminders of clinic appointments and calls from health monitors.

BBC World Trust committed to increase the capacity of local communities to use media and communications to improve health.

As another example of innovation with respect to community participation, Niger is implementing L'École des Maris (School for Husbands) to encourage men to improve the health of their families. On a voluntary basis, men from the community are trained to lead school meetings at the village level, with the aim of engaging men in maternal, newborn and child health. They serve as role models both within their families and the community. The programme has demonstrated positive results, such as more health-centre visits by women, more health centre visits by women accompanied by men and increased utilization of contraceptive methods.

Innovative approaches to financing

Although the commitments to the Global Strategy will make an important contribution to meeting the financing gap of US\$88 billion for women's and children's health in 2011-15, it is clear that more resources are needed. Commitments to innovative approaches to resource mobilization are therefore of particular importance to the Global Strategy. The Task Force for Innovative International Financing for Health Systems (the Task Force) assessed that current donor funding was not predictable, at scale, or sustainable at the levels required to achieve the health MDGs.²⁴ Innovative financing focuses on new ways to mobilize financing, usually outside tax revenue systems. In addition, and equally important, are innovative approaches to using existing and new resources. Innovative financing needs to be integrated with health planning and budgeting processes.

Commitments made to advance the Global Strategy include some innovative financing mechanisms. For example, Mali committed to removing taxes on insecticide-treated bed nets (ITNs), and provide free ITNs to women making their second antenatal visits as an incentive. As mentioned above, Nepal is stimulating demand for, and use of, nutrition interventions through conditional cash transfers. With these, pregnant and lactating women receive a cash payment conditional upon their receiving nutrition counselling and bringing their children for growth-monitoring sessions.

Some innovative approaches to financing were also discussed in the interviews. For example, Pfizer discussed its differential or tiered pricing, which, among other factors, takes into account the varying economic circumstances of the countries purchasing vaccines.



While some are focusing on innovative approaches to financing, more attention to innovation in this area is urgently needed. Innovative approaches that are shown to work need to be disseminated and adapted to different contexts. In addition, new financing mechanisms need to be developed and tested.

Innovation for accountability

The Commission on Information and Accountability emphasized the importance of the innovative use of Information and Communication Technologies (ICTs) to provide more accurate and timely data for monitoring and reviewing results and resources for women's and children's health. The Commission recommended that by 2015, all countries have integrated the use of ICTs in their national health information systems and health infrastructure. The Commission also highlighted the potential social networking offers for strengthening accountability mechanisms, while broadband technologies can accelerate connectivity between community, national and global levels, and progress towards generating, synthesizing and sharing comprehensive health information for improving women's and children's health.

While many stakeholders are focusing on accountability, including monitoring and evaluation, there was little focus on innovative approaches to accountability within the commitments. However, some stakeholders mentioned innovative monitoring and evaluation activities. For example, the John D. and Catherine T. MacArthur Foundation is combining technology and accountability, and looking at how their grantees use technology to improve accountability. The International Budget

Partnership stated that, “Promoting accountability in the area of maternal health through monitoring budget information is in itself innovative”.

As an improvement in the current Health Management Information Systems (HMIS), Nepal is piloting an innovative system called Health Sector Information System (HSIS). HSIS will give disaggregated data per health facility which can further be analyzed to give a clear picture about equity and access. It also provides comprehensive information about the participation of other sectors (e.g. private and NGO) in health activities.

There is great opportunity for innovation in the area of accountability. Some stakeholders, including low-income countries, expressed interest in technical assistance around monitoring and evaluation, indicating that innovative approaches on accountability would be well received. Chapter 8 of this report provides a detailed analysis of the Global Strategy commitments related to accountability.

Leveraging public-private partnerships and investing in innovation

Investing in innovation is critical to progress on women’s and children’s health. Corporations and academic, research and training institutes invest significantly in R&D and in the development and deployment of innovations. As one of its tasks, the Innovation Working Group (IWG) will catalyse additional investments in innovation related to the Global Strategy. For example, the first area of investment identified by the IWG is to support the scaling up of mHealth projects through public-private partnerships. The IWG issued a call of interest and organized a workshop to help develop proposals and identify 10 to 12 mHealth projects to receive catalytic funding by the end of the 2011.

The 2011 Global Campaign for the Health MDGs thematic report, *Innovating for Every Woman, Every Child*²⁵, uses a range of case studies to highlight the potential of innovation and public-private partnerships to improve health services delivery and promote health outcomes. Examples of promising innovations include: using retail distribution networks to bring vital medicines to underserved communities; private-sector training of factory workers to provide health education to communities; and the delivery of lab results via mobile phones and customized printers to facilitate more efficient communication in preventing mother-to-child transmission of HIV.

Innovating for Every Woman, Every Child also identifies several challenges in integrating innovation for health, particularly in moving from pilot projects to scalable and financially viable programmes with optimal impact. Further, “attracting financing, partners, and demand can be difficult, especially when organizations – public and private, large and small – are not used to working together”. The report identifies five key areas to improve the environment for innovation:

- Sharing information;
- Creating interfaces between the public and private sectors;
- Coordinating between innovators to avoid duplication and add value in ways that make scale easier to attain;
- Negotiating with multi-stakeholder partners; and
- Creating demand to support delivery of products, services or interventions in a sustainable way.

Innovative and sustainable public-private partnerships will play a critical role in catalysing progress towards the health MDGs. ■ ■ ■ ■

“We use cell phone technology to raise awareness and promote healthy behaviors that help to ensure healthy pregnancy and healthy mothers. Mothers receive text messages or voicemails with health information, such as when to get antenatal care visits and tips on healthy diets.”

– Government respondent, PMNCH 2011 Report



CHAPTER 7

COMMITMENTS MADE TO PROMOTE HUMAN RIGHTS AND EQUITY

The Global Strategy explicitly builds on existing human rights commitments and specifically emphasizes the need to:

Introduce or amend legislation and policies in line with the principles of human rights, linking women's and children's health to other areas (diseases, education, water and sanitation, poverty, nutrition, gender equity and empowerment).

Human rights commitments under international law, on which the Global Strategy is built, include the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC).²⁶ In addition, there is the International Labour Organization's Maternity Protection Convention, and the Human Rights Council has adopted a specific resolution on preventable maternal mortality and morbidity.²⁷ Overall, the right to the highest attainable standard of health is a globally recognized human right that is upheld in the constitution of the World Health Organization.²⁸ In this context, all commitments made to the Global Strategy towards improving women's and children's health are also inextricably linked with realizing human rights.

The actions taken by countries with respect to signing and ratifying human rights treaties are set out in Annex 5 for 74 countries. Table 7.1 summarises these actions. All countries have human rights obligations, including international assistance and cooperation. This table does not suggest that it is only the lowest-income and high-burden countries that have such international legal obligations, but rather highlights the linkages between human rights and making progress on women's and children's health and the Global Strategy.

The Convention on the Rights of the Child has been signed and ratified by 74% of countries (i.e. 55 of the 74 countries in Annex 5). The Maternity Protection Convention, however, has only been ratified by two of these countries – Azerbaijan and Mali.



In related commitments, states and other stakeholders have also endorsed the Programme of Action agreed at the International Conference on Population and Development; the Beijing Declaration and Platform for Action agreed at the Fourth World Conference on Women; the 54th session of the Commission on the Status of Women; the Maputo Plan of Action; the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA); and the African Union Summit Declaration 2010 for Actions on Maternal, Newborn and Child Health.

Ten stakeholders made specific rights-related commitments to advance the Global Strategy. Germany will make resources available for family planning and reproductive health and rights as part of its annual commitments to women's and children's health and its commitment to the Muskoka Initiative. Sweden explicitly based its commitments to advance the Global Strategy on its policy for global development, in its international policy on Sexual and Reproductive Health and Rights (SRHR), and in the Policy for Gender Equality and the Rights and Role of Women.

WHO, UNFPA, UNICEF, UNAIDS and the World Bank committed to mobilize political support for the Global Strategy. This included promoting the critical engagement of other sectors such as education, gender, nutrition, water and sanitation, culture and human rights. They also committed to sustaining the momentum of the Global Strategy beyond 2015.

The Ford Foundation and the John D. and Catherine T. MacArthur Foundation each committed to programmes that strengthen sexual and reproductive health and rights, to

ensure that young people are empowered to have access to the information and services they need and to ensure youth-friendly services.

Building on the background paper with human rights recommendations developed for the Global Strategy,²⁹ the PMNCH 2011 Report Advisory Panel³⁰ recommended that all Global Strategy commitments be analysed in relation to five human rights principles that are strongly linked with women's and children's health. These principles are:

- Ensuring entitlements to available, accessible, acceptable and quality health facilities, goods and services for women and children;
- Equity and non-discrimination;
- Gender equality;
- Women's economic empowerment, citizen voice and political participation; and
- Meaningful accountability.

The range of Global Strategy commitments related to these human rights principles are depicted in Figure 7.1 with illustrative examples highlighted in the text that follows.

Ensuring entitlements

Ensuring entitlements refers to the implementation of human rights treaties by developing legislation and allocating required resources. This enables related programmes to be implemented and services accessed, and progress made towards the realization of rights.

TABLE 7.1: Summary of countries' actions with respect to human rights treaties

INTERNATIONAL HUMAN RIGHTS TREATIES	NUMBER OF COUNTRIES (TOTAL = 74) WHO HAVE:			
	SIGNED AND RATIFIED	ACCEDED	SIGNED/PARTIAL AGREED	TAKEN NO ACTION
Convention on the Rights of the Child (CRC)	55 (74%)	18 (24%)	1 (1%)	0 (0%)
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	40 (54%)	32 (43%)	0 (0%)	2 (3%)
International Covenant on Economic, Social and Cultural Rights (CESCR)	14 (19%)	52 (70%)	4 (5%)	4 (5%)
Maternity Protection Convention, International Labour Organization 183	2 (3%)	N/A	19 (26%)	53 (72%)

A number of countries made commitments related to this category. For example, Cambodia is addressing financial barriers in order to promote universal access. Kyrgyzstan committed to ensuring 100% free medical care to pregnant women and to children under-five. Guinea aims to ensure access to free prenatal and obstetric care, both basic and emergency. The Global Health Council led the development of a global health community letter that called upon the US Congress to maintain funding for RMNCH and family planning programmes in the Fiscal Year 2012 budget.

The Government of India's commitment to advance the Global Strategy includes "strengthening its efforts in the 235 districts that account for nearly 70% of all infant and maternal deaths".

In addition, a recent landmark case in the Delhi High Court emphasizes the links between human rights commitments and commitments to ensure entitlements to available, accessible, acceptable and quality health facilities, goods and services. Responding to a public interest litigation case on the preventable deaths of two women from pregnancy-related causes, the High Court judgment stated that:

These petitions focus on two inalienable survival rights that form part of the right to life: the right to health (which would include the right to access and receive a minimum standard of treatment and care in public health facilities) and in particular the reproductive rights of the mother. The other right which calls for immediate protection and enforcement in the context of the poor is the right to food.³¹

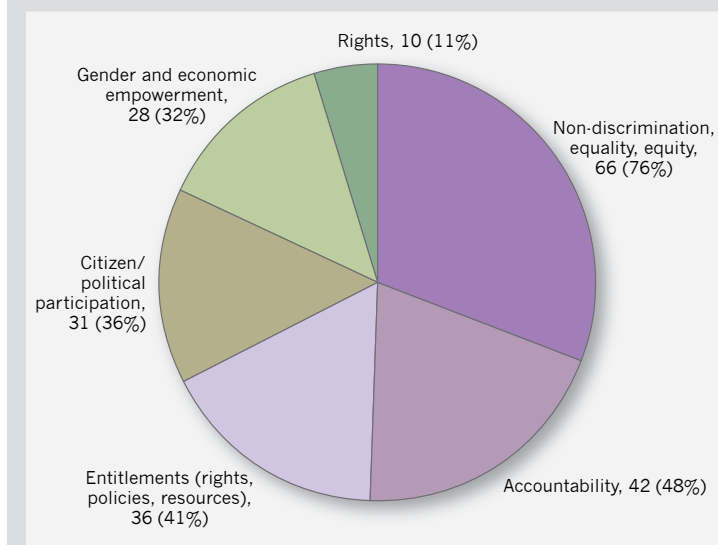
The Delhi High Court instructed India's central and state governments to compensate the claimants, take immediate corrective action on a range of specific interventions to prevent maternal and infant mortality, and to regularly monitor the related implementation schemes to ensure progress.³²

Cases such as this highlight the possibility of not only states, but also of the private sector and other non-state actors — who have made commitments to, or are responsible for, providing resources and interventions towards the realization of human rights — being held accountable for their actions or inactions under human rights law.

Equity and non-discrimination

As a focus in policies and programmes, equity and non-discrimination help ensure that the needs of the most disadvantaged and vulnerable populations are met. They also facilitate equal access to public services, for instance as related to universal access to high-quality health-care.

FIGURE 7.1: Commitments related to human rights, equity and empowerment (87 stakeholders)



Some Global Strategy commitments specifically addressed equity and non-discrimination. Australia committed to fund activities that equitably deliver health services using mobile health clinics to provide services to hard-to-reach areas. The International Partnership for Microbicides (IPM) has obtained royalty-free licences from pharmaceutical companies to develop its antiretroviral drugs as microbicides. These licences allow IPM to ensure that microbicides will be available at little or no cost to women in developing countries and reach the poorest and most vulnerable women.

Novo Nordisk's Changing Diabetes in Children® programme is specifically targeted at treating children in least-developed countries. It provides insulin free of charge that otherwise would not be accessible to this vulnerable group. The World Bank has committed, as part of its core business, specifically to target pockets of poor and marginalized populations. These groups are explicitly included in monitoring and evaluation indicators.

Gender and economic empowerment

Some stakeholders, particularly states, made policy commitments that could have far-reaching sociocultural impact and improve women's and children's health. For example, Bangladesh, Burkina Faso and Niger made commitments to introduce or enforce laws or policies raising the

minimum age of marriage, to prevent female genital mutilation and/or to reduce domestic violence.

Yemen committed to endorse a Safe Motherhood Law to prevent harmful practices, while Congo Brazzaville committed to pass a law to ensure equal representation of Congolese women in political, elected and administrative positions. Benin committed to enforce legislation to improve gender equality, and Burkina Faso to provide free schooling for all girls of primary age.

Citizen and political participation

These human rights underpin the principle that governance should permit people to play a full role in the functioning of the state. They include the right to hold public office and to participate in cultural activities and the work of nongovernmental and international organisations.

In this context, the TY Danjuma Foundation in Nigeria is developing tools to raise awareness of HIV/AIDS, address the “challenge of mentality change in the poorest communities”, build local capacity and inculcate a sense of ownership in remote areas. In another behaviour-change initiative, the Bill and Melinda Gates Foundation will promote preventive maternal and neonatal care practices and care-seeking by developing and applying large-scale communication and marketing approaches, and mobilizing local networks. The Planet Wheeler Foundation, with the Wellcome Trust, will support research to test a model developed by Development Media International (DMI) and the London School of Hygiene and Tropical Medicine (LSHTM). This model predicts that child mortality can be reduced by 10% to 20% in most developing countries by broadcasting radio and television messages on key life-saving behaviours, so that women and children can make informed decisions about their health.



Accountability

Accountability includes the right to public access to information. It also encompasses the need for transparency of governance and administrative processes, reports on progress made towards realizing human rights, and effective administrative or legislative remedies for acts that violate human rights.

Some stakeholders made specific commitments to improve accountability mechanisms. For example, Papua New Guinea and Zimbabwe committed to establish maternal death audits, while Nepal is putting in place a Governance and Accountability Action Plan. This is intended to ensure improved governance of the health sector, with social equity, access and inclusion as one indicator.

In the private sector, IT company SingleHop has committed to fighting human rights abuses, such as child pornography. Through its AbuseShield.org site, SingleHop intends to help the authorities by mobilizing the online community to report illegal, inhumane and malicious web content. Institute for Global Health of Barcelona, an academic think-tank, has committed to help develop and promote a multi-disciplinary and coordinated global research agenda in the context of the Global Strategy in Europe and internationally, with a common strategy for indicators and benchmarks, helping donors and governments to monitor progress.

Amnesty International has committed to “advocate for equal and timely access to reproductive health-care services for all women and girls and campaign for greater accountability for violations of reproductive health rights”.

The following chapter examines in further detail the Global Strategy commitments related to accountability. ■■■■

“We’re trying to get governments to look at performance indicators other than those traditionally used in public health – if you want to have a long-term solution to improve RMNCH, you have to empower women, which requires thinking outside the public health box.”

– NGO respondent, PMNCH 2011 Report

CHAPTER 8

COMMITMENTS MADE TO STRENGTHEN ACCOUNTABILITY FOR RESULTS AND RESOURCES FOR WOMEN'S AND CHILDREN'S HEALTH

A pillar of the Global Strategy is accountability for national, regional and global commitments to advance women's and children's health:

*Accountability...ensures that all partners deliver on their commitments, demonstrates how actions and investment translate into tangible results and better long-term outcomes, and tells us what works, what needs to be improved and what requires more attention.*³³

Accountability comprises three main components:³⁴

1. Monitoring involves finding out what is happening where, and to whom.
2. Review is a process that assesses whether or not commitments have been kept.
3. Remedial action involves making recommendations to stakeholders on how to address areas in need of improvement identified in the review process.

Investing in monitoring and evaluation

The Global Strategy recognizes that national leadership and ownership of results are necessary to strengthen accountability. Harmonized and sustained investment in national monitoring and evaluation systems is also required. This will improve the availability, quality and analysis of essential data on births, maternal and child deaths, health status, intervention coverage and allocation and disbursement of resources and expenditure. Global and regional mechanisms and processes to track progress must also be improved and harmonized for accountability to be strengthened.

To assess how Global Strategy stakeholders are supporting monitoring and evaluation efforts, and how they track their own commitments, interviewees were invited to report on any specific action taken to monitor and assess the implementation and impact of their commitment. They were also asked to comment on specific opportunities for operational research to guide implementation and for evaluations to track progress. The information gathered from the interviews and analysis of the commitments suggests that, in the main,



stakeholders have considered monitoring and evaluation in planning and implementation of their commitments, but that some gaps remain.

Several governments made specific outcome- and results-based commitments to advance the Global Strategy. These were based on indicators for monitoring progress on health outcomes and intervention coverage that are aligned with the 11 core indicators proposed by the Commission on Information and Accountability. These indicators, and others related to women's and children's health, are regularly monitored by the Countdown to 2015, which tracks progress on maternal, newborn and child survival, including health outcomes, coverage of essential interventions, equity, domestic and external financing, and policies and systems support.³⁵

Examples of health-outcome commitments come from Congo Brazzaville and Ethiopia. The former committed to reducing maternal mortality by 20% by 2015. The latter committed to a decrease in the maternal mortality ratio from 590 to 267 per 100 000 live births, and a decrease in the under-five mortality rate from 101 to 68 per 1000 live births by 2015.

Examples of commitments to improve the coverage of interventions come from Afghanistan and Haiti. The former committed to increase the proportion of deliveries assisted by a skilled professional, and the latter to increase the met need for family planning.

Many of the interviewees referred to the integration of a monitoring and evaluation component in their activities, to strengthen accountability. To improve the availability of data, Cambodia is expanding the surveillance and audit of maternal deaths through its Fast Track Initiative. India is implementing an annual health survey to study the impact of its National Rural Health Mission programmes, to reduce its total fertility rate and infant mortality rate. As mentioned in Chapter 7, Nepal is putting in place a Governance and Accountability Action Plan.

All grant-making foundations interviewed during the data-collection process have included a mandatory monitoring and evaluation framework in each grant. Recipients of financing from the Global Fund to Fight AIDS, Tuberculosis and Malaria are required to spend 5% of the grant on monitoring and evaluation. The GAVI Alliance has a comprehensive monitoring and evaluation programme included in its 2011-2015 Strategy and Business Plan and engages partners to conduct monitoring and evaluation of its investments in countries.

Reviewing progress through independent review and working with partners

The multi-stakeholder nature of accountability was recognized by several respondents. Examples were provided of how parliamentarians contribute to national accountability in Ethiopia, Nigeria, Tanzania and Zimbabwe. They do this by representing women and children, by legislating, and by budgeting for policies and programmes for women's and children's health. In Niger, evaluations are reviewed by biannual and annual conferences with partners, and an additional three or four indicators specifically focused on the health of women and children were being evaluated in some villages.

Several stakeholders, such as Save the Children, have mandated an independent external audit to monitor the implementation of their commitments. Others have established partnerships with academic institutes, including the University of Aberdeen, Johns Hopkins University, and the Liverpool School of Tropical Medicine. During the interviews, members of the academic and research constituency pointed out that they are well positioned and eager to be more involved in such work.

Many stakeholders to the Global Strategy consider monitoring and evaluation, and research activities, as crucial to ensuring accountability. They also see the need for greater coordination of action, since several stakeholders are currently working on quite similar issues. Their feedback suggested the need for a multi-constituency forum, where stakeholders can share best practices, and knowledge resulting from research. In this spirit, Care International commits to linking health systems and communities in systems of mutual accountability,

Remedial action: achieving results by defining outcomes and addressing challenges

The interviews also yielded examples of how data have been used to inform design and implementation of policies and programmes related to commitments to advance the Global Strategy. For example, a needs assessment in Mozambique highlighted the barriers women face in accessing institutional delivery and family planning services. As a result, the government is now providing family planning services to couples, and ensuring that women can access these services on their own.

Some institutions link their commitments with specific outcomes, such as the estimated number of lives saved and other health outcomes. For example, the United Kingdom has a monitoring and evaluation framework for women's and children's health that also explicitly measures the extent to which outcomes are equitable and poorer people benefit from interventions.

To reach desired outcomes and goals, it is important to identify and address challenges along the way. Through its "learning agenda", the David and Lucile Packard Foundation has developed reproductive health indicators that are linked with the pathways their projects utilise, to achieve specific outcomes. World Vision is developing a new project management information system, including a compendium of core health indicators. The World Bank has committed to expanding its results-based programmes by more than \$600 million, to scale up essential health and nutrition services and strengthen the underlying health systems, which are essential to sustain better health results over the years.

Taking forward the recommendations of the Commission on Information and Accountability

The Commission on Information and Accountability has made 10 recommendations (Annex 1) on how to strengthen global, regional and national accountability for results and resources for women's and children's health.³⁶ An independent Expert Review Group is being established to report "regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission's recommendations".³⁷

Respondents welcomed the report of the Commission and suggested that its recommendations can have a critical impact on accountability – nationally, regionally and globally, including the tracking of commitments to the Global Strategy.

The role of regional institutions and stakeholders in ensuring ownership and accountability has been highlighted as essential to progress. In August 2011, the African Union Commission convened discussions with African RMNCH Stakeholders to develop a joint framework to reconcile regional commitments to RMNCH, such as those agreed during the July 2010 AU Summit on MNCH, and the Campaign for Accelerated Reduction of Maternal and Child Mortality (CARMMA), with those pledged in association with the Global Strategy in order to encourage greater harmonization of the implementation and accountability process. This landmark Integrated Africa RMNCH Advocacy

Strategy will be implemented across AU member states by the AUC and partners from 2011 – 2015 to promote crucial integrated implementation of regional and global initiatives on MNCH. A further example of strong regional accountability is the new AU MNCH Taskforce tasked with important reporting MNCH progress to Heads of State Summits.

Strong examples of in country work include The International Budget Partnership expansion of its commitment by starting a process with the Maternal Health Task Force and the MacArthur Foundation. This will support pilot projects in Indonesia, Nigeria and Tanzania, specifically to monitor the commitments that these countries made to the Global Strategy.

Several respondents suggested that the process of contributing to this 2011 PMNCH report was important in itself. By responding to the questionnaire and engaging in the interview process, several respondents said it stimulated further reflection and dialogue within their institutions, and with partners, on how to report on their commitments to the Global Strategy.

PMNCH conceived this report to enhance the work of the Commission by providing information and analysis on the specific commitments pledged to date. This contribution comes on the heels of the Delhi Declaration, agreed by all partners and constituency groups of PMNCH at its 2010 Partners' Forum in New Delhi, in which PMNCH agreed to use its collective abilities to turn "pledges into action".

As set out in the Delhi Declaration, this includes agreeing to shared principles for action and accountability, including support for:

*a core set of indicators, integrated into country monitoring and evaluation mechanisms, so all partners are accountable for the commitments and results agreed to in the Global Strategy; a multi-stakeholder process to ensure inclusiveness and participation; harmonization of existing efforts to ensure complementarity between partners' work; and regular progress reports.*³⁸ ■■■■



CONCLUDING OBSERVATIONS



This report has set out to present an introductory analysis of the financial, policy and service-delivery commitments to advance the Global Strategy in order to inform discussion and action on the following topics:

1. Accomplishments of the Global Strategy, and the Every Woman, Every Child campaign, in terms of the commitments to date;
2. Opportunities and challenges in advancing Global Strategy commitments;
3. Stakeholders' perceptions about the added value of the Global Strategy; and
4. Next steps to strengthen advocacy, action and accountability, taking forward the recommendations of the Commission on Information and Accountability.

It has been less than a year since the Global Strategy was launched and the first commitments were made. This report has been undertaken with the view that accountability cannot start too early.

1. What has the Global Strategy, and the Every Woman, Every Child campaign, achieved in terms of the commitments to date?

- **Overall.** The campaign has amassed unprecedented support. One hundred and twenty-seven stakeholders made commitments to the Global Strategy in less than one year, valued at more than US\$41 billion, in addition to significant policy and service-delivery commitments. It must be emphasized, however, that this analysis is not a comprehensive stock-taking of all RMNCH-related financing, policies and programmes. This analysis only focuses on specific commitments to the Global Strategy. Furthermore, those policy and service-delivery commitments not expressed in explicitly financial terms have not been added to the overall total in US\$. Therefore, the US\$41 billion figure significantly underestimates the total value of the commitments.
- **Strong low-income country commitments.** Low-income countries made the most commitments (39) to the Global Strategy.

Their total estimated value is US\$10 billion, in addition to far-reaching policy and service-delivery commitments.

- **Prioritizing low-income countries.** Of the 477 references to countries in commitments and interviews, 333 (70%) focused on the 49 low-income, high-burden countries that are prioritized by the Global Strategy.
- **Far-reaching policy commitments.** Of the 127 stakeholders, 102 (80%) made commitments to effect policy changes that address structural barriers and social determinants of health in a sustainable way. These included removal of user fees, implementation of legal reform to improve access to high-quality health-care, and promotion of gender empowerment.
- **Reaching people with the services they need.** Strengthened health systems and service-delivery are a prime focus of the commitments. Of the 127 stakeholders, 99 (78%) made commitments to strengthening health systems and service-delivery. These included specific pledges to improve health services and incorporate innovative approaches to expand utilization, for example, by using mobile phones to raise awareness and promote healthy behaviours.
- **Supporting health workers.** Of the 127 stakeholders, 66 (52%) made commitments to building human resource capacities for health. These included pledges to increase the number of health workers (by more than 45 000), with 35% of these commitments focused on skilled birth attendants and 23% on midwives.
- **Strong financial commitments.** Of the 127 stakeholders, 59 (46%) made monetized commitments. These total more than US\$41 billion.
- **Promoting human rights and equity.** Of the 127 stakeholders, 87 (69%) made commitments that promote some dimensions of human rights. For example, to address equity by using mobile clinics to reach remote areas and women and children in greatest need, to reduce the costs of medicines by negotiating royalty-free licences from pharmaceutical companies, and to address accountability by working with local communities to establish maternal death audits.
- **Increasing coverage of essential interventions and quality of care.** Among the 106 stakeholders who named one or more specific RMNCH interventions in their commitments, 62 (58%) focused on adolescence and pre-pregnancy, 59 (56%) on care at the time of birth, and 57 (54%) on childhood interventions, with a clear concentration on immunization. Twenty-three stakeholders focused specifically on support to improve quality of care.

2. Opportunities and challenges in advancing Global Strategy commitments

- **Engaging new stakeholders and sectors.** More than 95% of commitments are from stakeholders traditionally operating in the health sector. As the Global Strategy emphasizes, there is both a need and opportunity to engage other sectors to provide resources and to address the structural barriers and the social determinants of women's and children's health. These sectors include, for example, education, nutrition, water and sanitation, business and infrastructure. There is also significant scope to engage other "non-traditional" supporters who can donate their time, image or popularity to this campaign (media, music/sporting celebrities etc).
- **Increasing the participation of middle-income countries and the business community.** Of the 127 stakeholders who made commitments to advance the Global Strategy, 14 (11%) were from the business community and five (4%) from middle-income countries. Both these sets of stakeholders can play a significant role in promoting women's and children's health in the lowest-income countries. There are already encouraging signs of significant interest and new commitments from the business community in 2011.
- **Bridging the funding gap.** Respondents for this report identified funding shortfalls as the most important constraint to implementation, and many also pointed out that there is insufficient clarity on and how and when the funds already committed can be accessed.
- **Ensuring value for money.** Of the 127 stakeholders making commitments, less than half (58) provided an estimated financial value for their commitment. Few provided details on the cost-efficiency and impact in terms of the potential lives saved as a result of implementing their commitment. As a result, it is difficult to assess how stakeholders plan to implement commitments to maximize cost-efficiencies and impact. This can be considered by the ERG in follow-up to the Commission.
- **Building on existing plans and processes.** Given the multiple stakeholders and the short time frame in which commitments were generated, greater attention should be focused on how stakeholders can coordinate with each other and with development partners to support country-led health plans, including their human rights commitments, with sustained, long-term investment in policies and programmes.
- **More focus across all high-burden countries.** Seven (14%) of the 49 low-income, high-burden countries attracted just one commitment, including

Congo Brazzaville, Gambia, Uzbekistan and Yemen. Korea PDR attracted no commitments. By contrast, 15 countries (31%) attracted more than 10 commitments, including Nigeria (22), Kenya (18) and Ethiopia (17). India, which is not among the 49 low-income countries, attracted 24 commitments.

- **Addressing gaps in the coverage of interventions.** Along the continuum of care, some key interventions had fewer commitments and references, which might translate into lower coverage overall. These included postnatal care for mothers (8 references in commitments or interviews), insecticide-treated bednets for children (6 references) and nutrition (16 references).
- **Using innovation to catalyse progress.** Only nine commitments explicitly mention using innovation to catalyse progress. In the interviews, many more stakeholders (50) expressed intention or interest in using innovative approaches to implement their commitments. There is an opportunity for the Innovation Working Group to work with the business community and other stakeholders to strengthen this dimension of the Global Strategy, including innovative approaches to harnessing information and communications technology to accelerate implementation and improve efficiency.

3. Why did stakeholders commit to advance the Global Strategy and what did they see as the added value?

Stakeholders made commitments to advance the Global Strategy for a range of reasons, including to:

- **Be part of an unprecedented global movement for women's and children's health.** The Global Strategy is seen as an opportunity for multiple stakeholders to mobilize for women's and children's health, and many saw it as the right thing to do. The Global Strategy provides a "rallying point" and platform for action.
- **Highlight ongoing work to a global audience.** Making a commitment offered global visibility to a range of stakeholders' work and encouraged others to do the same. However, as noted earlier, many stakeholders did not explicitly frame the excellent work they were already doing as a commitment. So, one of the challenges going forward is to see how all of this can be captured and reflected as part of the movement towards reaching the MDGs.
- **Prioritize RMNCH with political leadership and within organizations.** Some stakeholders said participating in the Global Strategy process had helped elevate, and then institutionalize, their financial and other commitments with the

political leadership of their countries and within their organizations.

- **Link with partners who can provide technical and financial support.** Many stakeholders expressed an interest in making a commitment in order to flag specific needs to potential partners.
- **Develop a global "accountability mindset".** Stakeholders welcomed the opportunity for themselves and others to be held accountable through regular reporting on progress. They found that having a common platform, where multiple actors engaged in a similar accountability process, was very valuable, and was important to build a global "accountability mindset" for women's and children's health. The Commission on Information and Accountability provides an accountability framework for all stakeholders, comprising interconnected processes to monitor, review and act.

4. What can further strengthen advocacy, action and accountability?

4.1 Strengthen alignment and integration

- **Common understanding of the commitment-making process.** Through the interview process it became clear that stakeholders have different understandings of what constitutes a "commitment". For example, some stakeholders base their commitments on new and additional activities, policies and/or financing. Others regard the commitment-making process as an opportunity to set out intended activities and policies, should future support be available for implementation. Others chose to package a selection of their ongoing RMNCH-related efforts to emphasize their support for the campaign. To promote a sustainable, long-term campaign, it is important that stakeholders have a common understanding of the commitment-making process and focus on improving reporting on the implementation and impact of the commitments in the future.
- **Link commitments to needs.** The preliminary analysis of commitments along the continuum of care from adolescence to childhood suggests that delivery of certain interventions with low coverage appears to have received relatively little attention. As mentioned, postnatal care and nutrition were not key areas of focus. This analysis can help inform the nature of future commitments to advance the Global Strategy.
- **Integrate efforts.** This analysis highlights some of the areas where commitments are concentrated and where there are gaps in priority actions. Opportunities for integration exist within the health sector, for example, between MDGs 4 and 5 and health-care related to non-communicable diseases.



The Global Strategy can be a platform to strengthen synergies between partners, help avoid duplication and facilitate more effective and efficient use of resources. This would help ensure that people get all the services they need, when they need them.

- Address underlying social and structural dimensions.** The report highlighted a wide range of commitments made to the Global Strategy by multiple stakeholders. Most current commitments are from those working within the health sector. Commitments that address fundamental structural barriers to, and social determinants of, women's and children's health require the engagement of multiple sectors across the MDGs, and with political and legal systems. Addressing the social and structural dimensions of health also requires focusing efforts on gender equality and empowerment, which are not only essential for health and development, but are also fundamental human rights.

4.2 Prioritize implementation, impact and sustainability

- Focus on implementation.** 2015 is fast approaching and implementation needs to be supported and prioritized by all stakeholders. The Commission follow-up will focus on what is actually being done to achieve the desired impact. The 11 indicators (while not an exclusive list) will allow implementers to know whether or not they are on track, and how to either consolidate successes or change course if needed.
- Maximize lives saved.** Commitments to advance the Global Strategy need to be guided by the extent to which they contribute to its ultimate goal of saving 16 million lives in 49 low-income, high-burden countries by 2015. A technical team, e.g. supported by the Countdown to 2015, could support the Every Woman, Every Child advocacy effort by helping to target new commitments to areas of greatest need, and to actions that could have maximum impact in terms of lives saved. This is an area that the independent Expert Review Group is well-placed to pursue.
- Sustain progress beyond 2015.** While commitments currently focus on accelerating progress towards MDGs 4 and 5, the global community also has the opportunity to commit to sustain these efforts beyond 2015. The MDGs are situated within a framework of international commitments to the progressive realization of human rights – including the right for all people to realize the highest attainable standard of health. There is also a recognized commitment across global health and development efforts to promote equity and to mobilize collective action across sectors and geographical regions. Global collective action, equity and human rights together provide a foundation to sustain MDG efforts beyond 2015.

4.3 Strengthen stakeholder capacities for accountability

- **Report on Global Strategy commitments.** The Commission recommends that all stakeholders publically share information on commitments, resources provided and results achieved annually. A majority of the stakeholders who were interviewed for this report also requested a process for regular reporting on commitments to promote mutual accountability. This report provides one potential vehicle for such analysis of the content and scope of the commitments, and can inform the implementation of the commitments, and provide inputs to the work of the independent Expert Review Group.
- **Taking political and structural factors into account.** The interview process of this report underlined the vital importance of analysing political and social dimensions, including gender inequities, to complement tracking of vital events, health outcomes and financial resources.
- **Promote transparency and multi-stakeholder participation.** PMNCH, with its multi-constituency platform, is well-placed to facilitate inclusive participation of all stakeholders in taking forward the Commission's recommendations.
- **Use innovation, including information and communication technologies (ICTs).** The Commission on Information and Accountability recommends the use of innovation, particularly ICTs, to strengthen vital registration and health information systems that underpin accountability for women's and children's health. Strengthening linkages with the Broadband Commission would help address some of the infrastructure and cost challenges for scaling up connectivity for health and development.³⁹



4.4 Acknowledge that women and children, and their families and communities are at the heart of the Global Strategy.

- **Promote health and human rights literacy and health-seeking behaviour.** Less than 10% of the commitments have addressed the need to promote health and human rights literacy and education, so that individuals and communities can have the information they need to make decisions about their health, claim their rights, and demand accountability. This is an area that can be strengthened in future commitments, including by strengthening the role of mass media and community media in promoting knowledge and positive health behaviours, and by using ICTs to catalyze progress.
- **Strengthen community systems and participation.** In addition to strengthening health systems, strengthening community systems is important to taking forward the Global Strategy. Communities play a critical role in providing health-care, facilitating access to health services, promoting citizen participation and empowerment, advocating for essential interventions and addressing structural barriers for health. To ensure progress, women and children, and their families and communities, cannot be viewed as passive recipients of services and goods. They are, and need to be, active participants in health and development and in the realization of their rights.

Ultimately the success of the Global Strategy will be determined by whether the global collective action it mobilized was able to save 16 million lives in the world's 49 poorest countries by 2015. PMNCH will continue to act as a platform for joint action and accountability to support this goal. This report has been one vehicle to do so, allowing those who made commitments to advance the Global Strategy to reflect and account for their efforts. The value of this exercise will be determined by the extent to which this report can inform future action and accountability. ■■■■

“We are committed to advocating for equity in all our programmes to ensure that disproportionate levels of mortality in poor and marginalised groups are no longer tolerated.”

– NGO respondent, PMNCH 2011 Report



RECOMMENDATIONS OF THE COMMISSION ON INFORMATION AND ACCOUNTABILITY FOR WOMEN'S AND CHILDREN'S HEALTH

Better information for better results

- 1. Vital events:** By 2015, all countries have taken significant steps to establish a system for registration of births, deaths and causes of death, and have well-functioning health information systems that combine data from facilities, administrative sources and surveys.
- 2. Health indicators:** By 2012, the same 11 indicators on reproductive, maternal and child health, disaggregated for gender and other equity considerations, are being used for the purpose of monitoring progress towards the goals of the Global Strategy.
- 3. Innovation:** By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.

Better tracking of resources for women's and children's health

- 4. Resource tracking:** By 2015, all 74 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: (i) total health expenditure by financing source, per capita; and (ii) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.
- 5. Country compacts:** By 2012, in order to facilitate resource tracking, "compacts" between country governments and all major development partners are in place that require reporting, based on a format to be agreed in each country, on externally funded expenditures and predictable commitments.
- 6. Reaching women and children:** By 2015, all governments have the capacity to regularly review health spending (including spending on reproductive, maternal, newborn and child health) and to relate spending to commitments, human rights, gender and other equity goals and results.

Better oversight of results and resources: nationally and globally

- 7. National oversight:** By 2012, all countries have established national accountability mechanisms that are transparent, that are inclusive of all stakeholders, and that recommend remedial action, as required.
- 8. Transparency:** By 2013, all stakeholders are publicly sharing information on commitments, resources provided and results achieved annually, at both national and international levels.
- 9. Reporting aid for women's and children's health:** By 2012, development partners request the OECD-DAC to agree on how to improve the Creditor Reporting System so that it can capture, in a timely manner, all reproductive, maternal, newborn and child health spending by development partners. In the interim, development partners and the OECD implement a simple method for reporting such expenditure.
- 10. Global oversight:** Starting in 2012 and ending in 2015, an independent "Expert Review Group" is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission's recommendations. ■■■■



ANNEX 2

QUESTIONNAIRE

PMNCH 2011 REPORT ON COMMITMENTS TO THE GLOBAL STRATEGY FOR WOMEN'S AND CHILDREN'S HEALTH

QUESTIONNAIRE

The purpose of this questionnaire

The information you provide will be used by the Partnership for Maternal, Newborn & Child Health (PMNCH) to produce a report on the commitments made by over 90 different organizations to the United Nations Secretary-General's Global Strategy for Women's and Children's Health. The report will be launched at the time of the United Nations General Assembly in September 2011, the first anniversary of the launch of the Global Strategy. The report will:

- i. Explain in greater detail the nature of the financial, policy, service-delivery and advocacy commitments made;
- ii. Give a snapshot of progress and constraints to implementation so far; and
- iii. Identify possible gaps and overlaps.

For further information about the report, see the [attached concept note](#).

Answering the questionnaire, and next steps

PMNCH staff will contact you by email and/or telephone to arrange an interview time. The questionnaire will be used to structure the interview with you. You might find it useful to read the [attached "Guide to the Questionnaire and Model Answers"](#) before the interview, so that you know why we are asking certain questions, and what a "model answer" may look like.

After the interview, PMNCH will provide you with a copy of the interview notes for your clearance and, where necessary, correction. The information provided will be aggregated and used in analyzing overall progress under the Global Strategy, and to highlight some early successes in the implementation of the commitments.

Note: The information provided will also be made publicly available on a website in September 2011 unless you ask us not to.

Questions are grouped under three broad headings:

- i. Commitments to enhance financing – these questions focus on the various implications of the financial commitments;
- ii. Commitments to strengthen policy, service-delivery and advocacy – these questions focus on these equally important commitments made to the Global Strategy; and
- iii. Other issues.



SECTION 1: UNDERSTANDING THE SPECIFIC FINANCIAL NATURE OF YOUR COMMITMENT BETTER

Confirming the accuracy of your financial commitment to the Global Strategy

Question 1.1

Does the following statement, which has been taken directly from the Summary of Commitments to the Global Strategy dated 1 October 2010, accurately reflect your commitment?

INSERT FINANCIAL COMMITMENT HERE IF APPLICABLE

Question 1.2

Your financial commitment to the Global Strategy was estimated in September 2010 in consultation with the UN Secretary-General's office to be INSERT FIGURE in INSERT TIME PERIOD. The following formula was used to arrive at that figure: INSERT FORMULA. In your view, does the figure of INSERT FIGURE accurately reflect your commitment to the Global Strategy?

Question 1.3

If not, how did you estimate your commitment and what was the final figure of your estimate?

Question 1.4

What progress have you been able to make in implementing your financial commitment to the Global Strategy? Are there any new or additional documents that give details of this?

Enabling better understanding by stakeholders of your commitment to enhance financing

Question 1.5

What is the start date of your financial commitment to the Global Strategy?

Question 1.6

What is the end date of your financial commitment to the Global Strategy?

Question 1.7

How does this financial commitment to reproductive, maternal, newborn and child health (RMNCH) differ from commitments you may have made prior to April 2010?

Question 1.8

To what extent is your commitment new and additional to previous spending for health? For example, is your commitment additional to what you would have spent in 2011 on RMNCH in the absence of the launch of the Global Strategy? Does this commitment increase the overall funding envelope for health, or does it involve a reduction in funding for other areas of health?

Question 1.9

How much do you estimate you will spend of your commitment to the Global Strategy in calendar years 2011-2015?

2011	2012	2013	2014	2015

Question 1.10

Is there anything specific you are considering to increase the *predictability* of funding, as this is an important theme of the Global Strategy?

Question 1.11

Does your commitment to the Global Strategy rely on external funding from bilateral donors, foundations, multilateral development agencies, or NGOs? If so, please give details.

SECTION 2: UNDERSTANDING THE DEVELOPMENT IMPACT OF YOUR COMMITMENT BETTER – THE COMBINED ROLE OF FINANCING, POLICY, SERVICE-DELIVERY AND ADVOCACY

Confirming the accuracy of your commitment, and understanding it better

Question 2.1

Does the following statement, which has been taken directly from the Summary of Commitments to the Global Strategy dated 1 October 2010, accurately reflect your commitment to strengthen policy, service-delivery or advocacy?

INSERT POLICY, Service-delivery OR ADVOCACY COMMITMENT HERE IF APPLICABLE

Question 2.2

What additional funding might be required to implement your policy, service-delivery or advocacy commitment? Were those additional funding needs included in any financial commitment you may have made to the Global Strategy (see question 1.1)?

Question 2.3

How does this policy, service-delivery or advocacy commitment to RMNCH differ from commitments you may have made prior to April 2010?

Achieving impact

Question 2.4

Does your commitment to the Global Strategy target a specific type of intervention: for example family planning, nutrition, skilled birth attendance, newborn health, immunization or other specific components of the continuum of care? If yes, what are they, and why were those particular interventions given special priority?

Question 2.5

Does your commitment to the Global Strategy involve a specific focus on a particular region of the world, or a specific country? If yes, which region or country? Why did you choose that region or country?

Question 2.6

Are there specific provisions in your commitment to improve equity of access and outcomes and/or to reach the poorest and most vulnerable? If yes, what are they?

Question 2.7

What specific provisions are you considering to ensure that the additional financing, policy, service-delivery or advocacy commitments you made to the Global Strategy will strengthen health systems at the country level?

Question 2.8

What specific decisions or planning processes have you put in place to implement your commitments?

Question 2.9

Are you planning anything particularly innovative that will help improve effectiveness, efficiency and impact of your commitment?

Question 2.10

What specific action are you taking to monitor and assess the impact of your commitment? Are there specific opportunities for operational research and knowledge generation that you are aware of in your or others' commitments?

Recent progress, constraints to implementation, and opportunities for future engagement

Question 2.11

What progress have you been able to make in implementing your commitments to the Global Strategy? Are there any new or additional documents that give details of this?

Question 2.12

What specific opportunities are there for other stakeholders, including governments, bilateral donors and foundations, multilateral organizations, civil society, health-care professionals, and academia, to participate in the delivery of your commitment?

Question 2.13

Have you encountered any constraints to implementation of your commitment?

Question 2.14

Are you aware of any specific needs for technical assistance or other support to help you, or others, make progress?

SECTION 3: OTHER ISSUES

Question 3.1

Where, when and how will you be reporting on implementation of your commitment to the Global Strategy?

Question 3.2

In what specific ways did the launch of the Global Strategy assist you in providing additional support for women's and children's health?

Question 3.3

Do you have any other comments you wish to make? ■■■■



LIST OF KEY INFORMANTS

Low-income countries

- Benin
- Cambodia
- Democratic Republic of Congo
- Mozambique
- Nepal
- Niger
- Nigeria
- Tanzania
- Yemen

Middle-income countries

- China
- India
- Indonesia
- Russia

High-income countries

- Australia
- Canada
- France
- Germany
- Italy
- Japan
- New Zealand
- Norway
- Sweden
- United Kingdom
- United States of America

Foundations

- Bill & Melinda Gates Foundation
- David and Lucile Packard Foundation
- Ford Foundation
- John D. and Catherine T. MacArthur Foundation
- Grand Challenges Canada
- Medtronic Foundation
- Planet Wheeler Foundation
- TY Danjuma Foundation
- United Nations Foundation

United Nations and other multilateral organizations

- European Commission
- UNAIDS
- UNFPA
- UNICEF
- WHO
- World Bank

Global partnerships

- GAVI Alliance
- Global Fund to Fight AIDS, Tuberculosis and Malaria

NGOs

- Amnesty International
- BBC World Service Trust
- BRAC
- CARE
- DKT International
- Family Care International
- Global Alliance to Prevent Prematurity and Stillbirth
- Global Health Council
- Global Leaders Council for Reproductive Health
- International Budget Partnership
- International Network of Women's Funds
- International Planned Parenthood Federation
- IntraHealth International
- Save the Children
- Women Deliver
- World Vision International

Business community

- Becton, Dickinson and Company
- Body Shop International
- GE & GE Healthcare
- Johnson & Johnson
- Merck
- Nestle
- Novo Nordisk
- Pfizer
- TMA Development, Training & Consulting
- ViiV Healthcare

Health-care professional associations

- International Confederation of Midwives
- International Council of Nurses
- International Federation of Gynecology and Obstetrics
- International Pediatric Association
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal College of Obstetricians and Gynaecologists
- Society of Obstetricians and Gynaecologists of Canada
- World Federation of Societies of Anaesthesiologists

Academic and research institutions

- All India Institute of Medical Sciences
- Institute for Global Health of Barcelona
- International Partnership for Microbicides ■■■■

ANNEX 4

COUNTRY CONTEXT AND CHALLENGES

FIGURE A4.1: Main causes of death

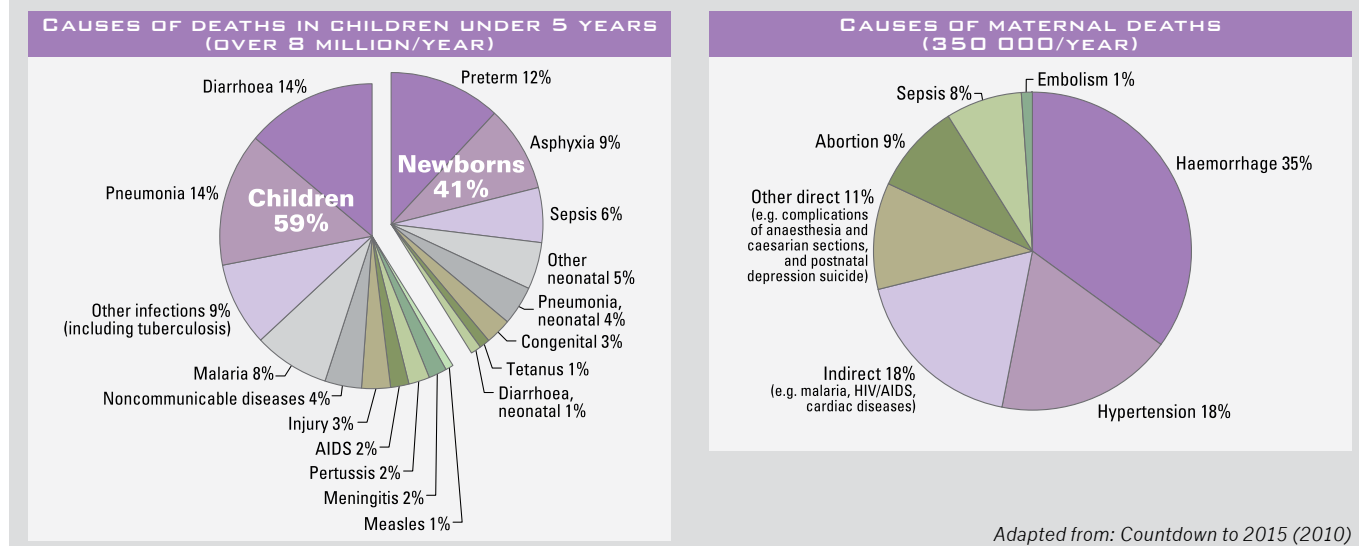


FIGURE A4.2: MDG 4: Child mortality rates - need to accelerate progress in Africa and Asia

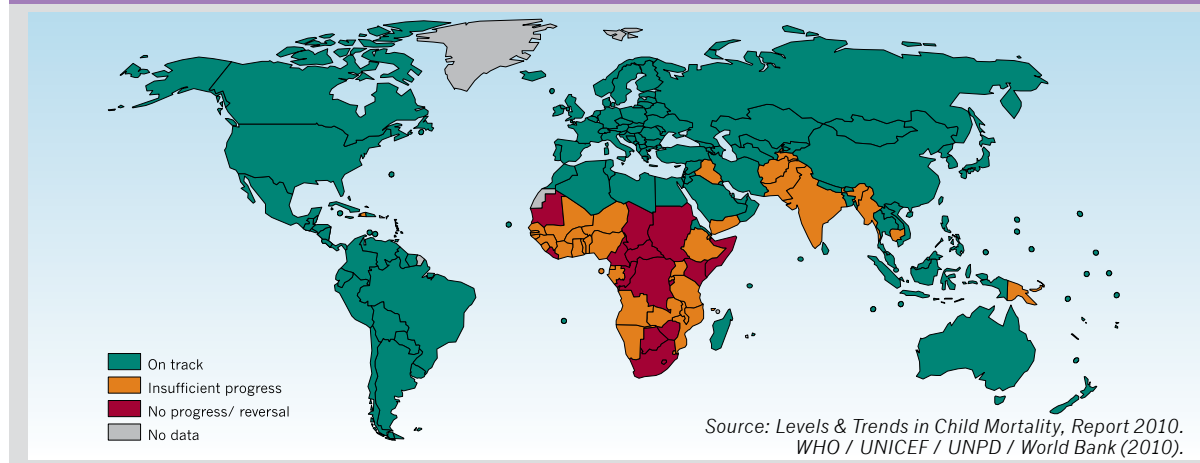


FIGURE A4.3: MDG 5: Maternal mortality ratio still unacceptably high in many countries

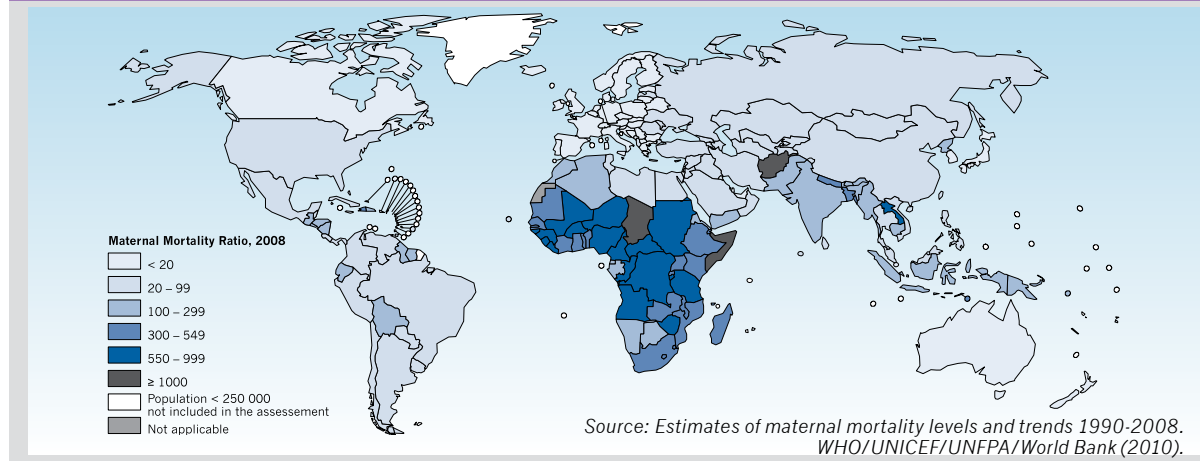


TABLE A4.1: Country context

COUNTRY	UNDER-FIVE DEATHS PER 1 000 LIVE BIRTHS	PROGRESS ON MDG 4 (ON-TRACK, INSUFFICIENT PROGRESS, OFF-TRACK)	MATERNAL DEATHS PER 100 000 LIVE BIRTHS	PROGRESS ON MDG 5A (ON-TRACK, INSUFFICIENT PROGRESS, OFF-TRACK)	% OF CHILDREN UNDER-FIVE WHO ARE STUNTED	NUMBER OF COMMITMENTS (INCLUDING OWN COMMITMENT)
LOW INCOME COUNTRIES (AS OF SEPTEMBER 22, 2010, WHEN THE GLOBAL STRATEGY WAS LAUNCHED)						
AFGHANISTAN	199	Off-track	1 400	Off-track	59%	11
BANGLADESH	52	On-track	340	Off-track	43%	16
BENIN	118	Off-track	410	Off-track	43%	7
BURKINA FASO	166	Off-track	560	Off-track	41%	11
BURUNDI	166	Off-track	970	Off-track	63%	2
CAMBODIA	88	Off-track	290	Off-track	42%	4
CENTRAL AFRICAN REPUBLIC	171	Off-track	850	Off-track	43%	3
CHAD	209	Off-track	1 200	Off-track	N/A	4
COMOROS	104	Off-track	340	Off-track	N/A	3
CONGO	128	Off-track	580	Off-track	30%	1
COTE D'IVOIRE	119	Off-track	470	Off-track	40%	7
DEMOCRATIC REPUBLIC OF CONGO	199	Off-track	670	Off-track	46%	11
ERITREA	55	On-track	280	On-track	44%	1
ETHIOPIA	104	Off-track	470	Off-track	51%	17
GAMBIA	103	Off-track	400	Off-track	28%	1
GHANA	69	Off-track	350	Off-track	28%	7
GUINEA (BISSAU)	193	Off-track	1 000	Off-track	47%	2
GUINEA (KONAKRY)	142	Off-track	680	Off-track	40%	3
HAITI	87	On-track	300	Off-track	29%	11
KENYA	84	Off-track	530	Off-track	35%	18
KOREA, DPR	33	Off-track	250	Off-track	45%	0
KYRGYZSTAN	37	On-track	81	Off-track	18%	2
LAO PDR	59	On-track	580	Off-track	48%	5
LIBERIA	112	Off-track	990	Off-track	39%	4
MADAGASCAR	58	Off-track	440	Off-track	53%	3
MALAWI	110	On-track	510	Off-track	53%	11
MALI	191	Off-track	830	Off-track	38%	12
MAURITANIA	117	Off-track	550	Off-track	32%	1
MOZAMBIQUE	142	Off-track	550	Off-track	41%	9
MYANMAR	71	Off-track	240	Off-track	47%	4
NEPAL	48	On-track	380	Off-track	49%	11
NIGER	160	Off-track	820	Off-track	47%	6
NIGERIA	138	Off-track	840	Off-track	41%	22
PAKISTAN	87	Off-track	260	Off-track	42%	12
PAPUA NEW GUINEA	68	Off-track	250	Off-track	43%	3
RWANDA	111	Off-track	540	Off-track	51%	9
SAO TOME AND PRINCIPE	78	Off-track	N/A	N/A	29%	1
SENEGAL	93	Off-track	410	Off-track	19%	6
SIERRA LEONE	192	Off-track	970	Off-track	36%	9
SOLOMON ISLANDS	36	On-track	100	Off-track	33%	1
SOMALIA	180	Off-track	1 200	Off-track	42%	5
TAJIKISTAN	61	Off-track	64	Off-track	39%	2
TANZANIA	108	Off-track	790	Off-track	44%	14
TOGO	98	Off-track	350	Off-track	27%	3
UGANDA	128	Off-track	430	Off-track	38%	13
UZBEKISTAN	36	On-track	30	Off-track	19%	1
VIET NAM	24	On-track	56	On-track	31%	3
YEMEN	66	Off-track	210	Off-track	58%	1
ZAMBIA	141	Off-track	470	Off-track	45%	13
ZIMBABWE	90	Off-track	790	Off-track	33%	8

COUNTRY	UNDER-FIVE DEATHS PER 1 000 LIVE BIRTHS	PROGRESS ON MDG 4 (ON-TRACK, INSUFFICIENT PROGRESS, OFF-TRACK)	MATERNAL DEATHS PER 100 000 LIVE BIRTHS	PROGRESS ON MDG 5A (ON-TRACK, INSUFFICIENT PROGRESS, OFF-TRACK)	% OF CHILDREN UNDER-FIVE WHO ARE STUNTED	NUMBER OF COMMITMENTS (INCLUDING OWN COMMITMENT)
LOWER-MIDDLE INCOME COUNTRIES						
ANGOLA	161	Off-track	610	Off-track	29%	3
ARMENIA	22	On-track	29	Off-track	18%	1
BHUTAN	79	N/A	200	On-track	38%	1
BOLIVIA	51	On-track	180	On-track	32%	6
CAMEROON	154	Off-track	600	Off-track	36%	7
DJIBOUTI	94	Off-track	300	Off-track	33%	1
EGYPT	21	On-track	82	On-track	29%	3
EL SALVADOR	62	On-track	110	Off-track	19%	2
GUATEMALA	40	On-track	110	Off-track	54%	2
GUYANA	35	On-track	270	Off-track	18%	1
HONDURAS	30	On-track	110	Off-track	23%	2
INDIA	66	On-track	230	Off-track	29%	24
INDONESIA	39	Off-track	240	Off-track	48%	4
IRAQ	44	On-track	75	Off-track	37%	1
LESOTHO	84	Off-track	530	Off-track	26%	4
MOROCCO	38	On-track	110	Off-track	47%	3
PARAGUAY	23	Off-track	95	Off-track	42%	1
PHILIPPINES	33	On-track	94	Off-track	18%	2
SUDAN	108	On-track	750	Off-track	34%	9
SWAZILAND	73	Off-track	420	Off-track	40%	3
TIMOR LESTE	56	Off-track	370	Off-track	29%	2
UKRAINE	15	Off-track	26	Off-track	54%	1
UPPER-MIDDLE INCOME COUNTRIES						
BOTSWANA	57	On-track	190	Off-track	29%	3
BRAZIL	21	On-track	58	Off-track	7%	6
CHINA	19	On-track	38	On-track	15%	7
COSTA RICA	11	On-track	44	Off-track	N/A	1
ECUADOR	24	On-track	140	Off-track	N/A	4
GABON	69	Off-track	260	Off-track	25%	2
JORDAN	25	On-track	59	Off-track	8%	1
LIBYA	19	On-track	64	Off-track	21%	1
MAURITIUS	17	On-track	36	Off-track	N/A	1
MEXICO	17	On-track	85	Off-track	16%	6
NAMIBIA	48	Off-track	180	Off-track	29%	2
PANAMA	23	On-track	71	Off-track	19%	1
PERU	21	On-track	98	Off-track	30%	5
RUSSIA	12	On-track	39	Off-track	N/A	2
SOUTH AFRICA	62	On-track	410	Off-track	33%	11
HIGH INCOME COUNTRIES						
EQUATORIAL GUINEA	148	Off-track	280	On-track	43%	1
PUERTO RICO	N/A	N/A	18	Off-track	N/A	3

Source: http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Upper_middle_income

HUMAN RIGHTS TREATIES AND COUNTRY STATUS

COUNTRIES	LOW-INCOME AND ADDITIONAL COUNTDOWN TO 2015 COUNTRIES	CONVENTION ON THE RIGHTS OF THE CHILD			INTERNATIONAL LABOUR ORGANIZATION CONVENTION 183		CONVENTION ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN			INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS			
		SIGNATURE	RATIFICATION	ACCESSION	VOLUNTARY AGREEMENT/PARTIAL ADOPTION	RATIFICATION	SIGNATURE	RATIFICATION	ACCESSION	SIGNATURE	RATIFICATION	ACCESSION	SUCCESSION
AFGHANISTAN	x	x	x				x	x				x	
ANGOLA		x	x						x			x	
AZERBAIJAN				x		x			x			x	
BANGLADESH	x	x	x						x			x	
BENIN	x	x	x				x	x				x	
BOLIVIA		x	x		x		x	x				x	
BOTSWANA				x					x				
BRAZIL		x	x		x		x	x				x	
BURKINA FASO	x	x	x		x				x			x	
BURUNDI	x	x	x				x	x				x	
CAMBODIA	x			x			x		x	x		x	
CAMEROON		x	x		x		x	x				x	
CENTRAL AFRICAN REPUBLIC	x	x	x		x				x			x	
CHAD	x	x	x						x			x	
CHINA			x	x			x	x		x	x		
COMOROS	x	x	x						x	x			
CONGO				x			x	x				x	
COTE D'IVOIRE	x	x	x		x		x	x				x	
DEMOCRATIC REPUBLIC OF CONGO	x	x	x				x	x				x	
DJIBOUTI	x	x	x						x			x	
EGYPT		x	x				x	x		x	x		
EQUATORIAL GUINEA				x	x				x			x	
ERITREA	x	x	x						x			x	
ETHIOPIA	x			x			x	x				x	
GABON		x	x		x		x	x				x	
GAMBIA	x	x	x						x	x		x	
GHANA	x	x	x		x		x	x		x	x		
GUATEMALA		x	x		x		x	x				x	
GUINEA (BISSAU)	x	x	x				x	x				x	
GUINEA (KONAKRI)	x			x	x		x	x		x	x		
HAITI	x	x	x				x	x					
INDIA				x			x	x				x	
INDONESIA		x	x				x	x				x	
IRAQ				x					x	x	x		
KENYA	x	x	x						x			x	
KOREA, DPR	x	x	x						x			x	
KYRGYZSTAN	x			x					x			x	
LAO PDR	x			x			x	x		x	x		
LESOTHO		x	x				x	x				x	
LIBERIA	x	x	x						x	x	x		

COUNTRIES	LOW-INCOME AND ADDITIONAL COUNTDOWN TO 2015 COUNTRIES	CONVENTION ON THE RIGHTS OF THE CHILD			INTERNATIONAL LABOUR ORGANIZATION CONVENTION 183		CONVENTION ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN			INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS			
		SIGNATURE	RATIFICATION	ACCESSION	VOLUNTARY AGREEMENT/PARTIAL ADOPTION	RATIFICATION	SIGNATURE	RATIFICATION	ACCESSION	SIGNATURE	RATIFICATION	ACCESSION	SUCCESSION
MADAGASCAR	X	X	X				X	X		X	X		
MALAWI	X			X					X			X	
MALI	X	X	X			X	X	X				X	
MAURITANIA	X	X	X		X				X			X	
MEXICO		X	X		X		X	X				X	
MOROCCO		X	X						X	X	X		
MOZAMBIQUE	X	X	X						X				
MYANMAR	X			X					X				
NEPAL	X	X	X				X	X				X	
NIGER	X	X	X		X				X			X	
NIGERIA	X	X	X				X	X				X	
PAKISTAN	X	X	X						X	X	X		
PAPUA NEW GUINEA	X	X	X		X				X			X	
PERU		X	X		X		X	X		X	X		
PHILIPPINES		X	X				X	X		X	X		
RWANDA	X	X	X				X	X				X	
SAO TOME AND PRINCIPE	X			X			X	X		X			
SENEGAL	X	X	X		X		X	X		X	X		
SIERRA LEONE	X	X	X				X	X				X	
SOLOMON ISLANDS	X			X					X				X
SOMALIA	X	X										X	
SOUTH AFRICA		X	X				X	X		X			
SUDAN		X	X									X	
SWAZILAND		X	X						X			X	
TAJKISTAN	X			X	X				X			X	
TANZANIA	X	X	X				X	X				X	
TOGO	X	X	X						X			X	
TURKMENISTAN				X					X			X	
UGANDA	X	X	X				X	X				X	
UZBEKISTAN	X			X					X			X	
VIET NAM	X	X	X				X	X				X	
YEMEN	X	X	X						X			X	
ZAMBIA	X	X	X		X		X	X				X	
ZIMBABWE	X	X	X						X			X	

CONVENTION ON THE RIGHTS OF THE CHILD

http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en

INTERNATIONAL LABOUR ORGANIZATION CONVENTION 183

<http://www.ilo.org/ilolex/cgi-lex/ratifce.pl?C183>

CONVENTION ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN

http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en

INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en

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