

The Partnership for Maternal,
Newborn & Child Health

2015

Accountability Report

Strengthening Accountability:
Achievements and Perspectives for Women's,
Children's and Adolescents' Health



The Partnership
for Maternal, Newborn
& Child Health

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Foreword





Mrs Graça Machel
Chair, PMNCH



Robin Gorna
Executive Director, PMNCH

Foreword

We are delighted to publish the 2015 Accountability Report of the Partnership for Maternal, Newborn & Child Health (the Partnership; PMNCH).

This comes at an exciting time, close to the launch of both the Sustainable Development Goals (SDGs) and the updated Global Strategy for Women's, Children's and Adolescents' Health (the Global Strategy). Together they represent a tremendous broadening of horizons.

For the first time, ideas such as sustainability, gender equality and optimum health throughout the life-course have entered the mainstream of global development. The Global Strategy envisages a world in which every person in every setting counts, can realize their human right to health and is able to hold governments and other duty-bearers to account. In such a world, there can be no excuse for failing a single woman, child or adolescent.

These changes have profound implications for the Partnership. Our role has always been to promote communication, cooperation and complementarity amongst diverse partners to drive action. Accountability means we are all held to account for our promises and our actions. We are proud to have more than 700 member organizations across seven diverse constituencies. Building on strengths of every partner must expand greatly to reflect the universality of the SDGs and the Global Strategy and to make sure that accountability means we are all held to account for our promises and our actions. A newborn, a child, a teenager in a rural community are the centre of our vision – even more than an NGO, a UN agency, a development partner, government or an academic institution. The individual's voice must be heard and taken into account.

To make this possible, we are working with partners to pioneer ways of engaging people, institutions and organizations in mutual accountability at the global, regional, country and sub-national levels and we are growing our work in this area. We aim to develop safe spaces in which women, children and adolescents can give their inputs openly and be heard with respect and dignity, adding their voices to the process of collective accountability.

This is an immense task, but it is one we have readily embraced and in which we passionately believe. This report describes the numerous consultation events and citizens' hearings we have facilitated with partner organizations over the last year, engaging more than 2,000 people in several countries and across regions to make their voices heard. And it tells us that commitment makers are delivering on their financial commitments and are well on their way to disbursing at least three quarter of their committed funding to the Global Strategy for the period 2011-2015.

We stand at a moment of transition, as the world's gaze shifts from 2015 to 2030. A new countdown begins today, and this immensely important accounting work will continue until the last preventable death has been counted. As the global community combines to implement the SDGs and the Global Strategy, the as-yet unheard voices of millions worldwide must guide our efforts to ensure greater accountability for resources, right and results to the health of women, children and adolescents.

Executive Summary



This is the fifth Partnership for Maternal, Newborn & Child Health (PMNCH; the Partnership) annual accountability report. It presents the final update on financial commitments to the Global Strategy for Women's and Children's Health (2010-2015)¹ and looks ahead to the implementation of its successor, the updated Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).² Lessons learned from tracking and analysing commitments to the 2010 Global Strategy are discussed in the light of how they can help strengthen accountability for the updated Global Strategy in key areas such as:

- Integrating human rights into all aspects of women's, children's and adolescents' health;
- Engaging with civil society organizations (CSOs), parliamentarians and other stakeholders to align accountability and advocacy;
- Building capacity to conduct budget analysis and citizens' hearings.

The report includes a short overview of the accountability work of the Countdown to 2015 for Maternal, Newborn & Child Survival (Countdown).

Core findings from tracking financial commitments to the 2010 Global Strategy

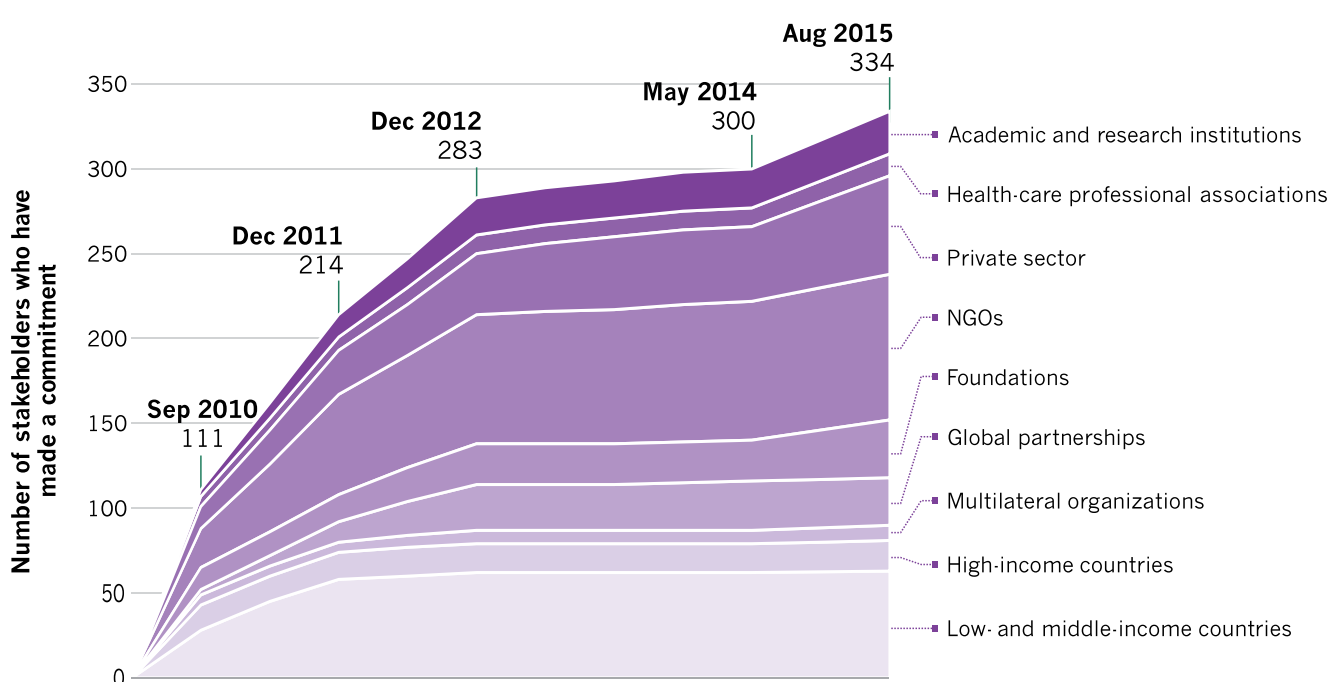
The analysis of financial commitments shows a number of encouraging trends in the implementation of Global Strategy commitments and financing for reproductive, maternal, newborn and child health (RMNCH).³ It also highlights areas that require additional focus.

1. Unprecedented support for the health of women and children.

By August 2015, 334 stakeholders had made 428 commitments to the Global Strategy (some made multiple pledges).⁴

Figure i

Global Strategy commitment-makers tripled to 334 in 2015



Source: Every Woman Every Child website.

2. Significant new financial commitments.

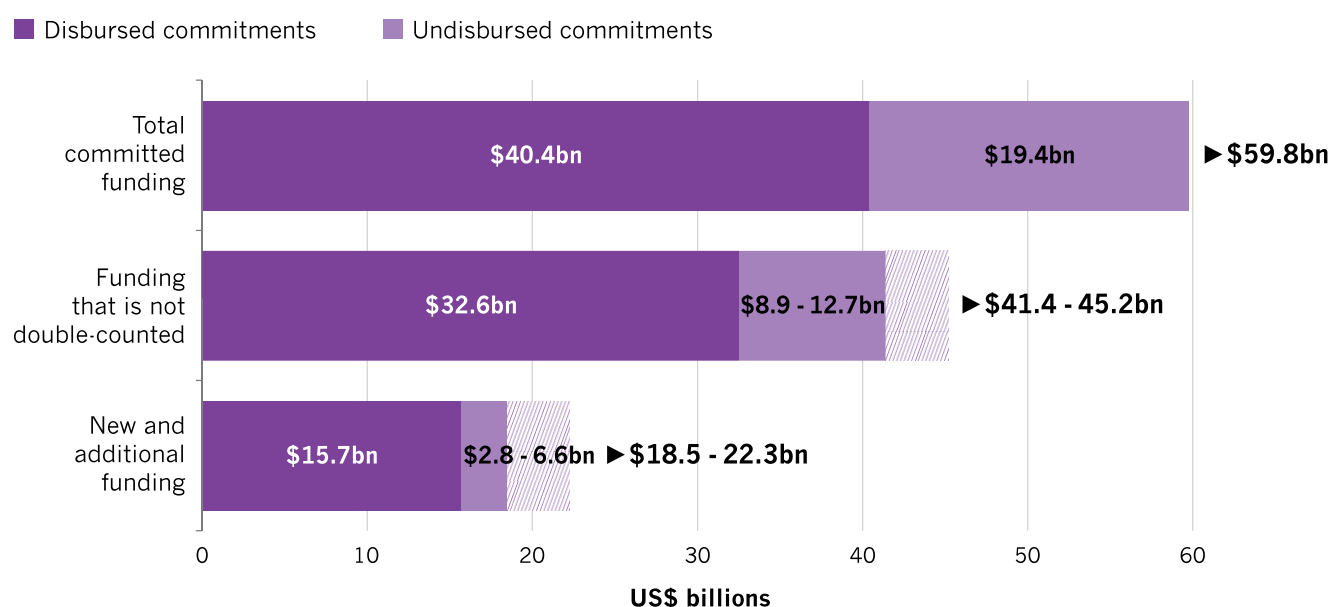
118 commitment-makers made financial commitments totalling almost US\$60 billion (US\$45 billion once double-counted funds have been removed⁵). US\$22 billion of these financial commitments were new and additional funding. The totals would be substantially higher if non-financial commitments were monetized.

3. Commitment-makers have disbursed at least three-quarters of their committed funding.

More than US\$40 billion (US\$33 billion once double-counted funds have been removed) of the US\$60 billion committed has now been disbursed – up from US\$34 billion in 2014 – indicating a disbursement rate of 74% since 2010 (Figure ii). The true rate is probably higher given delays in reporting.

Figure ii

Committed funding is being disbursed



Note: Actual disbursements are likely to exceed those shown: commitment-makers either provided data through Dec. 2013, Dec. 2014 or mid-2015. Striped segment visualize range of commitments. "Double-counting" relates to funding committed twice by different stakeholders. New and additional funding relates to investments that stakeholders committed in addition to their RMNCH spending levels prior to the Global Strategy.

Source: SEEK Development analysis

4. Overall donor funding has increased, but geographical inequities remain.

Commitments to the Global Strategy have contributed significantly to the trend of increased official development assistance for RMNCH.⁶ Donors disbursed US\$9.5 billion for RMNCH in the 49 Global Strategy countries in 2013; an increase of 31% since 2010.⁷ However, several high-burden countries received comparatively little donor funding, so inequities in the targeting of donor disbursements remain.

5. Domestic RMNCH spending has grown significantly since 2010, but funding levels remain insufficient.

Overall RMNCH expenditures by the 49 Global Strategy countries grew to a total of US\$2.8 billion in 2013; a 20% increase from 2010. However, expenditures on RMNCH have fallen in some countries, including in a number of fragile and conflict-affected states such as Haiti and the Central African Republic. Households are still the main source of RMNCH spending, and absorb much of the rise in health-care costs through out-of-pocket payments. The updated Global Strategy calls for greatly increased funding for RMNCH from domestic and international sources – and from both the public and private sectors – in order to hit targets for scaling up key health interventions by 2030.⁸

Key lessons learned from the Partnership accountability work

Based on the experience of the Partnership since the launch of the Global Strategy in 2010, this report has identified 12 key areas in which to improve overall accountability for the health of women, children and adolescents:

1. Support stakeholders in developing sound commitments, with strong linkages to internationally agreed goals and principles.

Technical support should be offered to stakeholders to help them produce clear, unambiguous commitments that are aligned with the Global Strategy, the SDGs and human rights obligations. In the past five years, the lack of specificity of commitments made it challenging to track their implementation. In addition, commitments were insufficiently focused on key goals (for example, only 16% specifically mentioned the MDGs), so assessing their impact was difficult. Commitments fell short of legally binding human rights obligations, despite women's and children's health being recognized as a fundamental human right.

2. Ensure that all tracking efforts are integrated.

Multiple accountability initiatives emerged for the Global Strategy, which led to a fragmented landscape. The updated Global Strategy proposes a single, integrated global accountability framework – including a comprehensive annual synthesis report on the State of Women's, Children's and Adolescents' Health prepared by an Independent Accountability Panel (IAP) – to improve overall coherence, cost-effectiveness and impact. This unified mechanism should be developed and deployed rapidly to avoid further duplication of tracking efforts.

3. Strengthen capacity to collect, analyse and synthesize data on resources, results and rights.

Additional investments are urgently required to strengthen existing capacity at global, regional and country levels for tracking progress for resources, results and rights, including the ability to cross-check self-reported data independently.

4. Highlight persistent cases of non-reporting.

Some commitment-makers repeatedly fail to meet the requirement to report annually on progress in implementing Global Strategy commitments. Under the new unified accountability framework, the IAP should highlight and comment on persistent cases of non-reporting. Stakeholders should receive support to help them overcome existing reporting barriers and improve accountability for their commitments.

5. Build on existing efforts to improve the tracking of funding.

Stakeholders should work together to harmonize and better utilize existing methodologies and approaches for tracking funding. An example is the policy-marker introduced by the OECD Development Assistance Committee in 2013 to track funding for RMNCH. Only a few donors have used the marker to date, and more extensive use is required if it is to produce meaningful data. The Global Strategy now includes an enhanced focus on adolescent health – as well as a stronger focus on non-financial commitments – a new and updated criteria for how to track commitments to adolescent's health as well as non-financial commitments will be needed. Formation of a time-limited technical working group should be considered to address this issue. As more countries acquire the means to finance their domestic health needs, institutionalized and standardized tracking of health expenditure will become increasingly important.



6. Make better use of existing mechanisms to track non-financial commitments, and agree on a method to monetize them.

The imprecise nature of many non-financial commitments to the 2010 Global Strategy has made it challenging to track their implementation and to identify meaningful criteria for measuring impact. However, there is an opportunity to strengthen the tracking of non-financial commitments by building on existing mechanisms. For example, all states report to various human-rights bodies on their progress in realizing the right to health (including the health of women and children).⁹ These mechanisms could potentially be updated to measure progress on the application of human rights to women's, children's and adolescents' health. To assist in assessing the value and impact of non-financial commitments, the time-limited working group (see point 5) should be tasked with developing an agreed method of monetizing non-financial commitments.

7. Collect disaggregated data to strengthen accountability for at-risk and vulnerable populations.

At-risk and vulnerable populations are often invisible in data collection and monitoring. To correct this, the collection and disaggregation of more financial and health-outcomes data are required, including by gender, age group, income and geography.

8. Hold individual commitment-makers accountable.

In the past, data aggregation has masked the lack of progress made by some individual commitment-makers. In future, disaggregated data should be used to hold them to account more rigorously by measuring their performance against their own commitments, and against identified human rights indicators and the SDG-related objectives of the Global Strategy.

9. Develop an accountability index to improve alignment between objectives and commitments.

An index, published annually, could rank individual commitments in terms of their contribution to the Global Strategy objectives. Existing indices, such as the Access to Medicine Index and the Access to Nutrition Index, could be used as models. The index should be closely linked to the unified accountability framework, and its rankings should be included in the State of Women's, Children's and Adolescents' Health report.

10. Facilitate a "mind shift" away from a traditional biomedical understanding of health, and expand accountability work to include monitoring of underlying determinants.

Continued efforts are needed to advocate for a holistic approach to public health. This should systematically integrate human rights and acknowledge the broader determinants of health and health inequalities – such as nutrition, access to education, discriminatory policies. Monitoring should be expanded to include the status of these underlying factors and the realization of related human rights.¹⁰ The updated Global Strategy reflects this broader definition of health (also captured in the SDGs). It recognizes the importance of cross-sectoral collaboration and synergy with other policy domains to address the determinants of health outside the health sector, and to counter narrow definitions of sexual, reproductive and maternal health.

11. Foster leadership of national civil society organizations (CSOs) and support local champions.

Civil society and local communities can play a critical role in holding states accountable for their commitments to the health of women, children and adolescents and for their human-rights obligations, including the right to health. National and local CSOs should be supported to work together to make their voices heard to make their voices heard at the national, regional and global levels. Increased efforts are required to support local champions, who are key to progress within countries. Additional *longer-term* funding (from domestic and international sources) is required to ensure that citizens can perform their function of holding duty-bearers accountable to rights holders.

12. Increase efforts to promote the role of parliamentarians and citizens' hearings.

Parliamentarians require support to fulfil their role as influential champions for the health of women, children and adolescents. Citizens' hearings are also a key tool to elevate the (local) voice of women and children to the national, regional and global levels. As such, they are important for improving accountability across levels and putting people at the heart of the SDGs. Creating better linkages between the global, regional and national levels is critical to increased accountability for women's, children's and adolescents' health.





Introduction

In September 2010, the United Nations Secretary-General (UNSG) Ban Ki-moon launched the **Global Strategy for Women's and Children's Health** (Global Strategy), which aims to save 16 million lives in the world's 49 poorest countries by 2015 and accelerate progress towards the achievement of Millennium Development Goals (MDGs) 4 and 5.¹¹ The Global Strategy has succeeded in mobilizing significant support and in uniting a broad range of stakeholders around a joint framework for action. As of July 2015, almost 350 stakeholders have made commitments toward achieving the goals articulated by the strategy.

Ensuring accountability for these commitments, and for women's and children's health and human rights more generally, has been a priority since 2010. Based on the accountability framework of the **Commission on Information and Accountability for Women's and Children's Health** (COIA),¹² the **independent Expert Review Group** (iERG) was formed in 2011 to review progress on the implementation of the COIA recommendations and to report on progress for women's and children's health to the UNSG.¹³

The **Partnership for Maternal, Newborn & Child Health** (PMNCH; the Partnership) has been key in advancing accountability for women's and children's health in recent years. Since 2011, it has produced four reports analysing the commitments made by countries and development partners to the Global Strategy. The Partnership further promotes accountability through a range of other activities. Most of these activities developed from the findings of the previous four accountability reports, which included gap analyses and recommendations. It also hosts the secretariat of the **Countdown to 2015 for Maternal, Newborn and Child Survival** (Countdown), which plays a central role in the follow-up to the Global Strategy by annually updating profiles that include progress data compiled on the 11 indicators selected by the COIA.¹⁴

In September 2015, the **Global Strategy for Women's, Children's and Adolescents' Health** (2016-2030) will be launched at the United Nations General Assembly (UNGA). As an update to the first Global Strategy, its vision is "a world in which every woman, child and adolescent realizes their rights to health and well-being,

and fully participates in shaping sustainable and prosperous societies beyond 2030” (refer to Appendix 1 for more details on the revised Global Strategy)¹⁵ and it highlights that “the survival, health and well-being of women, children and adolescents are essential to achieving all the **Sustainable Development Goals** (SDGs)”.¹⁶ Accountability continues to play a key role

in the context of the updated Global Strategy and a **new accountability framework** has been developed by the Global Strategy Accountability Working Group. Part of this new framework is an Independent Accountability Panel, which, once established, will play a key role for accountability in the health of women, children and adolescents (Appendix 2).

About this report

This report is the **fifth annual report by the Partnership on accountability for women’s and children’s health**. It provides the final update on financial commitments to the Global Strategy (2010-2015), and documents the work undertaken by the Partnership during the lifetime of this first Global Strategy to strengthen accountability for reproductive, maternal, newborn, child and adolescent health (RMNCAH). It focuses on challenges, **lessons learned** and opportunities for enhanced action on accountability for the delivery of the Global Strategy 2016-2030.

The **first objective** of this report is to provide an update on progress in implementing financial commitments to the Global Strategy. Building on the analyses conducted for the four previous accountability reports by the Partnership, this analysis of progress includes:

- A short overview of all financial and non-financial commitments made to the Global Strategy since its launch in 2010;
- An analysis of the value of financial commitments made to the Global Strategy through 2015, including the amounts that are double-counted and those that are new and additional;
- An assessment of progress in disbursing funding specifically pledged to the Global Strategy through 2015;
- An analysis of the broader financing trends for reproductive, maternal and child health by donors to assess how the Global Strategy may have impacted these trends, and an analysis of how this funding is aligned with the priorities spelled out in the Global Investment Framework for Women’s and Children’s Health (GIF).¹⁷

The **second objective** of this report is to describe the lessons learned from producing four reports analysing commitments to the Global Strategy, to inform future accountability processes. As tracking commitments will likely remain a critical pillar in the accountability work for the health of women, children and adolescents in the future, this report analyses the Partnership’s past experience to draw lessons on accountability for the updated Global Strategy.

The **third objective** is to assess further accountability activities catalysed by the Partnership, with a focus on those activities in which the Partnership, rather than individual partners, was involved. Most of these activities were undertaken in response to the findings and recommendations for action of the previous four accountability reports. Others follow the recommendations of the COIA and/or the iERG.¹⁸ They have mostly focused at the country- and regional levels:

- The Partnership’s engagement with RMNCAH civil society organizations (CSOs) for aligned advocacy and accountability at the community, national and regional levels, including enhancing capacity to undertake and respond to budget analysis, as well as collaboration on citizen’s hearings.
- Facilitating multi-stakeholder dialogues (MSDs), as well as discussions with parliamentarians around accountability for RMNCAH.
- Engaging with multiple stakeholders on the integration of human rights into health policies and programs, and building capacity to conduct country-level evaluations of the application of human rights to women and children’s health care provision.

In this context, the report also highlights the work of the Partnership’s members across constituencies, with a view to examining how the Partnership has enabled its reach, amplified country voices and increased capacities. In addition, the report includes a short overview of the accountability work of Countdown.

PANEL 1:**Methodology used to develop this report**

Data for the analysis presented in this report were collected using a range of methods, including:

- *An analysis of financial commitments to the Global Strategy:* This assessment is based on all financial commitments from the EWEK website.¹⁹ Based on methods developed for previous accountability reports by the Partnership, this financial analysis also estimates the amount of funding “double-counted”, and the value of additional funding (see Appendices 2 and 3 for details).²⁰
- *An analysis of disbursements against financial Global Strategy commitments, and an overall analysis of financing trends for women’s and children’s health:* Throughout 2015, key commitment-makers were approached to share their latest disbursement data. In addition, a review of key databases was conducted – the Organisation for Economic Co-operation and Development’s (OECD) Creditor Reporting System (CRS) database, which tracks official development assistance (ODA) disbursements, and the World Health Organization (WHO)’s “Global Health Expenditure Database” (GHED), which provides internationally comparable numbers on health expenditures.²¹ The Muskoka methodology was used to calculate the share of ODA benefitting the health of women and children.²²
- *A document review to analyse the Partnership’s accountability workstreams:* The review of the Partnership’s accountability work on commitment-tracking, human rights, as well as its work with CSOs and parliamentarians is based on an extensive desk review of documents produced by the Partnership and related Partnership members.²³
- *Key informant interviews:* Stakeholder consultations were conducted based on an interview questionnaire with 19 key-informants to identify successes, salient challenges and their possible solutions, and to determine lessons learned and where gaps in action or knowledge exist (Appendix 3).

The report is organized as follows: Chapter 1 provides the overview of stakeholder commitments to the Global Strategy and analyses its financial commitments, including an estimate of disbursements made to date against Global Strategy commitments. It also assesses broader financing trends to estimate how the Global Strategy has impacted overall RMNCAH financing.

Chapter 2 lays out the lessons learned from five years of tracking Global Strategy commitments. Chapter 3 assesses the work of the Partnership on human rights. Chapter 4 focuses on its work around citizens’ hearings and with CSO coalitions, and its engagement with parliamentarians. Chapter 5 provides conclusions and recommendations on the way forward.



Tracking financial commitments to the Global Strategy



Since 2011, the Partnership has produced **four reports analysing the commitments made to the Global Strategy**. In order to further understanding of the commitments to the Global Strategy, facilitate more effective advocacy to advance the Every Woman Every Child (EWEC) movement, and promote greater accountability in line with recommendations of the COIA, the Partnership developed the **2011 Report**, which analysed the nature and contents of commitments to the Global Strategy through May 2011, and also identified opportunities and challenges for advancement.²⁴ This first report was a pioneering and ground-breaking effort, as it specifically focused on commitments to one major global initiative and responded to the interest of the 49 countries targeted by the Global Strategy 2010, the international development community, media, and wider public to take a closer look at the commitments made at that time.

Building on this initial report, the **PMNCH 2012 and 2013 Reports** provided input to the annual iERG reports through their analysis of progress in implementing Global Strategy commitments.²⁵ Both reports used a

range of methods for data collection and analysis, such as key informant interviews, country case studies, thematic deep-dives, and web-based stakeholder surveys. For the report, methods were also developed to estimate financial commitments more accurately, including through the elimination of double-counting. Financial analyses were also conducted to assess the progress made in disbursing the funding committed to the Global Strategy and the impact of this funding on overall RMNCH financing trends.

The **2014 Report** provided a broad overview of stakeholder commitments to the Global Strategy and an update on financial commitments.²⁶ In **2015**, the Partnership provided key inputs on Global Strategy commitments to the 2015 EWEC Progress Report on the Global Strategy for Women's and Children's Health, as well as to the 2015 iERG report.²⁷ The following subsection builds on this previous work and provides a final high-level overview of stakeholder commitments to the first Global Strategy and the most recent update on the progress of commitment-makers in implementing their financial commitments.

Overview of commitments to the Global Strategy for Women's and Children's Health

The number of stakeholders that have made a commitment to support the Global Strategy has more than tripled since its launch in September 2010. By August 2015, a total of 334 stakeholders had made commitments to advance the Global Strategy (Figure 1).²⁸ Some commitment-makers made multiple commitments, bringing the total number of commitments to 428. Commitments were made by all constituencies of the

Partnership: low-income countries (LICs), middle-income countries (MICs), high-income countries (HICs), foundations, multilateral organizations, non-governmental organizations (NGOs), members of the business community, health workers and their professional associations, and academic and research institutions.

Thirty-four new stakeholders have joined the group of commitment-makers since May 2014, when the collection of information for the PMNCH Report 2014 was concluded. Of these 34 new commitment-makers, 17 made pledges in support of the Every Newborn Action Plan (ENAP).²⁹ The remaining 17 commitment-makers – including seven private companies and six philanthropic foundations – joined the EWEC movement by making ad-hoc commitments. Two new countries– Bolivia and Oman–also joined the EWEC movement.

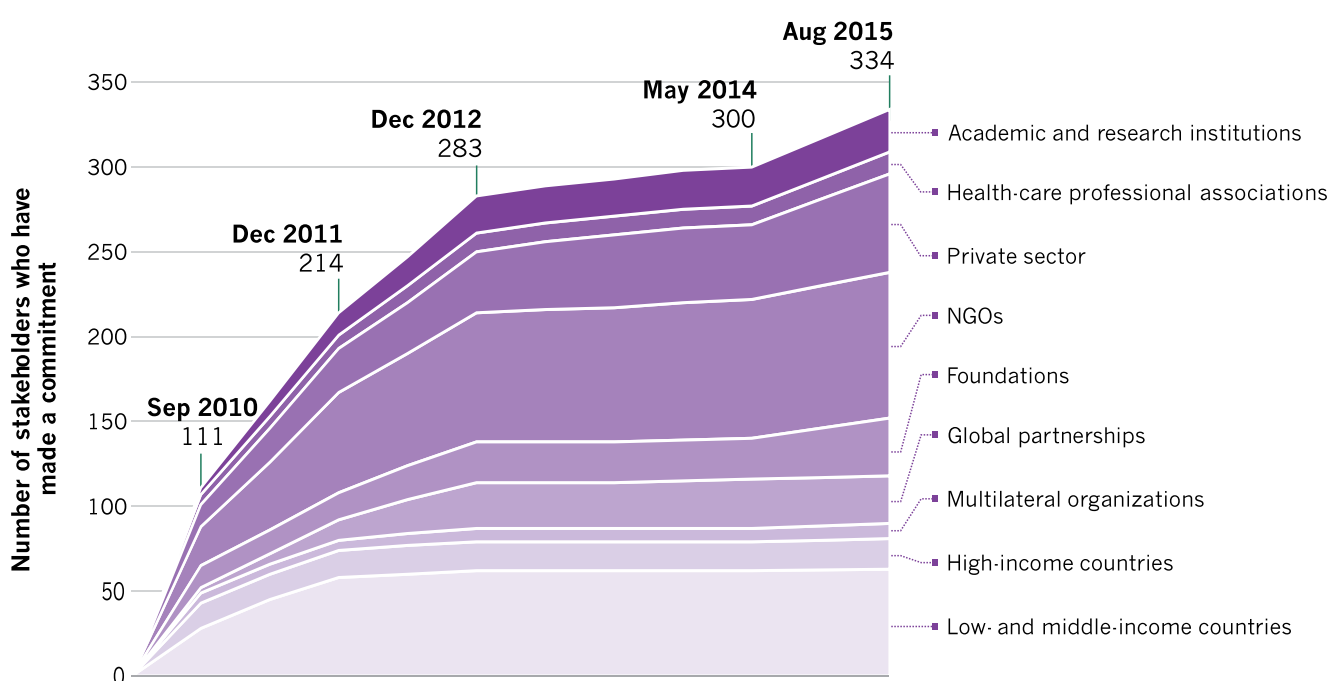
The ability of the Global Strategy and the EWEC movement to attract and maintain partners over time indicates a high degree of sustained political commitment to the health of women and children.



The Global Strategy (2010-2015) has mobilized unprecedented support for women's and children's health. Almost 350 stakeholders have made commitments since its launch in September 2010 to its end in 2015.

Figure 1

Global Strategy commitment-makers tripled to 334 in 2015



Source: Every Woman Every Child website.

Analysis of financial commitments to the Global Strategy for Women's and Children's Health

As of September 2015, financial commitments to the Global Strategy total US\$59.8 billion. This amount was committed by 118 stakeholders for the period 2011-2015.³⁰ However, a significant share of the overall commitment amount (US\$59.8 billion) is subject to

double-counting and needs to be subtracted to arrive at the actual value of financial commitments (see Panel 2, and Appendices 3 and 4 for details). When double-counted funding is removed, financial commitments for the timeframe of 2011-2015 amount to US\$44.5 billion (range: US\$41.4-45.2 billion).³¹

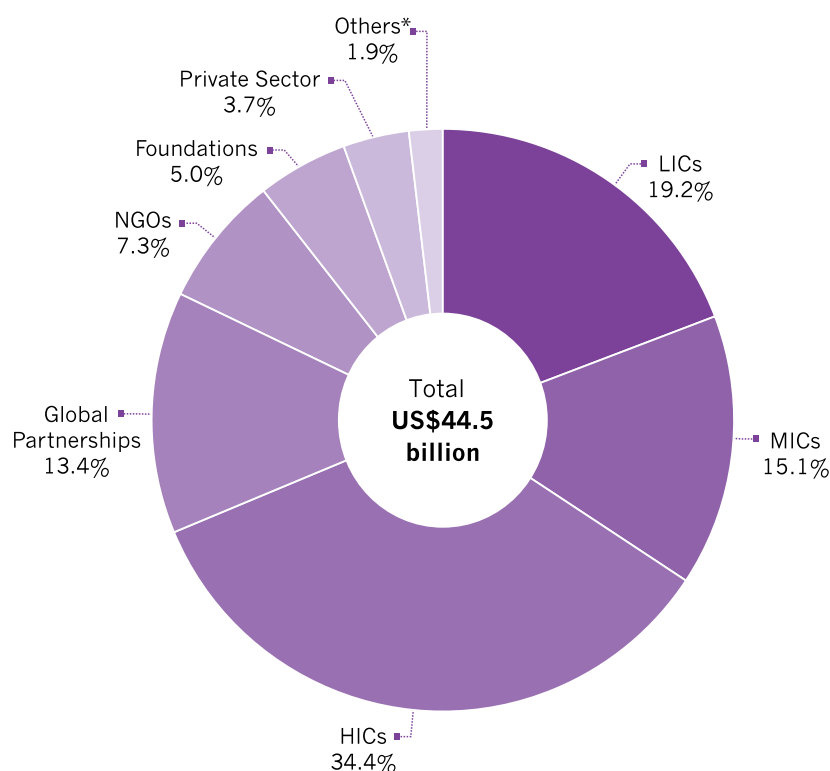


Financial commitments to the Global Strategy amount to US\$60 billion for the 2011-2015 period, and to US\$45 billion once doubled-counted figures are removed. A total of US\$19-22 billion is additional funding for the period 2011-2015.

Twenty-seven LICs and four MICs pledged a third (US\$15.2 billion) of the US\$44.5 billion committed to the Global Strategy. Another third (US\$15.3 billion) was pledged by 18 HICs. Global health partnerships, foundations, non-governmental organizations (NGOs), the private sector, and multilateral agencies also made substantial financial pledges (Figure 2). Efforts should be made to bring additional stakeholders into the EWEC movement in the future. In terms of financial commitments, a special focus should be given to a number of HICs, such as Singapore, United Arab Emirates, Switzerland, Saudi Arabia, Ireland, Austria,

Figure 2

Financial commitments across Partnership constituencies (up to September 2015)



In US\$ billion

Low-income countries	8.5
Middle-income countries	6.7
High-income countries	15.3
Global Partnerships	6.0
NGOs	3.3
Foundations	2.2
Private sector	1.6
Multilaterals	0.8
Health-care professional associations	0.03
Academic, research and training institutions	0.001

*Other includes multilaterals, health care professional associations, and academic, research and training institutions.

Italy, and Spain (in order of GDP per capita), who have not yet joined the movement. More countries should also be encouraged to commit non-financial as well as financial pledges – given the key importance of domestic financing going forward.

The funding pledged to Global Strategy also includes both previously existing RMNCH financing and additional investments that stakeholders committed to

disburse on top of their RMNCH spending levels prior to the Global Strategy. After excluding double-counted funding, additional resources for women's and children's health amount to an estimated US\$18.5-22.3 billion for the period 2011–2015. International development partners account for US\$13.1 billion of the additional funding and LICs for an estimated US\$5.4–9.2 billion. Of the additional funding, an estimated US\$13.1-16.8 billion is targeted specifically at the 49 Global Strategy focus countries.³²

PANEL 2: Double-counting and additionality of commitments

“Double-counting” relates to funding committed twice by different stakeholders. Controlling for double-counting in Global Strategy commitments is essential to avoid artificially increasing the funding figures. To avoid double-counting of commitments made by international stakeholders, financing sources were differentiated from financing channels, a differentiation introduced by the Institute for Health Metrics and Evaluation (IHME).

One important instance of double-counting occurs when a source of international financing, such as a donor country or a foundation, channels funding through multilateral organizations, global health partnerships or CSOs, and when both the source and the channel count this funding as part of their commitment. While it is legitimate that both the source and the channel count the funding as part of their commitment, it is important to assess and subtract double-counted financing to arrive at an accurate picture of overall financial commitments made. Commitments by LIC and MIC governments are also likely to be financed partly by external resources, which means that their commitments may overlap with commitments made by donors. Methods for calculating double-counted funding were developed for previous accountability reports by the Partnership, and are laid out in Appendix 5.

“Additional funding” relates to new funding that stakeholders have committed to provide on top of RMNCH spending levels prior to the Global Strategy. It is important to stress that many stakeholders indicated that it was difficult to determine whether their funding was additional. In these cases their commitment was not counted as such, as we used a conservative approach and only included confirmed additional funding.



Tracking disbursements against Global Strategy commitments

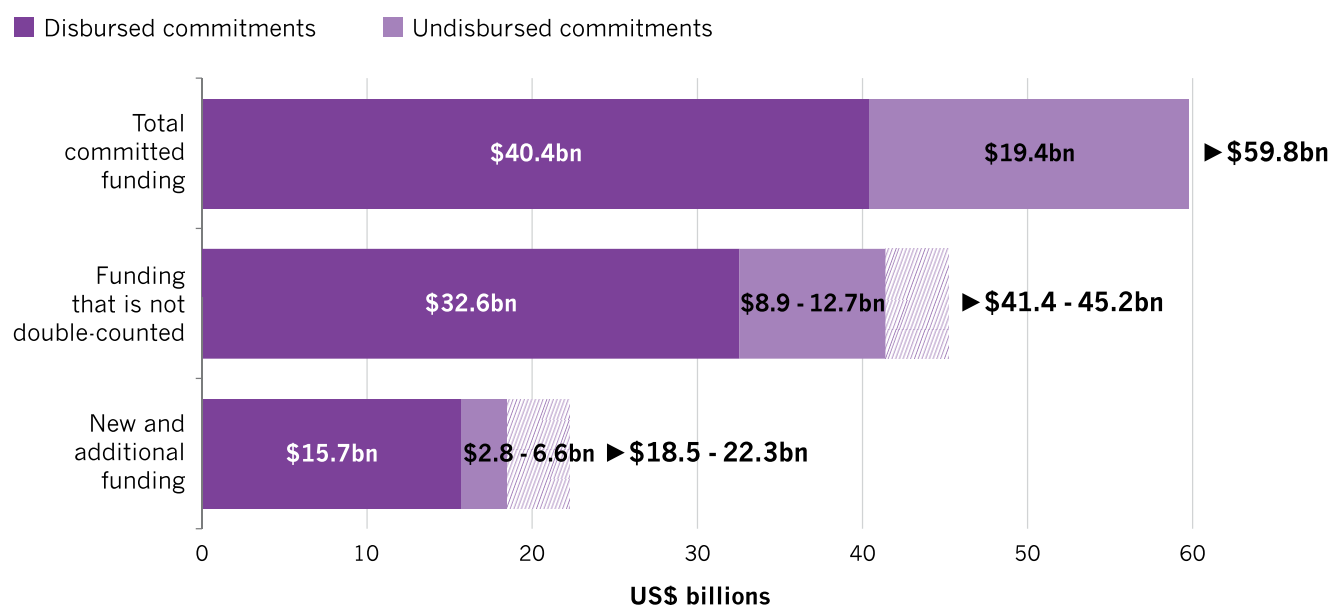


At least US\$33 billion of the US\$45 billion in financial commitments (once double-counted funds have been removed) have been disbursed by commitment-makers (74%). As there is a time lag in reporting, actual disbursements are likely to be higher.

Latest available data show that the progress of commitment-makers in disbursing their committed funding is on track. Almost 70% (US\$40 billion) of the US\$60 billion committed have been disbursed. Once double-counted funds are excluded, the disbursement rate is even higher: 74% or US\$33 billion of the US\$41.4-45.2 billion have been disbursed.³³ These figures capture disbursements made from 2011 to 2013 for most commitment-makers. However, a number of key commitment-makers were able to report on disbursements until end of 2014/mid-2015.³⁴ Given these reporting delays, the actual amount disbursed is very likely higher than currently documented.

Figure 3

Disbursements against Global Strategy commitments



Note: Actual disbursements are likely to exceed those shown: commitment-makers either provided data through Dec. 2013, Dec. 2014 or mid-2015. Striped segment visualize range of commitments. "Double-counting" relates to funding committed twice by different stakeholders. New and additional funding relates to investments that stakeholders committed in addition to their RMNCH spending levels prior to the Global Strategy. Source: SEEK Development analysis.

Update on overall RMNCH financing trends



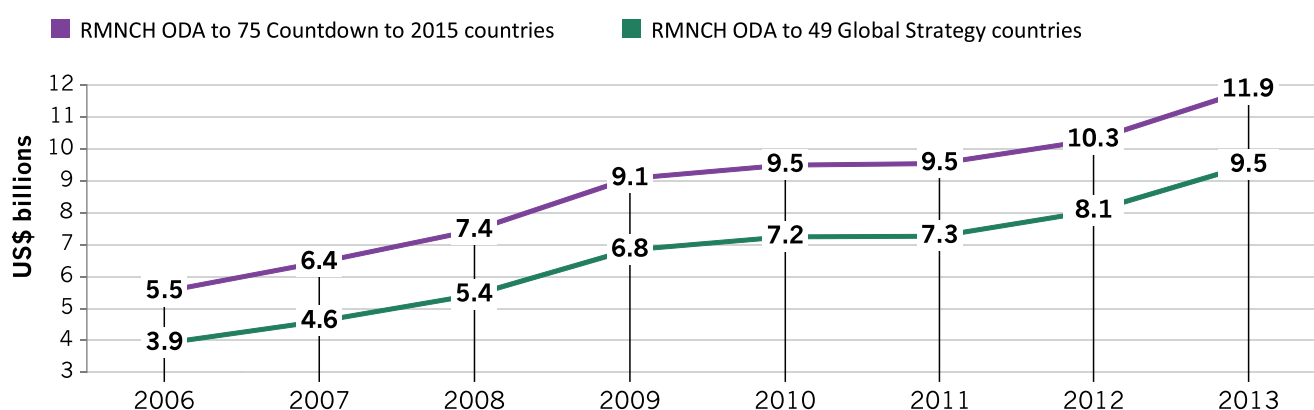
In 2013, donors disbursed US\$9.5 billion to improve RMNCH in the 49 Global Strategy countries, an increase of 31% since the launch of the Global Strategy in 2010. Disbursements to the 75 Countdown countries totalled US\$11.9 billion in 2013, an increase of 25% since 2010. Increased spending by commitment-makers to the Global Strategy drove this increase.

This section analyses the broader RMNCH financing trends – ODA for RMNCH by international donors – to assess how the Global Strategy may have positively influenced these trends. To estimate donor disbursements to RMNCH, data from the CRS database was analysed using the Muskoka methodology.

Our analysis reveals that donors disbursed a total of US\$9.5 billion for RMNCH interventions in the 49 Global Strategy countries in 2013, resulting in an increase of 31% since the launch of the Global Strategy in 2010. Disbursements to the 75 Countdown priority countries – of which the 49 Global Strategy countries are a subset – also rose by 25%, from US\$9.5 billion in 2010 to US\$11.9 billion in 2013 (Figure 4).³⁵ These increases are driven by major commitment-makers to the Global Strategy (e.g. Canada; Norway; the United Kingdom), indicating that the Global Strategy has had a significant positive influence on overall RMNCH financing trends. In 2013 alone, RMNCH ODA to the 49 Global Strategy and the 75 Countdown countries grew by 18% and 15%, respectively, compared to 2012.³⁶

Figure 4

RMNCH ODA disbursements to 49 Global Strategy and 75 Countdown countries, 2006–2013



Note: Gross disbursement in US\$ billions - 2012 prices.

Source: OECD CRS.

Figure 4 shows that 80% of donor disbursements for RMNCH to the 75 Countdown countries in 2013 were allocated to the 49 Global Strategy priority countries – which constituted the poorest countries at the time of the Global Strategy launch. This share has increased

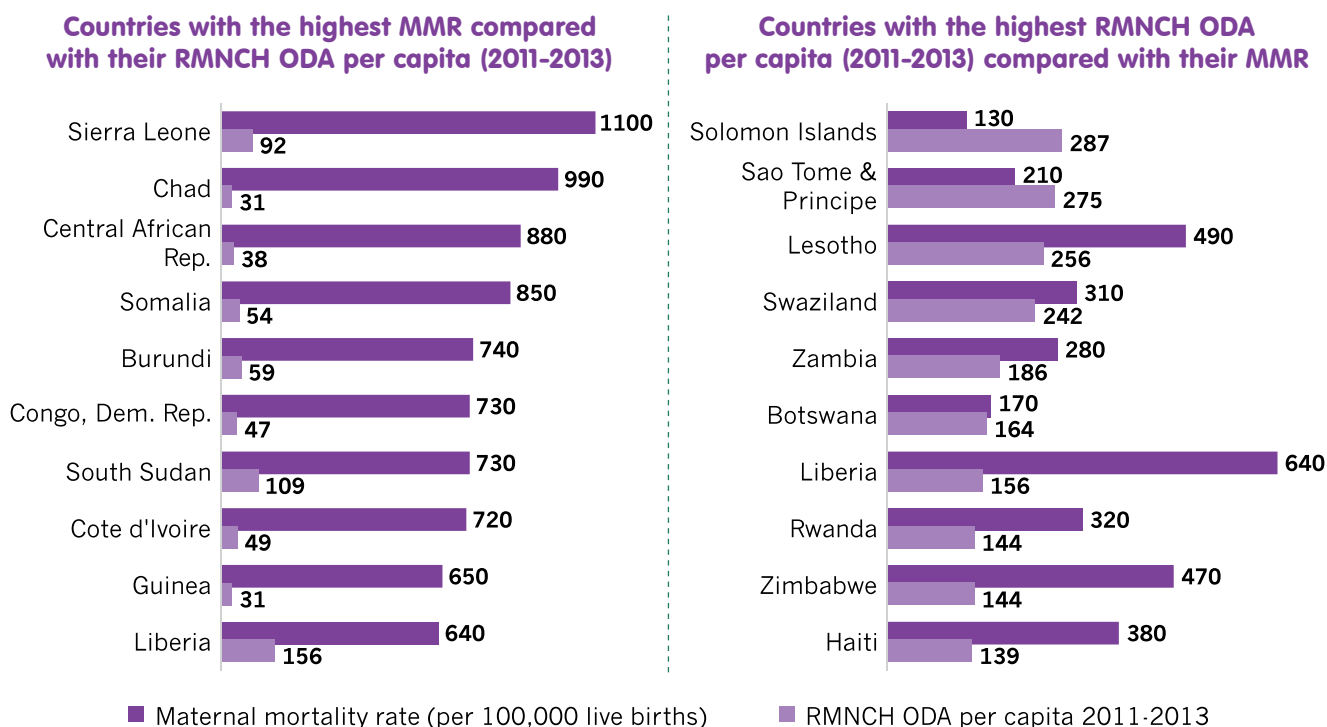
continuously since 2007 when it stood at 71%. In addition, some of the countries with the highest high maternal mortality ratios (MMR), such as Sierra Leone, Chad and Cote d'Ivoire, experienced a rise in RMNCH donor support in 2013 after a period of a decline.

However, despite the stated focus on equity in the Global Strategy and repeated references in the annual accountability reports by the Partnership and the iERG to the importance of equitable investments, there remain inequities in the geographical targets of donor

disbursements. Figure 5 illustrates that a number of LICs with very high MMRs still receive comparatively little donor support, and there are similar geographical inequities when analysing RMNCH ODA and countries' under-five mortality burden (Figure 5).

Figure 5

Geographical targeting of donor funding and countries' needs, 2011-2013



Note: There are similar geographic inequities when analyzing RMNCH ODA and countries' under-five mortality burden.

Source: OECD CRS & WHO, UNICEF, UNFPA, World Bank: Trends in maternal mortality, 1990-2013.

Other resource-tracking exercises undertaken by Countdown and IHME have found similar overall trends in donor financing flows for RMNCH. The latest Countdown to 2015 analysis estimates that RMNCH funding to the 75 Countdown countries grew by 15% between 2010 and 2012 (findings for 2013 are forthcoming).³⁷ IHME finds that donor funding for maternal, newborn and child health increased by 30% between 2010 and 2013.³⁸ While overall trends are similar among the different tracking exercises, there are diverging findings for individual years or on overall absolute amounts. These result from methodological differences (see also Chapter 2 and Appendix 6 for an overview of the different tracking initiatives).³⁹

Donor funding for key priorities identified in the GIF has increased.⁴⁰ Our analysis shows that since 2010, funding for family planning to the 49 Global Strategy



Donor funding for family planning and other key interventions has increased since the launch of the Global Strategy.

countries and the 75 Countdown countries rose by 60% and 50%, respectively (Appendix 7). However, 2010 baseline spending for family planning was very low, and the growth rate in donor support started to slow down in 2013. Donor funding for maternal and newborn health grew steadily and significantly between 2010 and 2013, but like family planning, remains underfinanced. HIV-related RMNCH funding⁴¹ continues to be the largest funding area, followed by immunization.⁴²

Government RMNCH expenditures



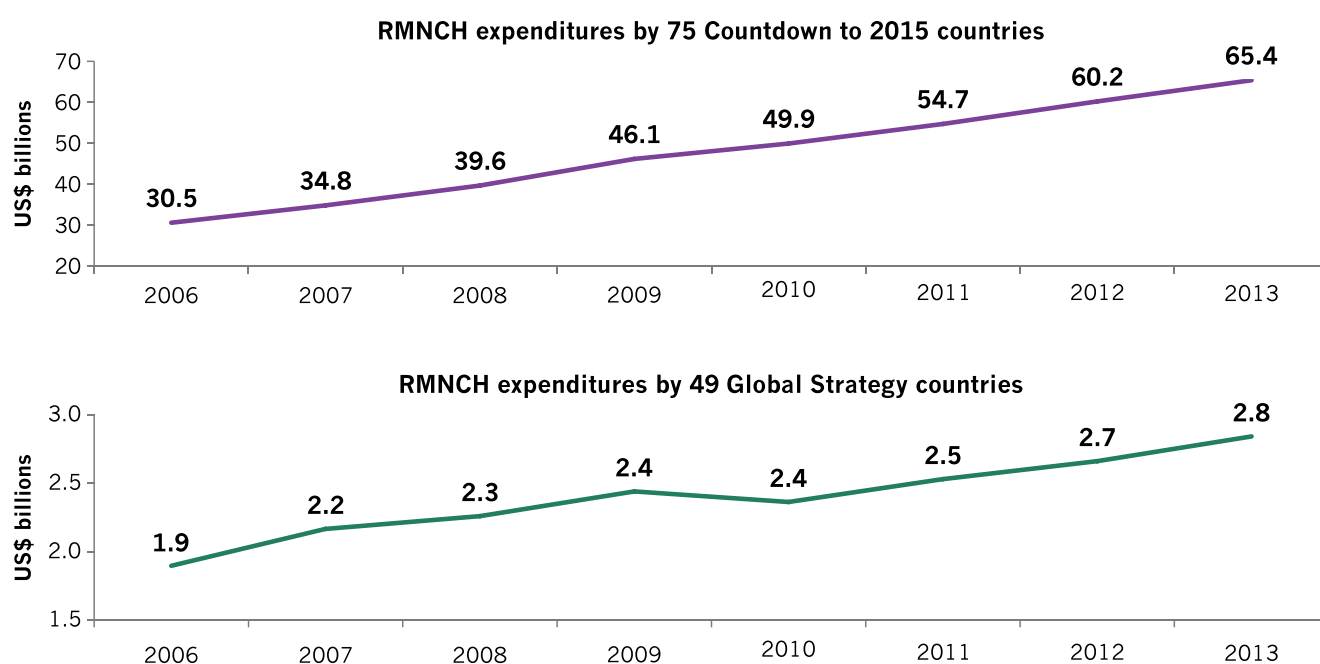
Government expenditures for RMNCH in the 49 Global Strategy countries and in the 75 Countdown countries have increased since the launch of the Global Strategy. However, it is critical that countries increase their domestic RMNCH investments much more rapidly. Many of them are projected to experience substantial economic growth and should have the required fiscal space for increased RMNCH investments.

Government expenditures for RMNCH in the 49 Global Strategy countries and in the 75 Countdown countries have also shown substantial increases since the launch of the Global Strategy (Figure 6). In 2013, government expenditures reached a total of US\$2.8 billion in the 49 Global Strategy priority countries and US\$65.4 billion in the 75 Countdown countries. This corresponds to an increase in government expenditures for RMNCH of 20% and of 31%, respectively, over 2010 spending levels.

In order to estimate the actual spending by LIC and MIC governments and to avoid any double-counting with donor financing for RMNCH, funding that LIC and MIC governments received from donors was excluded.⁴³ In addition, to calculate government RMNCH expenditures in LICs and MICs, it was assumed that 25% of total government health expenditures benefitted RMNCH. This assumption is in line with the financial estimates laid out in the Global Strategy.⁴⁴ However, as this is only a proxy, which was used due to lack of better data, results need to be considered as rough estimates.

Figure 6

Government RMNCH expenditures in the 75 Countdown and the 49 Global Strategy priority countries, 2006 – 2013



Note: Expenditures in US\$ billions - 2005 prices.

Source: GHED and CRS.

The impressive increase in RMNCH expenditures among the 75 Countdown countries is due primarily to a surge in spending by nine upper middle-income countries (UMICs) such as Botswana, Brazil, China, and Mexico; one HIC (Equatorial Guinea); and India, the largest lower middle-income country (LMIC). These countries alone account for 93% of the additional RMNCH expenditures by the 75 Countdown countries between 2010 and 2013. When these 11 countries are excluded, the increase of RMNCH expenditures in the 75 Countdown countries is substantially smaller, equalling the growth rate in the 49 Global Strategy countries (20% between 2010 and 2013).

However, a recent analysis of health accounts data from 12 countries shows that, on average, 49% of all RMNCH expenditures were covered by households and 39% by external sources.⁴⁵ Government expenditures accounted for only 21% of all RMNCH expenditures in these 12 countries. These study findings show that due to insufficient government spending, private individuals continue to absorb much of the health care costs through out-of-pocket payments. Annually, an estimated 150 million people worldwide experience financial catastrophe due to the cost of care, while many others forgo necessary treatment because of the inability to pay.⁴⁶

Moving forward, it will be important that domestic financing increases further. Recent projections indicate significant continued economic growth in LICs and LMICs. Ensuring that this growth translates into increased domestic spending on health is critical.⁴⁷ Under international human rights law, states are obligated to invest in the health of women, children and adolescents, including across the spectrum of sexual and reproductive health, with a particular view to the availability, accessibility, acceptability and quality of care.⁴⁸ The role of technical support and political advocacy will become increasingly important for the successful expansion of their fiscal space and revenues for health.



While overall government expenditures increased since 2010, RMNCH expenditures fell in a number of countries, including in a number of fragile and conflict-affected states.

While the overall trend in government RMNCH spending is encouraging, there are governments that have decreased their health expenditures since 2010. This includes Burundi, Guinea, Guinea-Bissau, Sao Tome and Principe, Solomon Islands, and Vietnam.

Government expenditures fell in fragile and conflict-affected states, such as Haiti and the Central African Republic, which decreased their health expenditures by 69% and 33% between 2010 and 2013. This is worrying trend – as people living in fragile and conflict-affected states are disproportionately affected by major health problems. Going forward, one new way to finance health improvements among people living in conflict or post conflict settings would be to create pooled funds that transfer funding to frontline providers through performance contracts. These pools would be governed through participatory mechanisms and placed under citizens' control.⁴⁹



Lessons learned from five years of commitment tracking (2011-2015)

During the course of the past five years, the Partnership was confronted with different challenges to tracking progress in the implementation of commitments to the Global Strategy. A key objective

of this report is to reflect on the experiences and challenges of these past tracking efforts and to draw out lessons learned. In this section, ten lessons learned are highlighted.

Support stakeholders in developing sound commitments with strong linkages to the SDGs and related human rights

In the past five years, the lack of specificity of commitments made it challenging to track progress in the implementation of commitments. One particularly crucial example relates to the additionality of commitments. The vast majority of commitments did not make clear whether the activities are new and additional, or whether they just refer to former activities that are reengineered, and would have been implemented by stakeholders anyway. Often, it was only clarified during the tracking process whether a commitment was additional or not. There are also several commitments that broadly refer to general goals, without making reference to any activities, or investments. Ultimately, this raises the question of what constitutes a commitment, and what needs to be in place (for a pledge) to qualify as a commitment.

In addition, commitments were not sufficiently focused on the health-related MDGs (MDGs 4 and 5 in particular). An analysis conducted for this report shows that only 69 commitments out of a total 428 specifically mentioned the MDGs (16%). Some MDG areas received more attention than others with MDG 5 attracting the most commitments and fewer commitments made towards MDG 4. Despite their critical importance to women's and children's health, relatively few commitments relating to MDG 1 (poverty), MDG 2 (female education) and MDG 7 (WASH) were registered. As a result, several proven high-impact interventions did not receive due attention including breastfeeding, pneumonia diagnosis and treatment, water, sanitation and hygiene, household air pollution, female education and employment (Appendix 8).

Some commitments made under the Global Strategy also fell short of legally binding human rights obligations to which states signed up decades ago.

Moving forward, tailored support should be provided to stakeholders so that new commitments are well positioned to accelerate achievement of all sustainable development goals (SDGs) targeted by the updated Global Strategy. This could comprise, for example, including SDG impact targets and indicators, deliverables,

time-lines and a description of how progress will be measured and reported against the upcoming SDG goals targeting the health of women and children.⁵⁰ Clearer criteria for commitment-making would also improve the tracking of progress in implementing commitments. While work is ongoing to further update the guidelines for making commitments to the Global Strategy 2010-2015, stakeholders will require additional support to meet the requirements. Going forward a clear plan about roles and responsibilities is therefore crucial.

Ensure that all tracking efforts are integrated

The Partnership was asked to specifically review the implementation of Global Strategy commitments. This targeted approach – with a focus on one global initiative – made the tracking effort more manageable, and the results easier to understand and therefore more attractive to countries, partners and the wider public. Being able to both show how individual commitments added up to a broader goal and to highlight the progress achieved in reference to this goal, made the overall effort more meaningful and effective for advocacy for women's and children's health.

At the same time, a targeted approach to accountability has its drawbacks. As the accountability reports were not a comprehensive stocktaking of all major efforts in women's and children's health, other initiatives were left out. Certain stakeholders, including major donors, did not make major commitments to the Global Strategy, but rather made substantial contributions outside of the Global Strategy framework. These commitments were therefore not (or only partially) reflected in the tracking of Global Strategy commitments, which led to a perception of underreporting. In this context, commitment-makers highlighted that commitments may merely be political statements, that much of the action lies outside these commitments, and that this action would not be visible

through a commitment-focused tracking approach.⁵¹ In addition, multiple accountability initiatives emerged in recent years, which led to a fragmented landscape for RMNCAH accountability, resulting in inefficiencies, with commitment-makers criticizing the duplicative requests from different tracking initiatives.

Moving forward, all accountability efforts for the health of women, children and adolescents should be integrated as much as possible. As described in the renewed Global Strategy, the Unified Accountability Mechanism is the agreed way forward to harmonize global reporting to improve overall coherence, cost-effectiveness and impact. The Independent Accountability Panel, which will be established as part of the new accountability framework, is envisioned to develop a comprehensive annual synthesis report on the State of Women's, Children's and Adolescents' Health. This report represents an effort to ensure alignment and consistency of reporting requirements across existing initiatives and accountability mechanisms to ensure that all significant contributions to the health of women, children and adolescents are covered and to mitigate the reporting burden of countries. It will be crucial to rapidly operationalize and implement this unified mechanism to avoid any further duplication of tracking efforts in the future.

Establish stronger capacity to collect, analyse and synthesize data on resources, results and rights to allow for better tracking of progress and to mitigate the limitations of self-reported data

Much of the data gathered for previous accountability reports by the Partnership were the result of self-reporting (through web-based surveys and interviews). Self-reported data can overstate progress made, and it is also difficult to learn lessons from what has not worked, as commitment-makers tend to share positive progress. Survey responses included few examples of implementation that had not gone according to plan. To the extent possible, alternative data sources were used (including for cross-checks), such as disbursement data from the OECD-DAC; however, the use of such data was restricted due to a lack of

alternative data sources for key commitment areas, such as health worker training, the establishment of new facilities and improvements in service quality.

In the future, there is an urgent need to strengthen capacity for a more independent analysis of progress data, as well as for its collection. Additional investments are required to strengthen existing capacity for tracking progress in the implementation of commitments, including the ability to independently cross-check self-reported data. To mobilize the necessary resources, the costs for establishing this capacity should be estimated.

Highlighting and comment on non-compliance in reporting

The percentage of commitment-makers who completed the progress surveys conducted for the 2012 and 2013 accountability reports of the Partnership dropped from 76% in 2012 to 45% in 2013.⁵² This declining response rate posed a considerable challenge to making sure the analysis was comprehensive and not biased, and is an important indication that new approaches are required to encourage commitment-makers to participate in efforts to monitor progress. Information collected on progress made by different constituency groups also differed, with, for instance, weaker responses from the private sector.

While the current EWEC guidelines on making Global Strategy commitments require annual progress updates, stronger processes are needed to ensure

regular progress reporting by commitment-makers. If commitment-makers repeatedly fail to meet the reporting requirements, the Independent Accountability Panel should highlight and comment on this non-compliance in the State of Women's, Children's and Adolescents' Health report. However, stakeholders should also be supported in their reporting efforts, to help them overcome existing reporting barriers and improve accountability for their commitments.

To collect more detailed and reliable information on the implementation of commitments, it could also be considered to better tailor the reporting to the needs of constituency groups. Companies, for instance, could document progress in implementing their RMNCAH commitments as part of their shareholder reports.

Build on existing efforts to improve the tracking of RMNCAH funding

Over the past five years, the Partnership has developed methods to track financial commitments to the Global Strategy, to estimate which funding is double-counted, and which is new and additional. As highlighted above, commitments were often imprecise, so information on double-counting and additionality had to be collected as part of the assessment process. Future commitments should include information on disbursement channels, such as multilateral agencies and global health partnerships, and whether committed funding is made on top of baseline spending. The tracking of financial commitments also suffered from a time lag between disbursements and reporting on them (a time lag of up to two years). Many donors have aligned their reporting with the CRS database of the OECD DAC, which makes it difficult to track whether donors are living up to their commitments in a timely manner (the CRS currently includes data until 2013; 2014 data will only become available in December 2015). As the CRS database also lacks categories for the tracking of RMNCH financing, a number of alternative tracking initiatives have emerged that use different approaches, and – to some extent – produce divergent findings. Tracking progress on pledges made by LICs and MICs to increase domestic financing for women's and children's health was even harder due to data challenges.

Going forward, ongoing efforts to track international and domestic financing for RMNCH should be advanced. The OECD Working Party on Development Finance Statistics decided to introduce an RMNCH marker to its reporting system to track funding for

RMNCH. The marker was used for the first time in 2014 for reporting on 2013 aid flows and will be evaluated after a two-year trial period. Although this initiative is important, so far only a limited number of DAC donors have used the marker (donors require more time to adjust their systems for its use). Without a much more rigorous use of this marker, it will not produce meaningful data. In addition, an enhanced dialogue among the tracking initiatives, including the Partnership, Countdown, and IHME, is needed to facilitate possible future harmonization and alignment of approaches. To improve the dialogue between initiatives, the formation of a time-bound technical working group within the broader remit of the Unified Accountability Mechanism should be considered, which would include representatives from the different initiatives, as well as other health financing experts.

The Lancet Commission on Investing in Health projected substantial economic growth into the next decade, which should enable countries to spend more on health themselves. With more countries able to finance their domestic health needs and fewer dependent on external support, the tracking of domestic resources will become increasingly important. WHO is implementing measures to improve the tracking of national expenditures for RMNCH through the Health Accounts Country Platform Approach⁵³ but more resources, both technical and financial will be needed to institutionalize the tracking of domestic financing for women's and children's health in a larger number of countries.

Collect disaggregated data to enhance strengthen accountability for at-risk and vulnerable populations

Ensuring accountability for at-risk and vulnerable populations is a critical challenge. Often, these groups are invisible in data collection and monitoring. Enhancing accountability for at-risk and vulnerable

groups requires more disaggregated financial and health outcome data, including by gender, age group, income, and geography. This level of tracking is also aligned with states' human rights obligations.

Make better use of existing mechanisms to track non-financial commitments

The initial absence of strong guidelines for the making of commitments led to a very diverse and uncategorized set of commitments, especially of non-financial commitments, such as to policy, service delivery, advocacy, research, and in-kind commitments. This also resulted in challenges to progress reporting as many commitment-makers would not track progress towards their non-financial commitments systematically, and instead reported on a variety of activities that may or may not be linked to their commitment.⁵⁴

Tracking non-financial commitments continues to be of key importance in the context of the revised Global Strategy. There is scope for strengthening accountability for the health of women, children and adolescents by building on existing mechanisms. For example, by making better use of existing human rights instruments. All states report on their progress in realizing the right to health, including health of women and children, to various human rights mechanisms, including the Universal Periodic Review (UPR), the Committee on Economic, Social and Cultural Rights (CESCR), the Committee on the Elimination of Discrimination Against Women (CEDAW), and the Committee on the Rights of the Child (CRC). While efforts are needed to improve further the quality of information provided to these mechanisms on RMNCAH issues, the resulting recommendations from these reviews are one example of concrete means by which to strengthen accountability for women's and children's health.

In addition, to leverage the different Partnership constituencies more effectively, establishing a constituency-led and owned accountability approach could be considered. Constituencies could be highly instrumental in encouraging commitment-makers to collect and report progress data more systematically. This could be an innovative, more effective and more cost efficient way to track progress on the implementation of commitments for women's,

children's and adolescents' health. Again, it would be important to ensure that self-reported progress data is sufficiently cross-checked. At the same time, it should be recognized that any reporting option requires significant effort and resources, both from those providing information and those collecting it.



Develop and agree on a method to monetize non-financial commitments

Significant non-financial commitments have been made to the first Global Strategy, but their financial value has never been estimated due to the lack of an agreed upon costing approach. Therefore, the full value of all commitments made to the Global Strategy has never been estimated.

In the future, a method for monetizing non-financial commitments should be developed to estimate the overall value of commitments made. The proposed time-limited working group for the harmonization of financial tracking approaches should be tasked with the development of a costing method.

Hold individual commitment-makers accountable and leverage collected information for mutual learning

The ultimate question is for what purposes the information collected during the commitment-tracking is used. Previous accountability reports reported on aggregated progress – for example, overall disbursement levels – rather than on the progress and shortcomings of individual commitment-makers. Consulted stakeholders suggested to move away from aggregated reporting and to more strongly hold individual commitment-makers accountable in a fully transparent and public way. In the future, individual commitment-makers should be held to account more rigorously by measuring their performance against their own commitments, as well as against identified human rights indicators and the SDG-related goals of

the updated Global Strategy. Moreover, this newly tracked information could be leveraged for the benefit of mutual learning – it should be used to inform all relevant stakeholders what has worked in the past and what not.

In addition, a stronger focus on evaluating outcomes and impacts is required. Countdown has done very important work in the compiling and presenting of available data especially on coverage of health and policy interventions (Panel 2). However, there remains a recognized need to develop more comprehensive tracking mechanisms – through outcome assessments and other means.

Develop an accountability index

To hold individual commitments-makers accountable, an Index could be developed and released publicly at regular intervals ranking individual commitment makers according to the relative impact of their commitments. This approach could be piloted with the private sector, and there are two Indices that could serve as models: The Access to Medicine Index independently ranks pharmaceutical companies'

efforts to improve access to medicine in developing countries and the Access to Nutrition Index, which ranks food and beverage companies on their nutrition-related policies, practices and performance worldwide.⁵⁵ The index should be closely linked to the Unified Accountability Mechanism, and its standings should be included in the State of the Women's, Children's and Adolescents' Health report.

PANEL 3:

About Countdown to 2015 for Maternal, Newborn and Child Survival

Countdown to 2015 for Maternal, Newborn and Child Survival is a global movement to track, stimulate and support country progress towards achieving the health-related MDGs, particularly MDGs 4 and 5. Established in 2003, Countdown includes academics, governments, international agencies, professional associations, donors, nongovernmental organizations and other members of civil society, with The Lancet as a key partner. Members of the Countdown community share a common goal of using data to increase accountability for women's and children's health. Countdown specifically focuses on tracking coverage of a core set of evidence-based interventions proven to reduce maternal, newborn and child mortality.

The initiative produces periodic publications, reports and other materials on key aspects of reproductive, maternal, newborn and child health, using available data to hold stakeholders to account for global and national action. At the core of Countdown reporting are two-page country profiles, updated approximately every two years, that present key demographic, nutritional status and mortality statistics; coverage levels and trends for proven reproductive, maternal, newborn and child health interventions; and policy, health system, financial and equity indicators to enable assessment of country progress in improving reproductive, maternal, newborn and child health. Countdown plays a central role in the follow-up to the Global Strategy by annually updating one-page profiles showcasing the 11 indicators selected by the COIA for Women's and Children's Health. Countdown also prepares equity profiles highlighting disparities in coverage in the 75 countries.

Countdown analyses are guided by a conceptual model consistent with the results-based evaluation framework for health systems strengthening that was developed by a working group of members from Countdown, WHO, the World Bank, Gavi, and the Global Fund. The model shows the range of indicators included in Countdown's four linked datasets on coverage, equity, policies and systems, and financial flows and illustrates possible pathways through which policy, systems and financing measures in a given context impact levels and trends in coverage of proven reproductive, maternal, newborn and child health interventions.

Countdown recognizes the paramount role of social, political, economic, cultural and environmental determinants in shaping population health. Many of these broader determinants influence health outcomes by increasing access, utilization and coverage with available life-saving interventions. Intervention coverage is thus the specific niche occupied by Countdown in the array of initiatives aimed at monitoring the MDGs. *Countdown* harnesses the global learning potential of its datasets through cross-cutting research and country case studies that allow for an in-depth exploration of the "how" and "why" of progress in reproductive, maternal, newborn and child health. These have been completed to date in Niger for child survival and in Bangladesh for maternal survival, with additional work nearing completion in Afghanistan, Pakistan, Ethiopia, Tanzania, Malawi, Peru, Kenya and China.



Strengthening accountability for RMNCAH and human rights

The role of human rights is paramount to the health of women, children and adolescents. Many of the barriers preventing individuals from realizing their potential and living healthy lives are related to violations of their human rights, including violence, stigmatization, discrimination, and denial of health care services. Harm done by acts of violence, discrimination and other human rights abuses can cause not only immediate harm, but also lasting effects on an individual's development, and on their mental, emotional and social health. The health of women, children and adolescents cannot be fully protected or promoted, without strengthening the integration of human rights in laws, policies and practice.

The COIA emphasized the link between human rights and RMNCAH by recommending to structure the accountability framework for women's and children's health around the right to health, equity, and gender equality.⁵⁶ The updated Global Strategy is based on established human rights treaties and commitments,⁵⁷ highlighting that only a "comprehensive human rights-based approach will overcome the varied and complex

challenges facing women, children and adolescents and transform their health by 2030".⁵⁸ Evidence suggests that using a human rights-based approach has a positive impact on the health of women, children and adolescents.⁵⁹

In recent years, the Partnership has contributed to strengthening **linkages between accountability mechanisms for human rights and health**, and has supported the development of tools and the building of an evidence base to better integrate human rights into policy and practice. For example, in 2010, the Partnership was involved in the development of and follow-up to the UN Human Rights Council Resolution on Maternal Mortality, which highlights the strong connection between accountability for the improvement of women's and children's health and human rights monitoring mechanisms. In 2013, the Partnership produced a Knowledge Summary on strengthening the links between human rights and accountability.⁶⁰ This Summary synthesizes the latest RMNCAH evidence to coordinate partner messaging around key policy events; describes human rights

oversight mechanisms at different systemic levels (community, national, regional, global and non-state accountability entities); and explores potential synergies for achieving both human rights and public health goals. The Partnership has also produced inputs for iERG reports regarding human rights.

In addition, the Partnership has contributed to the development of practical technical guidance to help countries apply human rights standards and principles in health policies and programs for women, children and adolescents, an effort coordinated by the **Office of the High Commissioner for Human Rights (OHCHR)**. To date, two guidance documents have been presented and welcomed by the Human Rights Council: one on maternal mortality and morbidity in September 2012 and one on under-five child mortality and morbidity in September 2014.⁶¹

As part of a joint workplan, the Partnership works closely with OHCHR and other partners to **catalyse action at country and community level** in part through MSDs to align national human rights and RMNCAH plans. The underlying principle of this work is to support national governments and other stakeholders to be able to better fulfil their human rights obligations, as well as their commitments made under the Global Strategy—and to cultivate a robust enabling environment for accountability for RMNCAH to be achieved.

In 2013, OHCHR, WHO, the United Nations Population Fund (UNFPA) and other workplan partners, organized a regional workshop in Malawi to promote the implementation of a human rights-based approach for maternal and child health in South Africa, Malawi, Uganda and Tanzania. One key outcome of the workshop was that the countries committed to conduct an assessment on the state of accountability for maternal and child health and human rights at country-level. In 2014, an assessment tool was developed by the Partnership for the four countries to analyse the status of human rights within the implementation of their national women's and children's health plans. In Uganda, an MSD was organized in November 2014 (Panel 3) and informed by the results from this assessment. OHCHR, with support from the Partnership, will facilitate similar dialogues in Tanzania and Malawi later in 2015 and in 2016 to align advocacy, action and accountability.

To accompany this tool, a series of reflection guides have also been published to support in-country dialogues around integrating human rights in RMNCAH for different stakeholder groups, specifically health policy makers and national human rights institutions. Two additional guides – for health care professionals and the judiciary – are in development. The aim of this series is to incite collective deliberations among each stakeholder group on the application of rights-based approaches to maternal and child health, and to analyse, for example, the problems that are happening to whom and where, as well as why they are happening, and who or what institution is responsible.⁶²

PANEL 4:

Strengthening human rights for women's and children's health in Uganda

In Uganda, in November 2014, the results of the country-level assessment were used as the basis for a national MSD. MSDs are a core element of the Partnership's human rights accountability work because they have the potential to align advocacy, action and accountability within national human rights and RMNCAH plans. Conversely, human rights are also critical for ensuring that all voices are represented at the MSDs, as well as included in resulting solutions or outcomes. In Uganda, the MSD convened for the first time health, human rights and development stakeholders with the aim to review multi-sectoral progress to reduce maternal and child mortality; to identify remaining gaps, challenges and priorities; and name potential actions and entry points for implementing rights based approaches in RMNCAH policies and programs. A country brief for the iERG and human rights bodies on RMNCAH and human rights progress were also developed and used as input for this event.

Those who came together included officials from the ministries of health, education and gender equality; directors of health facilities from all districts; UN representatives; parliamentarians; CSOs representing a myriad of interests (Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ); health; disability); and the national human rights institution. Enabling people to sit down together and discuss the barriers in practice as well as on paper proved critical from an accountability and human rights perspective. Various next steps were identified including 1) increased capacity for monitoring sexual and reproductive health violations and 2) better monitoring of the status of economic, social and cultural rights more generally.

Lessons learned and future directions

Responsibility to guarantee human rights of individuals resides first with states, which are obliged to respect, protect and promote the human rights of their population, including the right to health. As such, a human rights-based approach to health accountability requires states to meet their obligations to their commitments to uphold the health and rights of women, children and adolescents, and to provide options for remedy and redress for violations of these rights, such as discriminatory policies like child marriage and systemic denial of sexual and reproductive health services to adolescents. Multiple stakeholders from a range of sectors, however, also have a role to play to hold states to account and improve women's and children's health, including, for example, by analysing the causes and consequences of rights violations; mitigating these causes through strengthening legal remedies for rights violations; promoting human rights literacy; and providing age- and gender-appropriate protection services and safe spaces for women, children and adolescents in different areas, including health facilities.

Engaging civil society and communities is critical to ensure that states respect their human rights obligations, including promoting and guaranteeing the right to health and related rights. Community-based mechanisms with the potential to hold states accountable for human rights violations include human rights impact assessments, maternal death reviews, health tribunals, and local and traditional courts.⁶³ Results from a trial in Uganda show that community involvement in the form of monitoring of primary care providers positively influenced both the quality of care and medical-attention seeking behaviour of community members, leading to better health outcomes.⁶⁴ Other actors such as the media, service providers and government officials are also crucial to promoting human rights literacy and capacity, and for raising awareness of rights violations to hold the state accountable to its RMNCAH-related obligations under international human rights law.

What is urgently required, consulted stakeholders stated, is a “mind shift” away from the still wide-spread, traditional understanding of health as a largely biomedical concept. Continued efforts are needed to advocate for a human rights approach, which recognizes the need for a holistic and comprehensive approach, including attention to determinants of health outside the health sector, as well as attention to sexual and reproductive health issues beyond maternal health. This shift entails acknowledging the broader social determinants of health and health inequalities – such as nutrition, access to education, discriminatory policies – and expanding accountability work for health outcomes to include monitoring the status of these underlying factors and the realization of the related human rights as well. This includes devoting particular attention to marginalized populations, who are often invisible in data collection and monitoring. In the context of the health system, this shift means that patients (as individual beneficiaries of a healthcare system) are recognized as rights holders, and improving health is not reduced to merely its economic or developmental benefits, but acknowledged as a fundamental obligation.

While consulted stakeholders for this report emphasized that it is crucial to engage multiple sectors and actors, they also argued that this is complex, and takes time to engage a critical mass of key actors to advocate for better implementation and monitoring of human rights in law, policy and practice. Local champions – a national actor who drives processes – were considered as the most important success factor to advance processes in countries effectively, build this critical mass of actors, and inform this shift and effect change. These champions can be supported by international actors but without local leadership and political will, progress can be difficult. Identifying local champions is therefore a critical lesson.

Stakeholders also reported that funding is limited to support countries in developing and implementing comprehensive, evidence- and human rights-based national health plans, with a focus on reaching the most vulnerable and marginalized groups. This includes investing in growing the evidence-base, and establishing systematic, robust monitoring and evaluation mechanisms to understand the impact of applying human rights on health and development outcomes.





Promoting accountability through citizens' hearings, civil society, and parliamentarians



The Partnership, spearheaded by White Ribbon Alliance (WRA), the International Planned Parenthood Federation (IPPF) and Save the Children, contributed to the organization of over 100 citizens' hearings in 23 countries to enable stakeholders to discuss challenges to improving RMNCAH and call on governments to account for the delivery on MDGs 4 and 5, bringing together tens of thousands of citizens and more than 400 organizations. These hearings culminated in a global dialogue between citizens and governments at the 68th World Health Assembly (WHA) in 2015, and connected citizens and key decision makers for RMNCAH like never before.

In 2014, the IERG recommended to further include civil society in intergovernmental processes, especially at the WHA. Based on this recommendation, the Partnership, led by the **White Ribbon Alliance (WRA), World Vision, the International Planned Parenthood Federation (IPPF) and Save the Children**, have worked to hold over 100 citizens' hearings at the national and subnational levels in around 23 countries in Africa and Asia.⁶⁵ They continue to work expand to at least 7 more countries.⁶⁶ Building on these local and national hearings, the partners organized the world's first Global Citizens Dialogue at the 68th WHA in May 2015.

The national hearings **connected citizens and key decision makers** for RMNCAH in country like never before, and contributed to stronger awareness and accountability around RMNCAH. Citizen participation in monitoring and tracking health systems can be highly effective and the hearings presented an

innovative platform for a range of stakeholders to publically call on governments to account for their delivery on the MDGs 4 and 5, and push for a strong accountability framework for the updated Global Strategy and within the SDGs. Citizens and CSOs—including those capacitated by the Partnership (see following section)—engaged with parliamentarians, representatives from ministries of health, finance and foreign affairs, as well as other political leaders and the media. Examples of these hearings include:

- In Indonesia, over 42 focus group discussions on priorities for RMNCAH were held across the country to inform the national citizens' hearing in March 2015.
- In Nigeria, a citizens' hearing took place right before the election and the recommendations will be shared with the newly elected government in 2015.
- In Tanzania, citizens' hearings occurred in five districts, bringing together 860 citizens. These recommendations, made jointly by district leaders and citizens, were broadcasted in a national TV debate.
- In Uganda, 800 citizens came together for district hearings. The resulting recommendations were received by the Prime Minister and the Minister of Health in March 2015.

Media engagement in the citizens' hearings was high – many were broadcast on national TV and radio – highlighting the role of the media as a key non-state accountability actor with the ability not only to raise awareness for accountability issues such as human rights and inadequate progress towards commitments, but also reinforce instruments of accountability such as the hearings themselves. The outcomes and recommendations of these consultations were submitted to the process for the updated Global Strategy. In addition, they were used to inform the agenda for the **Global Citizens' Hearing**. During the 68th WHA, a formal statement from citizens from around the world on what they would like to see in the next development agenda for women, children and adolescents, was submitted to the UNSG during a high-level EWEC event.

These hearings form a key part of the Partnership's call for more robust accountability in the updated Global Strategy framework and for elevating citizen engagement to be a core part of the SDGs. The citizens' voice is a fundamental component of securing accountability for RMNCAH from duty bearers (for example, national governments, relevant ministries and health systems) to rights holders (for example, individuals). Citizen-led efforts ensure that commitments made are relevant to local contexts, and that their implementation is full and appropriate, and impact achieved.



Since 2013, the Partnership has provided support for building the capacity of CSO alliances in five Sub-Saharan African countries to improve health budget analysis and advocacy. This budget accountability work has contributed to increased allocation for RMNCAH in Uganda and Tanzania, among other things.

Previous accountability reports by the Partnership emphasized the need to enhance country capacity to undertake budget tracking and gap assessments for RMNCAH accountability. Budget tracking refers to monitoring and analysing health budgets against costed plans and actual expenditures for RMNCAH at the national and local levels as well as assessing budgeting for specific RMNCAH areas, such as family planning. The data generated, which often does not exist otherwise, can assist CSO coalitions and other key groups, such as parliamentarians and the media, to hold the governments accountable for RMNCAH outcomes and commitments.⁶⁷

The Partnership has included building the capacity for budget analysis and tracking in its work with CSO alliances. It has co-hosted **three regional workshops**—in Nairobi, Kenya (2013),⁶⁸ in Dakar, Senegal (2014),⁶⁹ and in Harare, Zimbabwe (2015)⁷⁰—designed to strengthen the capacity of national CSO alliances for conducting and responding to health budget analysis. In total, stakeholders from 17 countries from Sub-Saharan Africa participated in these workshops.

The Kenya workshop convened teams of stakeholders from Tanzania, Uganda, Kenya, Sierra Leone and Liberia, including CSO coalitions, representatives of national parliaments, Ministries of Health, as well as the media.⁷¹ The multi-sectorial, regional budget-tracking workshop in Senegal also brought together a broad range of actors from five francophone countries in Sub-Saharan Africa, and the regional workshop in Zimbabwe assembled six additional Anglophone countries.⁷² During all three workshops, participating CSO coalitions were supported in developing budget analysis capacity, and shaping advocacy workplans to respond to the salient budgetary RMNCAH challenges in their countries.⁷³ Following these workshops, important country-specific activities were undertaken to enhance capacity for budget advocacy and analysis,

including national budget training workshops for CSOs in Sierra Leone, Uganda and Tanzania and continued situational analysis of budget allocation in Liberia, Kenya, and Uganda.⁷⁴

Key achievements from CSO-improved budget-tracking capacity for RMNCAH as a result of these activities include, among other things:

- **Driving change in budget allocation for maternal and child health in Uganda:** The CSO coalition successfully advocated for the increase of almost US\$100 million allocated to the health sector in the national budget in 2012, and to US\$20 million more in 2013-2014 for human resources in emergency obstetric and newborn care (EmONC). Recruitment money was released, resulting in more

than 6,000 medical workers contracted for work in public facilities.⁷⁵

- **Promoting timely disbursement of funds in Sierra Leone:** After the Nairobi workshop in 2013, the CSO coalition worked to identify bottlenecks around late disbursement of funds to the health sector, which was undermining the quality of RMNCAH service delivery. Research findings served to inform advocacy and popular mobilization efforts including engaging with the Ministry of Finance, parliamentarians and the media; developing advocacy briefs⁷⁶ about the impact of late disbursement of RMNCAH on the health status of women and children; creating score cards to inform and increase general public knowledge and awareness through policy and popular mobilization, empowering the public to hold decision makers accountable.⁷⁷

PANEL 5:

Budget tracking to promote increased government commitment to Comprehensive Emergency Obstetric and Newborn Care (CEmONC) in Tanzania

The Tanzania RMNCAH CSO coalition was created in 2012 as part of the Partnership's program of support under the leadership of the White Ribbon Alliance Tanzania (WRA-TZ) and the Tanzania Midwives Association (TAMA). The establishment of the coalition—and subsequent activities—was also supported by the WRA Global Secretariat, which contributed direct funding for a multi-year strategy, and dedicated implementation action at the subnational and national levels. While this initiative created the first national CSO coalition in Tanzania working across the RMNCAH continuum of care, the WRA-TZ had been working in country since 2004 and played a crucial role through both its coordination experience and the trusted relationships it has established with multiple partners at the national level including the government. The first meeting gave the NGOs the opportunity to share what each was doing and develop a range of strategies and joint efforts, with a primary focus on advocacy for improved MNCH through increased budget and increased numbers of skilled birth attendants. The coalition launched an advocacy campaign, encouraging young people to train as midwives and began to undertake budget advocacy.⁷⁸

In 2013, the Tanzanian CSO coalition participated in the Partnership's Kenya workshop to specifically build the capacity of its member organizations to understand and apply data for improved RMNCAH budget accountability to influence appropriate policy change. In line with its advocacy objectives, the coalition focused its budget accountability work on ensuring the implementation of the government's commitment to provide Comprehensive Emergency Obstetric and Newborn Care (CEmONC) in at least 50% of health facilities.⁷⁹

Major achievements and continued budget monitoring undertaken by the coalition

- August 2013 – May 2014: Coalition advocated to the MOH and Prime Minister's Office to create a specific budget line for CEmONC, also engaged with district councillors to submit budgets with funds earmarked for CEmONC.
- March 2014: Tanzania's Prime Minister directed all 169 District Councils to develop a strategy and budget for improving CEmONC and to include a specific line for CEmONC in their annual health plans.
- July 2014: All district budgets included a line item for CEmONC.

August 2014 – 2015: Partners continue to advocate for sufficient funds to meet the government's commitment and for the budget to be implemented effectively.

Existing evidence suggests improved CEmONC services in several regions.⁸⁰ However, limited funds remain a barrier for the full provision of CEmONC in Tanzania. The country has achieved the MDG 4 to improve child survival, yet progress for maternal and newborn survival is lacking, indicating the need for continued accountability and advocacy efforts.

This work is iterative and catalytic, drawing on accountability monitoring functions such as budget and situational analysis to identify opportunities for increased RMNCH advocacy and to sensitize decision makers about RMNCAH issues.⁸¹ National CSO RMNCAH alliances are employing their budget advocacy capacity in dialogues with key decision makers to improve the budget process; continuing to engage media to call for changes at district and national levels; and also mobilizing the public to strengthen the citizens' voice to inform the accountability agenda for RMNCAH at the local, national and global levels, and effectively improve health outcomes.⁸² Moving forward, the Partnership will continue to provide support as countries advance and adapt their multi-pronged budget advocacy work plans. Such support activities comprise accountability monitoring by generating evidence on budget processes and service provision, including at the district levels,⁸³ analyzing the evidence to improve advocacy efforts, refine advocacy goals, and create platforms for exchange and effective dialogue.

With the Partnership's support, CSO country alliances can also engage beyond national boundaries. In Uganda, for example, the coalition supports the East African Community Open Health Initiative to Improve Maternal and Child Health in East African Partner States, a collaborative platform of exchange of information and capacity for better accountability for improved RMNCH health outcomes. This supranational work demonstrates an explicit link between national, regional, and global commitments, action and accountability, and aligns with the Global Strategy's accountability framework.



The Partnership has contributed to the creation and strengthening of national advocacy coalitions in a range of countries to promote the alignment of RMNCAH advocacy strategies and strengthen accountability work.

In 2012, recognizing the significant potential of joint efforts for enhanced RMNCAH accountability, the Partnership started to strengthen national CSO alliances across the continuum of care in order to maximize knowledge sharing, and to harmonize evidence-based accountability and advocacy to support the implementation of government commitments to women's and children's health.

The Partnership played a catalytic role in establishing CSO coalitions in ten countries in Sub-Saharan Africa and South and Southeast Asia and has pledged continued support and consultation for the future.^{84,85} These coalitions are anchored by two focal points per country—one nationally and one internationally headquartered NGO—in order to better integrate national accountability initiatives with regional and global accountability mechanisms. In the case of the Africa-based coalitions, for example, the Partnership works with the Africa MNCH Coalition⁸⁶ to build capacity among the coalitions to facilitate the



implementation of the African Union's (AU) Integrated RMNCH Advocacy Strategy, which seeks to reconcile existing African commitments and platforms with the Global Strategy, to improve accountability for RMNCAH. For eight of the countries, these were the first CSO coalitions to cover the entire continuum of care. For the two where coalitions already existed (Ethiopia and Bangladesh), membership was expanded and the advocacy framework re-focused on improved generation and use of evidence. This support has resulted in enhanced, targeted RMNCAH accountability and advocacy, including in:

- Collaboration with parliamentarians on policy and budget support to better reflect RMNCAH commitments in national health plans in nearly all countries;
- Engagement with and deployment of the media as an accountability actor to raise the profile and coverage of RMNCAH issues in Indonesia, Ghana, Nigeria and Tanzania;
- Strengthened capacity and joint planning across local and national CSOs to improved action around accountability.
- The creation of voluntary contribution schemes in Indonesia, Ghana and Uganda to cover the cost of alliance activities, reflecting strengthening community support for accountability;
- The creation of a joint advocacy toolkit in Tanzania to increase the enrolment of youth in midwifery training, in line with the alliance's accountability and advocacy workplan.
- Enhanced budget advocacy capabilities and improved data collection to strengthen CSO capacity for policy advocacy through the design of locally relevant strategies.

With the Partnership's support, CSO country alliances can also engage beyond national boundaries. In Uganda, the coalition supports the East African Community Open Health Initiative to Improve Maternal and Child Health in East African Partner States, a collaborative platform of exchange specifically to improve RMNCH health outcomes. This supra-national work demonstrates an explicit link between national, regional, and global commitments, action and accountability, and aligns with the Global Strategy's accountability framework.



The Partnership engages with parliamentarians to capitalize on the pivotal role they play in order to strengthen national accountability mechanisms and improve RMNCAH outcomes. Its work shows that there is great potential to strengthen national accountability mechanisms through parliamentarians.

Engagement with parliamentarians is a central area for RMNCAH accountability and advocacy as parliaments hold unique accountability role vis-a-vis governments. Parliaments alone have the *legal mandate* to hold governments to account, and to formally change national accountability mechanisms and influence processes. The role of parliaments is to represent their voters at the national level—to legislate, monitor and approve budgets and oversee government actions. They are therefore mandated as well as well positioned to combat existing constraints to the implementation of commitments made globally and nationally and improve RMNCAH processes and outcomes.⁸⁷

The Partnership, recognizing the critical position that parliaments have for action and accountability around the health of women, children and adolescents, strives to work closely with groups of parliamentarians around the world on RMNCAH accountability at the national level. One primary platform for engagement with parliamentarians is the IPU, which has provided leadership to the global parliamentary community on women's and children's health. The Partnership has been a close collaborator of the IPU, providing technical and advocacy support around RMNCAH since 2008.

The IPU, in fulfilment of its commitment to the Global Strategy on Women's and Children's Health, it developed a **resolution** on maternal, newborn and child health (MNCH). In April 2012, the 126th Assembly of the IPU unanimously adopted this resolution without reservations.⁸⁸ The resolution calls for all member-parliaments to implement all possible measures in order to reach the MDGs 4 and 5. Further, it highlights the human rights, political and socioeconomic imperatives against which parliamentarians must act to improve women's and children's health. The resolution reinforces the IPU mandate to work with its partners to strengthen parliamentary capacity in support of RMNCAH—and improve accountability for RMNCAH (Panel 6).

The IPU, with assistance from the Partnership, complements these supra-national activities with direct support for national and regional parliament efforts to implement the MNCH Resolution. It focuses in particular on providing funding and technical assistance to parliaments in key countries where maternal and child death rates are highest to put the resolution's provisions into practice, and includes funding and technical assistance to help parliaments better leverage their position within governments for enhanced RMNCAH accountability. With its particular insight on functioning and challenges encountered by parliaments when implementing the MNCH Resolution, IPU identifies actions to support an enabling environment for improved national RMNCAH accountability through the development of favourable legislation, ensuring oversight of laws and policies, and improving budget allocation and accountability for expenditure. For example, the IPU

conducted an assessment of the legislative environment in Kenya to see the extent to which it supports/undermines women's and children's health and it contributed to efforts to strengthen oversight on RMNCAH in Lesotho, Uganda and Rwanda.

Recognizing both that the citizen's voice is fundamental to truly appropriate and effective RMNCAH accountability work and the role that parliamentarians have to represent this voice, IPU also organized in person and radio dialogue sessions in Uganda to facilitate discussion between parliaments and their constituencies around citizen concerns relating to women's and children's health. Key on-the-ground issues highlighted in these fora include equity, accountability for adequate resourcing on RMNCAH, the need to strengthen health systems and ending practices with negative implications for women and children.

PANEL 6:

Examples of Partnership collaboration with the Inter-Parliamentary Union on RMNCAH accountability in parliaments

Knowledge generation and dissemination

- Provided technical and financial input to the first annual accountability report of the IPU on the 2012 MNCH resolution.
- Helped disseminate the MNCH resolution among institutional members and partners to engage with members of parliaments through professional associations and alliances.
- Supported the creation of "Sustaining Parliamentary Action to Improve Maternal, Newborn and Child Health", a handbook to support parliamentarians in their efforts to implement the MNCH resolution in 2013. An orientation manual for induction of new parliaments on MNCH accompanies the Handbook.

Capacity building and promotion of enabling environment

- Provided support to 70 countries with the highest burden of maternal and child deaths by designing indicators related to parliamentary engagement on RMNCAH to inform accountability oversight and monitoring.
- Support the induction of parliaments on women's and children's. To date, the East African Legislative Assembly, Uganda and Kenya have all been inducted.
- Helps coordinates platforms on women's and children's health at all systemic levels, including at IPU Assemblies and high-profile regional workshops on RMNCAH accountability.

The Partnership, lead by IPU and in close cooperation with WHO, organized two events at the 132nd IPU Assembly, Hanoi, Vietnam, March 2015: (1) to introduce the draft of the updated Global Strategy to the global parliamentary community and discuss the role of parliamentarians as catalysts for action within this framework and (2) to review parliaments' progress in their implementation of the 2012 MNCH resolution, thereby encouraging accountability for commitments made.

To ensure greater impact of parliamentarians' work in African countries, the Partnership has also worked in close cooperation with its partners to help further align the work for the health of women and children of the Pan African Parliament (PAP) with that of the IPU. In preparation of the 2013 PAP Conference of African Women Parliamentarians on the theme of "Violence Against Women – From Legislation to Effective Enforcement", the Partnership worked closely with Africa Health, Social and Human Development (Afri-Dev) to develop the messaging for and around the event. It has also developed knowledge summaries on reaching child brides and human rights, and on the AU strategy briefs on the girl child and human rights to inform discussions.

The Partnership hosted a symposium on RMNCAH in Kampala, Uganda, in March 2015 that gathered East African Community (EAC) Health Ministers and parliamentarians. Attendees explicitly called for increased budget allocation for health, the implementation of a scorecard system for greater accountability of results and resources, expanded access to and use of contraception, and a greater focus on the health of adolescents, in particular their reproductive health. They also called to strengthen human resources for health. As a key outcome, participating ministers and parliamentarians committed to implementing these recommendations as well as to reporting on the status of implementation in the future.

Lessons learned and future directions

The Partnership's work shows that there is great potential to strengthen countries' accountability mechanisms through community participation, citizens' hearings, civil society platforms, and parliamentarians. There have been a number of lessons learned on these areas.⁸⁹

- Citizens' hearings are a key tool to elevate the (local) voice of women and children at the national and global levels. While this is a new approach, and not yet fully evaluated, they appear to be crucial for improving accountability at global and national level and putting civil society engagement. This is a key component of rights-focused accountability.
- Strengthening national platforms for RMNCAH is crucially important to ensure meaningful participation of all key stakeholders in accountability processes. However, conditions should be created so that national and local CSOs can be more strongly and meaningfully engaged to further elevate their voices to the national and global level, and effectively lead accountability efforts. Continuous funding and support is required to ensure that national actors and community partners can effectively perform their accountability function.
- Accountability tools need to be better tailored to national contexts, including making clear what the updated Global Strategy means in the domestic context and how it fits into existing regional and national initiatives. For example, currently knowledge about the Global Strategy and its accountability framework (e.g. COIA recommendations) remains rather limited, especially among African parliamentarians, who are much more aware of the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), led by the AU. This further underlines the need to improve coordination among the efforts of global and regional accountability mechanisms.
- Experience from the past years show that parliamentarians are key to enhance accountability for RMNCAH. In this context, electoral cycles are connected to challenges and opportunities that demand better design and targeted circulation of RMNCAH advocacy tools. Although new parliamentarians need to be sensitized and capacitated, which requires continuous activities and the need for increased support, they also present a key accountability opportunity as they could also become new champions for the health of women and children. In turn, this presents a two-fold political opportunity for them: there is not only a solid human rights mandate for them to work to improve RMNCAH, but also a fiscal one, as there is a clear financial benefit to investing in women's and children's health.^{90, 91, 92, 93, 94} Stronger dialogue between parliamentarians from LICs and MICs, and HICs on accountability and rights could be instrumental to gain a different perspective on how RMNCAH and related rights should look like and be operationalized within a policy and budgetary framework.





Conclusions

Tracking financial commitments to the Global Strategy

This report has highlighted the unprecedented support generated for the health of women and children by the EWEC movement. More than 400 commitments from over 300 stakeholders were made between 2010 and 2015. Commitment-makers disbursed US\$33 billion against the US\$45 billion in commitments (free of double-counting). At least 74% of the financial commitments have thus been disbursed since the launch of the Global Strategy. The actual amount is certain to be higher given delays in reporting.

Overall ODA for RMNCH continues on an upward trajectory. Donors disbursed a total of US\$9.5 billion for RMNCH interventions in the 49 Global Strategy countries in 2013, an increase of 31% since the launch of the Global Strategy in 2010. Disbursements to the 75 Countdown countries rose by 25%, from US\$9.5 billion in 2010 to US\$11.9 billion in 2013. These increases are

driven by key commitment-makers to the Global Strategy, indicating demonstrating the strategy's significant positive influence on overall RMNCH financing trends. Domestic expenditures for RMNCH have increased as well. The 49 Global Strategy countries increased RMNCH expenditures to a total of US\$2.8 billion in 2013, a 20% increase from 2010. The 75 Countdown countries expanded their domestic funding for RMNCH by 31% between 2010 and 2013.

However, despite the overall increases in domestic and international RMNCH financing, funding levels remain insufficient. The World Bank has estimated that US\$33.3 billion would be needed in 2015 alone in the 63 high burden, low and lower middle income countries included in the "Countdown to 2015" initiative. There are also worrying declines in spending, including in fragile and conflict-affected states, such as Haiti and the Central African Republic.

The current gap in financing can be bridged only through dramatic increases from domestic and international sources and from both public and private sectors. Moving forward, those high-income countries that have not yet joined the EWEC movement should be

strongly encouraged to do so. Further commitments from LIC and MIC countries are also absolutely crucial; many of them will experience substantial economic growth and should be able to increase their spending for RMNCAH.

Lessons learned and future directions

Ensuring accountability for women's and children's health has been a priority since the launch of the Global Strategy in 2010. Within this framework, a lot of progress on accountability has been made and significant lessons have been learned. Going forward, efforts need to be strengthened to better track progress in the implementation of financial and non-financial commitments, to reveal inequities through more disaggregated data, to more strongly hear citizens' voices, and to conduct increased impact assessments. It is critical to invest more in all aspects of accountability to ensure that commitments are honoured, rights are observed, and impact is achieved.

More specifically, this report has identified 12 key areas in which to improve overall accountability for the health of women, children and adolescents:

- Support stakeholders in developing sound commitments with strong linkages to internationally agreed goals and principles SDGs and related human rights:** Moving forward, technical support should be offered to stakeholders to help them produce clear, unambiguous commitments that are aligned with the Global Strategy, the SDGs and human rights obligations. In the past five years, the lack of specificity of commitments made it challenging to track their implementation. In addition, commitments were insufficiently focused on key goals (for example, only 16% specifically mentioned the MDGs), so assessing their impact was difficult. Commitments fell short of legally binding human rights obligations, despite women's and children's health being recognized as a fundamental human right.
- Ensure that all tracking efforts are integrated:** All accountability efforts for the health of women, children and adolescents should be harmonized and integrated as much as possible. The Unified Accountability Mechanism, including the comprehensive annual synthesis report on the State of Women's, Children's and Adolescents' Health is the agreed way forward to harmonize global reporting to improve overall coherence, cost-effectiveness and impact. It will be
- crucial to rapidly operationalize and implement this unified mechanism to avoid any further duplication of tracking efforts in the future especially for tracking financial and non-financial commitments to RMNCAH and the Global Strategy more specifically.**
- Strengthen capacity to collect, analyse and synthesize data on resources, results and rights to allow for better tracking of progress and to mitigate the limitations of self-reported data:** In the future, there is an urgent need to strengthen global, regional and country level capacity for a more independent analysis of progress data, as well as for its collection. Additional investments are required to strengthen existing capacity for tracking progress in the implementation of commitments, including the ability to cross-check self-reported data independently. Estimating the costs of establishing this capacity would be critical to mobilize the needed financial resources.
- Highlight persistent cases of non-reporting:** Stronger processes are needed to ensure regular progress reporting by commitment-makers. If commitment-makers repeatedly fail to meet the requirements to report annually on progress in implementing Global Strategy commitments, the Independent Accountability Panel, which will be established as part of the new accountability framework of the updated Global Strategy, should highlight and comment on persistent cases of non-reporting in the report on the State of Women's, Children's and Adolescents' Health. At the same time, stakeholders should receive support to help them overcome existing reporting barriers.
- Build on existing efforts to improve the tracking of RMNCAH funding:** Ongoing efforts to track international and domestic financing for RMNCH should be advanced. This includes the policy marker, which was introduced by the OECD DAC in 2013 to track funding for RMNCH. An enhanced dialogue among the tracking initiatives is also needed to harmonize the different approaches. The formation of a time-bound technical working group within the

broader remit of the Unified Accountability Mechanism should be considered. With more countries able to finance their domestic health needs, the tracking of domestic resources will become increasingly important. More funding will be needed to institutionalize and standardize the tracking of domestic financing for RMNCAH in a larger number of countries.

- **Make better use of existing mechanisms to track non-financial commitments, and agree on a method to monetize them.** There is opportunity for strengthening the tracking of non-financial commitments by building on existing mechanisms. For example, all states report on their progress in realizing the right to health, including health of women and children, to various human rights mechanisms. Moreover, the different Partnership constituencies could be highly instrumental in encouraging commitment-makers to collect and report progress data. To assist in assessing the value of non-financial commitments the time-limited working group for the harmonization of financial tracking approaches should be tasked with developing an agreed method of monetizing non-financial commitments.
- **Collect more disaggregated data to enhance accountability for at-risk and vulnerable populations.** Enhancing accountability for at-risk and vulnerable populations requires more disaggregated data, including by gender, income and geography.
- **Hold individual commitments-makers accountable and leverage collected information for mutual learning:** Previous accountability reporting presented aggregated data on progress in the implementation of commitments; however, in the future, individual commitment-makers should be held to account more rigorously by measuring their performance against their own commitments, and against identified human rights indicators and the SDG-related objectives of the Global Strategy. Moreover, this newly tracked information could be leveraged for the benefit of mutual learning – it should be used to inform all relevant stakeholders what has worked in the past and what not.
- **Develop an accountability index:** An index, published annually, would rank individual commitments in terms of their contribution to the Global Strategy objectives. Existing indices, such as the Access to Medicine Index and the Access to Nutrition Index, could be used as models. The index should be closely linked to the Unified Accountability Mechanism, and its rankings should be included in the State of Women's, Children's and Adolescents' Health report.
- **Facilitate a “mind shift” away from a traditional biomedical understanding of health and expand RMNCAH accountability work to include monitoring of underlying determinants.** Continued efforts are needed to advocate for a holistic approach to public health. This should systematically integrate human rights and attend to the many determinants of health existing outside the health sector as well as to sexual and reproductive health issues beyond maternal health. This shift entails acknowledging the broader determinants of health and health inequalities—such as nutrition, access to education, discriminatory policies—and expanding accountability work for health outcomes to include monitoring the status of these underlying factors and the realization of the related human rights as well.⁹⁵ This expanding and evolving understanding of health is also captured in the SDGs, which recognize that addressing the determinants of health outside the health sector requires cross-sectoral collaboration and synergy with other policy domains.
- **Foster leadership of national civil society organizations (CSOs) and support local champions:** National and local CSOs should be supported to work together to make their voices heard to further elevate their voices to the national, regional and global level. Engaging civil society and local communities can play a critical role in holding states accountable for their commitments to the health of women, children and adolescents and for their human-rights obligations, including the right to health. Local champions – a national actor who drives processes – are a key success factor to effectively advance processes in countries, and increased efforts should be taken to support them. Additional *longer-term* funding from domestic and international sources is also required to ensure that national actors and citizens can perform their function of holding duty bearers accountable to rights holders.
- **Increase efforts to promote the role of parliamentarians and citizens' hearing:** Parliamentarians provide a key opportunity as they could be built up as influential champions for the health of women and children. Citizens' hearings are also a key tool to elevate the (local) voice of women and children at national, regional and global levels. As such, they are important for improving accountability across levels and putting people at the heart of the SDGs. Creating better linkages between the global, regional and national levels is critical to increased accountability for women's, children's and adolescents' health.



Appendices



Appendix 1

Global Strategy

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■ AT A GLANCE: THE GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH

VISION

By 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies.

Implementing the *Global Strategy*, with increased and sustained financing, would yield tremendous returns by 2030:

- An end to preventable maternal, newborn, child and adolescent deaths and stillbirths
- At least a 10-fold return on investments through better educational attainments, workforce participation and social contributions
- At least US\$100 billion in demographic dividends from investments in early childhood and adolescent health and development
- A "grand convergence" in health, giving all women, children and adolescents an equal chance to survive and thrive

GUIDING PRINCIPLES

- Country-led
- Universal
- Sustainable
- Human rights-based
- Equity-driven
- Gender-responsive
- Evidence-informed
- Partnership-driven
- People-centred
- Community-owned
- Accountable
- Aligned with development effectiveness and humanitarian norms

OBJECTIVES AND TARGETS (aligned with the SDGs to be achieved by 2030)

SURVIVE

End preventable deaths

- Reduce global maternal mortality to less than 70 per 100,000 live births
- Reduce newborn mortality to at least as low as 12 per 1,000 live births in every country
- Reduce under-five mortality to at least as low as 25 per 1,000 live births in every country
- End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases
- Reduce by one third premature mortality from non-communicable diseases and promote mental health and well-being

THRIVE

Ensure health and well-being

- End all forms of malnutrition and address the nutritional needs of children, adolescent girls, and pregnant and lactating women
- Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights
- Ensure that all girls and boys have access to good-quality early childhood development
- Substantially reduce pollution-related deaths and illnesses
- Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines

TRANSFORM

Expand enabling environments

- Eradicate extreme poverty
- Ensure that all girls and boys complete primary and secondary education
- Eliminate all harmful practices, discrimination and violence against women and girls
- Achieve universal access to safe and affordable drinking water and to sanitation and hygiene
- Enhance scientific research, upgrade technological capabilities and encourage innovation
- Provide legal identity for all, including birth registration
- Enhance the global partnership for sustainable development

ACTION AREAS

(based on evidence of what is required to reach the objectives)

1. Country leadership

Reinforce leadership and management links and capacities at all levels; promote collective action.

2. Financing for health

Mobilize resources; ensure value for money; adopt integrative and innovative approaches.

3. Health system resilience

Provide good-quality care in all settings; prepare for emergencies; ensure universal health coverage.

4. Individual potential

Invest in individuals' development; support people as agents of change; address barriers with legal frameworks.

5. Community engagement

Promote enabling laws, policies and norms; strengthen community action; ensure inclusive participation.

6. Multisector action

Adopt a multisector approach; facilitate cross-sector collaboration; monitor impact.

7. Humanitarian and fragile settings

Assess risks, human rights and gender needs; integrate emergency response; address gaps in the transition to sustainable development.

8. Research and innovation

Invest in a range of research and build country capacity; link evidence to policy and practice; test and scale up innovations.

9. Accountability

Harmonize monitoring and reporting; improve civil registration and vital statistics; promote independent review and multi-stakeholder engagement.

IMPLEMENTATION

Country-led implementation supported by the Every Woman Every Child movement and an Operational Framework. The power of partnership harnessed through stakeholder commitments and collective action. We all have a role to play.

Appendix 2

Unified Accountability Mechanism

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9. Accountability for results, resources and rights

Accountability is essential to accelerating progress for women's, children's and adolescents' health. It enables the tracking of resources, results and rights and provides information on what works, what needs improvement, and what requires increased attention. Accountability ensures that decision makers have the information required to meet the health needs and realize the rights of all women, children and adolescents and to place them at the heart of related efforts.

The United Nations Commission on Information and Accountability for Women's and Children's Health (CoIA) defined accountability as a cyclical process aimed at learning and continuous improvement and involving three principal stages: monitor, review and act (see Annex 5).^{3,4} The CoIA placed the focus for action "soundly where it belongs: at the country level", but acknowledged that accountability is the responsibility of all partners and spans the local, country, regional and global levels.³

The enhanced Accountability Framework for the *Global Strategy* (see Figure 4) builds on the CoIA's principles, framework and recommendations. The Accountability Framework is aligned with the High-level Political Forum on Sustainable Development, which will have the central role in overseeing follow-up and review of progress on the SDGs at the global level.⁷⁶ It is also aligned with the Roadmap for Health Measurement and Accountability and its 5-Point Call to Action, which was adopted by WHO, USAID, the World Bank, countries and partners in June 2015 to advance a common agenda for health measurement.⁷⁷ Its overarching aim is to establish a clear structure and system to strengthen accountability at the country, regional and global levels and between different sectors. Ultimately, the *Global Strategy* is accountable to all women, children and adolescents as rights holders, including the underserved and marginalized.

Actions

- 1. Harmonize monitoring and reporting.** Minimize the reporting burden on countries by harnessing existing data sources disaggregated by gender, geography and income to track progress on implementing the *Global Strategy*, and by repurposing reports and scorecards already in use for women's, children's and adolescents' health. Develop these reports by countries with support from the H4+— the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Entity for Gender Equality and Women's Empowerment (UN Women) and the World Bank—through a collaborative and transparent process. Report on progress in implementing the CoIA recommendations, including tracking reproductive, maternal, newborn, child and adolescent health expenditures and results against the agreed targets and indicators. Use regional peer review and regional reports to link accountability at the global and country levels.
- 2. Strengthen civil registration and vital statistics.** Support countries' efforts to strengthen their accountability mechanisms and institutions, including monitoring and reporting on results. Ensure that all countries have a functioning civil registration and vital statistics system so that births, marriages and deaths and their causes can be registered and monitored. Ensure that the deaths of women, children and adolescents are monitored and audited, so that appropriate follow-up actions can be taken.
- 3. Promote multi-stakeholder engagement to monitor, review and act.** Promote multi-stakeholder engagement and cross-sector collaboration for follow-up actions at all levels. Health sector reviews involving all stakeholders

3. Commission on Information and Accountability for Women's and Children's Health. Keeping promises, measuring results. Geneva: WHO, 2011.

4. Independent Expert Review Group (iERG). *Every Woman Every Child: a post-2015 vision*. The third report of the independent Expert Review Group on Information and Accountability for Women's and Children's Health. Geneva: WHO, 2014.

can provide a platform for monitoring, review and action. Parliamentarians and civil society can monitor and hold governments accountable, thereby ensuring citizens' voices are heard. To ensure a transparent and independent review, an Independent Accountability Panel will prepare an annual report on the State of Women's, Children's and Adolescents' Health (see Box 7). The Partnership for Maternal, Newborn & Child Health (the Partnership) will play a coordination role in the global Accountability Framework to ensure all stakeholders can act on recommendations.

Figure 4. The *Global Strategy* Accountability Framework



Box 7. The State of Women's, Children's and Adolescents' Health annual report and the Independent Accountability Panel

Global accountability for the implementation of the *Global Strategy* will be brought together in a unified framework. In an effort to harmonize global reporting, minimize the reporting burden on countries and support cost-effectiveness, a comprehensive synthesis report of the State of Women's, Children's and Adolescents' Health will be produced using information routinely provided from United Nations agencies and independent monitoring groups. This annual report will be developed in an independent and transparent manner and will provide the global community with the best evidence for progress on women's, children's and adolescents' health towards achieving the *Global Strategy* objectives and the SDGs. The report will provide recommendations and guidance to all stakeholders on how to accelerate progress for improved health outcomes for women, children and adolescents.

The **Independent Accountability Panel** will take the lead in writing the annual report with support from a small secretariat housed at the Partnership. The annual report should not require additional data collection.

Each report will have a theme based on the findings of the previous year's report and be submitted to the United Nations Secretary-General. Member States and other stakeholders will be encouraged to discuss the report at the High-level Political Forum on Sustainable Development, which will be reviewing progress on the SDGs, the World Health Assembly, meetings of human rights treaty bodies and other high-level political assemblies and events, and to take appropriate actions.

76. Format and organizational aspects of the high-level political forum on sustainable development. A/RES/67/290. New York: United Nations, 2013.

77. USAID, World Bank Group, WHO. Measurement and accountability for results in health: A common agenda for the post-2015 era. 2015. <http://ma4health.hsaccess.org/home>.

Appendix 3

List of interviewees

Interviewee	Affiliation
Christopher Armstrong	Government of Canada
Henrik Axelson	Independent Consultant (Ex-PMNCH)
Aleksandra Blagojevic	Inter-Parliamentary Union
Lola Dare	Chestrad
David Evans	Swiss Tropical and Public Health Institute
Stefan Germann	World Vision International
Leith Greenslade	Office of the UN Special Envoy for Financing the Health MDGs
James Kintu	World Vision Uganda
Nana Kuo	Executive Office of the UN Secretary-General
Jean-Marie Mbonyintwali	Parliament of RWANDA
Rose Mlay	White Ribbon Alliance for Safe Motherhood Tanzania (WRATZ)
Lillian Nabatanzi	Forum Coordinator at Parliament Of Uganda for the Network for African Women Ministers and Parliamentarians (NAWMP)
Nhlanhla Ndlovu	Independent Consultant working on budget analysis and advocacy
Lucinda O'Hanlon	Office of the United Nations High Commissioner for Human Rights
Jerome Pfaffmann	UNICEF
Jennifer Requejo	Countdown to 2015
Rotimi Sankore	Africa Health, Human & Social Development (Afri-Dev)
Lale Say	WHO
Gradijah Walker	Save the Children Liberia

Appendix 4

Method for calculating the total financial commitments of low-income countries

In line with the methods used in the PMNCH 2011 report, the starting point of the analysis of financial commitments to the Global Strategy was an analysis of the commitment statements from the *Every Woman Every Child* website. Only commitments that are explicitly expressed in financial terms were included. The database on financial commitments to the Global Strategy, established by the Partnership in 2011 and 2012, was updated. To estimate the financial commitments made by 24 low-income countries (LICs) the methods of the PMNCH 2011 Report were used:

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.

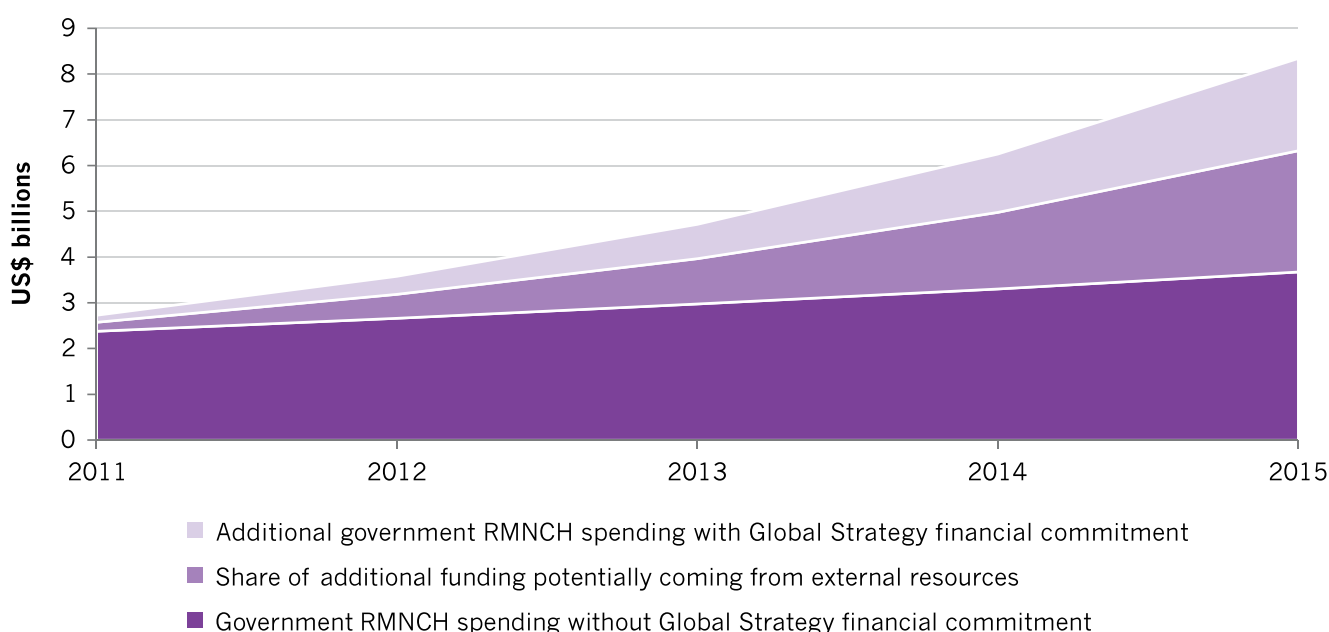
2. Based on trends of annual government health spending in 2006-2009, an estimate was made of what total government health spending on RMNCH would have been in 2011-2015 if no commitment to the Global Strategy had been made (the darkest area in Figure A1).

3. Total government health spending on RMNCH in 2011-2015, if spending were increased to meet the target in the Global Strategy commitment, was estimated (all areas in Figure A1). Unless another target year was specified in the commitment, a linear rate of increase in government health spending until 2015 was assumed.

The total additional government health spending on RMNCH in 2011-2015 (the two lighter areas in Figure A2) is the estimated value of governments' financial commitments. Figure A1 also shows the expected share of funding that is potentially subject to double-counting.

Figure A1

Government health spending on RMNCH in 25 low-income countries, with and without financial commitments to the Global Strategy, 2011-2015⁹⁶



Appendix 5

Controlling for double-counting

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

One particular challenge in this context was to estimate the funding channelled through NGOs. While good data were available for global health partnerships and multilateral agencies, only a small number of NGOs were able to estimate the extent to which their commitment relied on financial resources from international donors (and donors were also unable to specify the proportion of their commitment channelled through NGOs). As described in the table below, a different approach had to be used to estimate the extent to which NGOs' commitments are double-counted. While LIC and MIC governments are also a potential source of funding (i.e., they generate new resources for health, e.g. through taxes), their commitments are likely to be financed partly by external resources, which means that their commitments could also overlap with commitments by international sources.

Table A2

Approaches to controlling for double-counting

Multilateral agencies and global health partnerships	<ul style="list-style-type: none"> Commitments by bilateral and private donors channelled through multilateral organizations and global health partnerships were counted. Donor commitments were then subtracted from the amounts pledged by the different multilaterals and global health partnerships.
NGOs	<ul style="list-style-type: none"> NGOs were asked to provide information on the extent to which their commitment relied on funding from international donors. To fill data gaps, relevant documents were reviewed to estimate the share of donor funding that was channelled through NGOs (e.g. annual reports, IHME data). On average, we estimated that about 60% of NGO commitments were subject to double-counting.
LICs	<ul style="list-style-type: none"> In order to estimate the amount of external resources for health provided to the government budget of LICs, we calculated ODA for health channelled through the public sector for the 27 LICs that made financial commitments for 2008-2012 (source: CRS data). Considering a one-year time lag between donor disbursements and expenditure by recipient countries, we calculated the proportion of these external resources for health in total government health expenditures in the 27 LICs (for each LIC, the mean for 2009-2013 was drawn, source: GHED). Subsequently, the interquartile range (IQR) for the 27 LICs was calculated. The IQR is the range of the middle 50% of the data, excluding extreme values ("outliers"). The IQR is considered a more robust statistical measure than the range. The calculated IQR (15% and 50% of LIC commitments) was subtracted from projected LIC spending.
MICs	<ul style="list-style-type: none"> In order to estimate the amount of external resources for health provided to the government budget of MICs, ODA for health channelled through the public sector was calculated for the three MICs that made financial commitments (source: CRS data). The share of these external resources for health of total government health expenditures in the three MICs was calculated (for each MIC, the mean for 2009-2013 was drawn, source: GHED). Subsequently, the median for the three MICs was calculated. The calculated median of 2.3% was subtracted from the amount committed by the MICs.

Appendix 6

Overview of different methods to track spending on RMNCH

Muskoka methodology

The Muskoka relies on data of the OECD's Creditor Reporting System (CRS). It applies percentages to funding reported to the OECD under certain purpose codes or to selected multilateral organizations. The percentages applied vary depending on the intended target group of the respective donor activity. Activities targeting entirely or mostly women of reproductive age and/or children under five are assigned 100%; activities targeting the general population are counted at 40%. Disease-specific interventions are attributed at 18.5% for tuberculosis, 46.1% for HIV/AIDS and 88.5% for malaria. Basic drinking water supply and sanitation is counted at 15.0%.⁹⁷

IHME's approach

IHME tracks Development Assistance to Health (DAH). DAH includes financial and in-kind contributions from all donors reporting to CRS and NGOs delivered to low- and middle-income countries, as classified by the World Bank. DAH differs from ODA as DAH includes both private and public transfers, while ODA includes only public resources. The approach draws on data from the OECD CRS, donor databases, NGO databases and data obtained directly from donors. It relies on an automated keyword search of project descriptions reported under health and population sector codes. IHME's method largely avoids overlaps between MNCH funding and other DAH categories such as HIV/AIDS and malaria. It only captures funding explicitly earmarked for MNCH, e.g. pooled funding or health systems funding are not included.⁹⁸

Countdown to 2015's approach

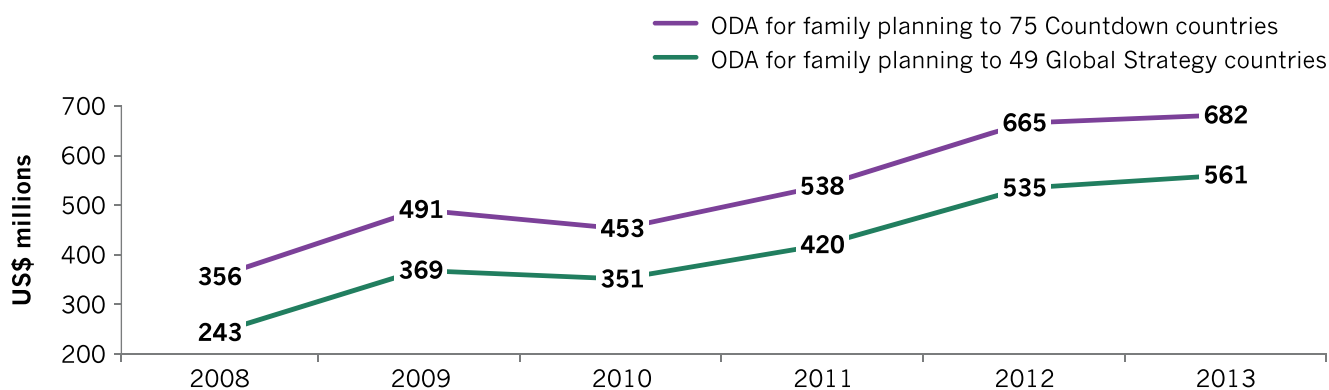
Countdown to 2015 analyses data reported to the OECD's CRS. The method assesses project descriptions that donors report to the OECD. Based on its own classification of RMNCH activities Countdown screens the CRS database for RMNCH financing. Projects are manually reviewed based on project title and descriptions, and categorized accordingly. For projects that specifically target the health of women and children, such as child immunization, the entire disbursement would be included in the RMNCH financing estimate. For other activities such as funding reported under HIV and malaria purpose codes as well as pooled funding and health systems funding, Countdown assesses the extent to which these activities contribute to RMNCH.⁹⁹

Appendix 7

Commitment analysis - additional figures on RMNCH financing trends

Figure A1

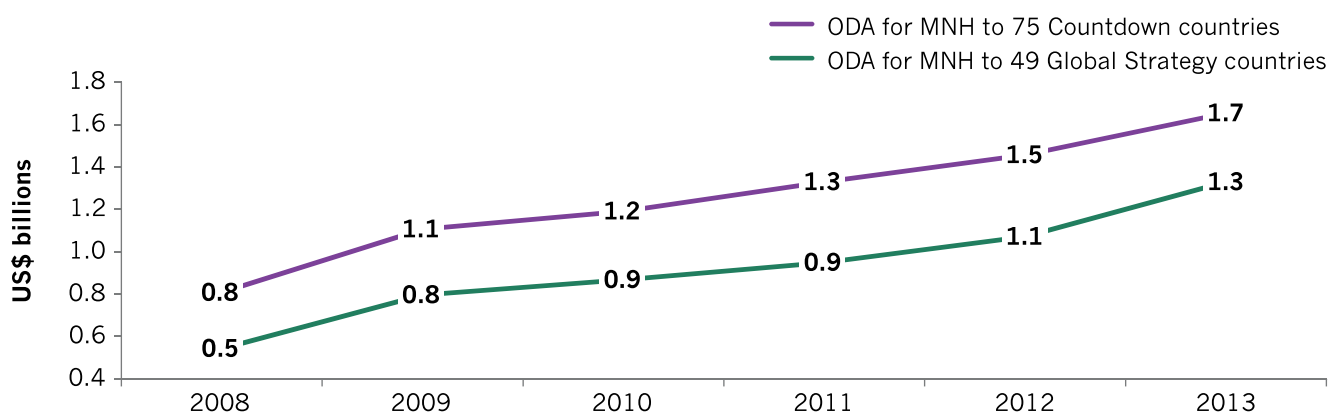
Disbursements for family planning to 49 Global Strategy and 75 Countdown countries, 2008 – 2013



Gross disbursements in US\$ millions - 2012 prices. Source: CRS database.

Figure A2

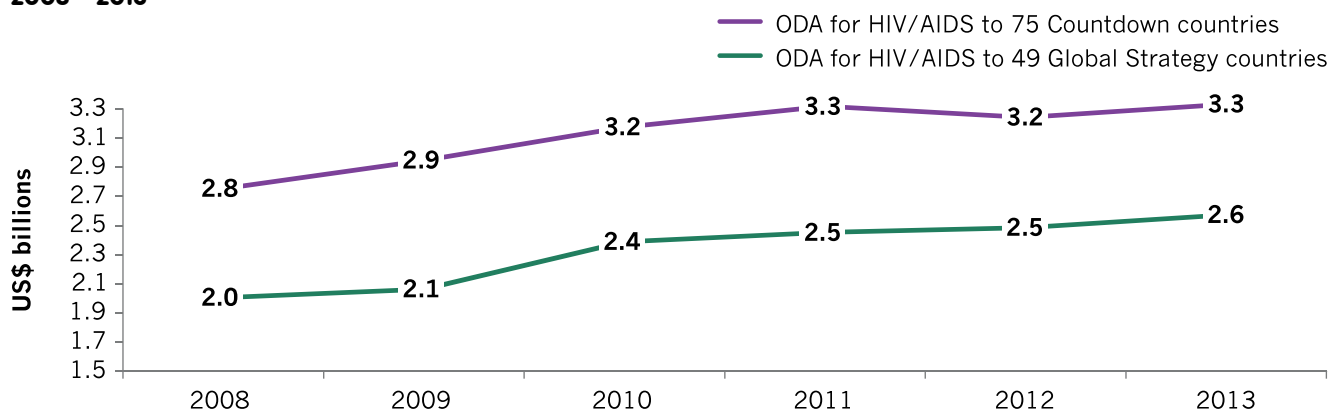
Disbursements for MNH to 49 Global Strategy and 75 Countdown countries, 2008 – 2013



Gross disbursements in US\$ billions - 2012 prices. Source: CRS database.

Figure A3

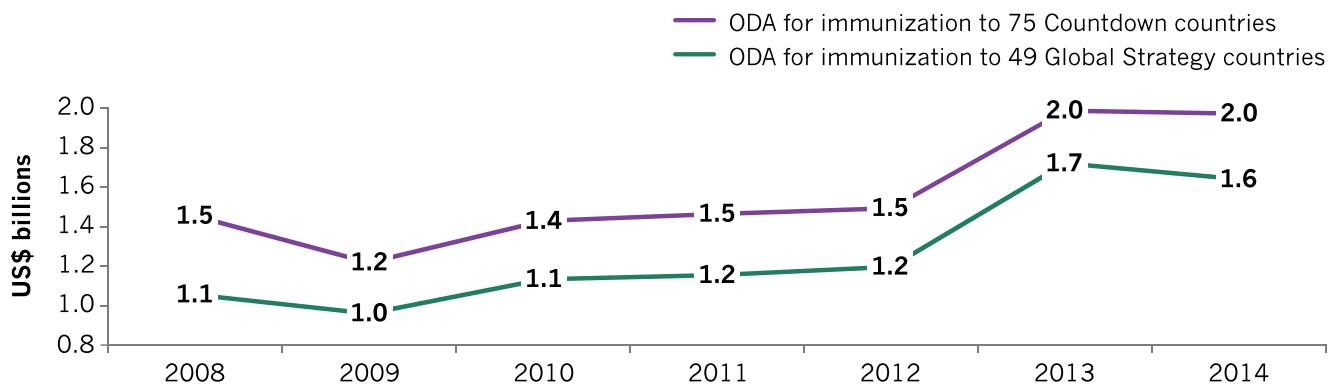
Disbursements for HIV/AIDS that support women and children to 49 Global Strategy and 75 Countdown countries, 2008 – 2013



Gross disbursements in US\$ billions - 2012 prices. Source: CRS database.

Figure A4

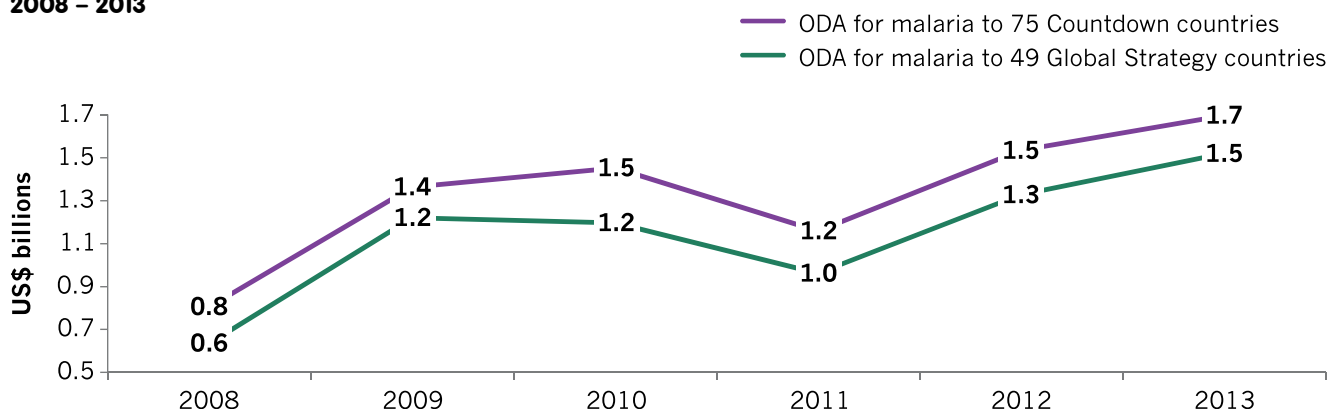
Disbursements for immunization to 49 Global Strategy and 75 Countdown countries, 2008 – 2014



Disbursements in US\$ billions - current prices. Source: GAVI, WHO & UNICEF data.

Figure A5

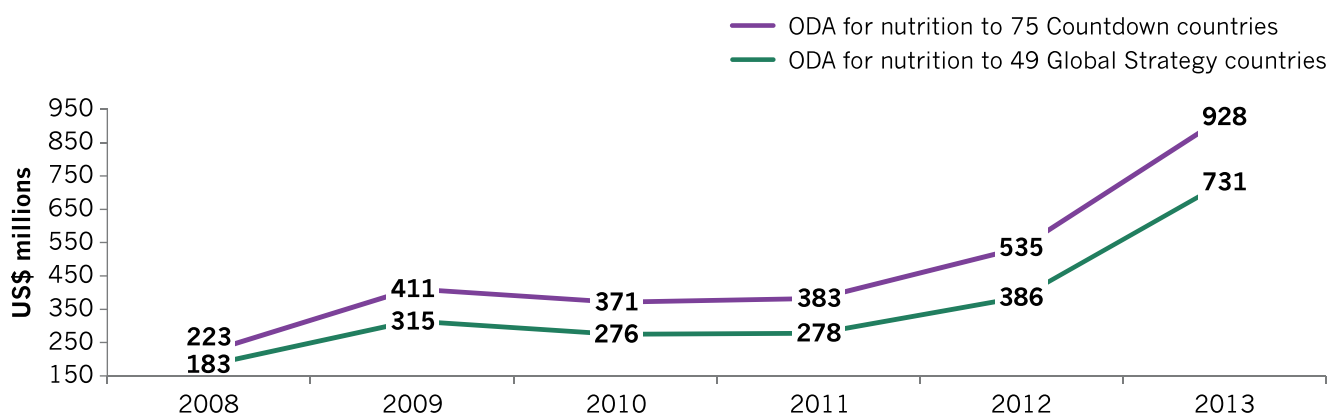
Disbursements for malaria that support women and children to 49 Global Strategy and 75 Countdown countries, 2008 – 2013



Gross disbursements in US\$ billions - 2012 prices. Source: CRS database.

Figure A6

Disbursements for nutrition to 49 Global Strategy and 75 Countdown countries, 2008 – 2013



Gross disbursements in US\$ millions - 2005 prices. Source: CRS database.

Appendix 8

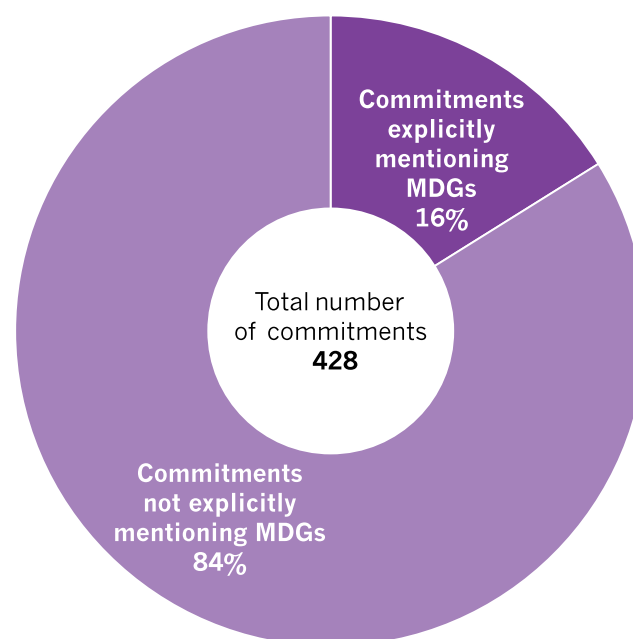
Alignment of Global Strategy commitments with the MDGs

An analysis based on an automated term search within commitment texts to assess the alignment of Global Strategy commitments with any of the Millennium Development Goals (MDGs) found that commitments could have been more closely aligned with the health MDGs (MDGs 4-6) for greater impact. Only a small minority of commitments (16% or 69 out of 428) specifically mentioned the MDGs (Figure A1).

In addition, an analysis of the commitments made by governments and the private sector/business community shows that some MDG areas received substantially more attention than others and that the different stakeholder groups target different MDG areas.

Figure A1

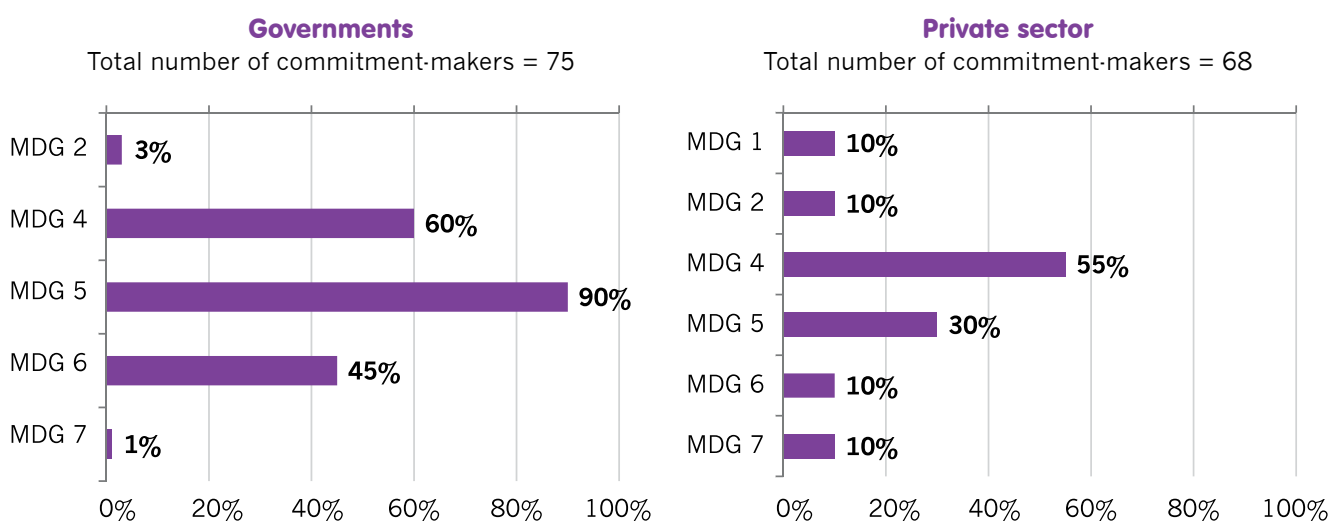
Financial and non-financial Global Strategy commitments explicitly mentioning the MDGs



Source: Every Woman Every Child website.

Figure A2

Alignment of Global Strategy commitments by selected constituencies with the MDGs



Percentages do not add up to 100% as several commitment-makers target multiple MDGs.

Source: Every Woman Every Child website.

Endnotes

1. United Nations Secretary-General (UNSG). The Global Strategy for Women's and Children's Health (Global Strategy). New York, United Nations, 2010.
2. EWEC: SURVIVE, THRIVE, TRANSFORM - The Global Strategy for Women's, Children's and Adolescents' Health. New York, 2015.
3. This financial analysis focuses on funding for reproductive, maternal, newborn and child health (RMNCH), as there is no methodology for tracking investments to reproductive, maternal, newborn, child and adolescent health (RMNCAH) to date. It should be noted, however, that funding flows for RMNCH also contribute to the improvement of adolescent health.
4. Commitments to the Global Strategy are listed on the EWEC website, <http://everywomaneverychild.org> (accessed 26 August 2015). These numbers are based on an analysis of commitments on the EWEC website.
5. Double-counting relates to funding committed twice by different stakeholders. For example, there could be a bilateral donor commitment to a global health partnership that is reported as a Global Strategy commitment by both the donor and the partnership.
6. The overall analysis of trends in donor funding for RMNCH was conducted using the Creditor Reporting System (of the OECD DAC) and the Muskoka method. Organisation for Economic Co-operation and Development (OECD). Development Co-operation Directorate. Creditor Reporting System (CRS) Database. Paris: 2013, <https://stats.oecd.org/Index.aspx?DataSetCode=CRS1> (accessed 16 March 2015); the Muskoka method is usually based on data of the OECD's CRS. It applies percentages to funding reported to the OECD under certain purpose codes or to selected multilateral organizations. The percentages applied vary depending on the intended target group of the respective donor activity. Activities targeting entirely or mostly women of reproductive age and/or children under five are assigned 100%; activities targeting the general population are counted at 40%. Disease-specific interventions are attributed at 18.5% for tuberculosis, 46.1% for HIV/AIDS and 88.5% for malaria. Basic drinking water supply and sanitation is counted at 15.0%, <http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html> (accessed 26 August 2015).
7. The 49 Global Strategy focus countries were the 49 lowest-income countries according to the World Bank list of economies as of April 2008. These countries were in the focus of work of the Taskforce on Innovative International Financing for Health Systems and then became the focus countries of the Global Strategy. These countries are: Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Cote d'Ivoire, Eritrea, Ethiopia, The Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, Kenya, Democratic Republic of Korea, Kyrgyz Republic, Lao PDR, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, Tajikistan, Tanzania, Togo, Uganda, Uzbekistan, Vietnam, Yemen, Zambia and Zimbabwe.
8. Every Women, Every Child (EWEC): SURVIVE, THRIVE, TRANSFORM - The Global Strategy for Women's, Children's and Adolescents' Health. New York, 2015.
9. This includes the Universal Periodic Review (UPR), the Committee on the Elimination of Discrimination Against Women (CEDAW Committee), and the Committee on the Rights of the Child (CRC). United Nations. Human Rights, Universal Periodic Review, <http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx> (accessed 26 August 2015); United Nations. Committee on the Elimination of All Forms of Discrimination against Women, <http://www.un.org/womenwatch/daw/cedaw/committee.htm> (accessed 26 August 2015); United Nations. Committee on the Rights of the Child, <http://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIndex.aspx> (accessed 26 August 2015).
10. In the context of the health system, this shift also means that citizens (as individual beneficiaries of a healthcare system) are recognized as rights holders, and improving health is not reduced to merely its economic or developmental benefits, but acknowledged as a fundamental obligation. Key Informant Interview.
11. UNSG. The Global Strategy for Women's and Children's Health (Global Strategy). New York, United Nations, 2010.
12. Commission on Information and Accountability for Women's and Children's Health (COIA). Keeping Promises, Measuring Results. Geneva, Switzerland, 2011.
13. In 2010, the UNSG's Global Strategy for Women's and Children's Health called for the World Health Organization (WHO) to lead a process of determining the most effective institutional arrangements for ensuring global reporting, oversight and accountability for women's and children's health. In response, COIA was created in 2011, which proposed a framework and made recommendations on for global reporting, oversight and accountability mechanisms for women's and children's health. In its recommendation 10, COIA suggested a time-limited independent Expert Review Group (iERG) to operate until 2015, with the WHO hosting the secretariat for this group. The Partnership for Maternal, Newborn and Child Health (PMNCH), iERG, Background, Delivering on Recommendation 10, COIA, Recommendation 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", <http://www.who.int/pmnch/activities/accountability/ierg/en/> (accessed 14 August 2015).
14. Countdown is a global movement to track, stimulate and support country progress towards achieving the health-related MDGs, particularly goals 4 and 5. For further information and country profiles, see <http://www.countdown2015mnch.org/> (accessed 14 August 2015).
15. EWEC: SURVIVE, THRIVE, TRANSFORM - The Global Strategy for Women's, Children's and Adolescents' Health. New York, 2015.
16. EWEC: SURVIVE, THRIVE, TRANSFORM - The Global Strategy for Women's, Children's and Adolescents' Health. New York, 2015.
17. Stenberg K et al. (on behalf of the Study Group for the Global Investment Framework for Women's and Children's Health). Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. *Lancet*, 2014; 383: 1333–1354.
18. Commission on Information and Accountability for Women's and Children's Health (COIA). Keeping Promises, Measuring Results. Geneva, Switzerland, 2011; EWEC:

- From commitments to action. The First Report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health. Geneva, WHO, 2012; EWEC: Strengthening Equity and Dignity through Health. The Second Report of the iERG on Information and Accountability for Women's and Children's Health. Geneva, WHO, 2013; EWEC: a post-2015 vision: The Third Report of the iERG on Information and Accountability for Women's and Children's Health. Geneva, WHO, 2014.
19. Financial commitments are defined as commitments expressed in explicit financial terms, <http://www.everywomaneverychild.org/commitments/all-commitments> (accessed 26 August 2015).
 20. For further information on double-counting, see also, The PMNCH 2014 Accountability Report: Tracking Financial Commitments to the Global Strategy for Women's and Children's Health. Geneva, Switzerland, 2014.
 21. OECD. Development Co-operation Directorate. CRS Database, <https://stats.oecd.org/Index.aspx?DataSetCode=CRS1> (accessed 16 March 2015). & World Health Organization. Global Health Expenditure Database.: <http://apps.who.int/nha/database> (accessed July 1, 2015).
 22. For background on the Muskoka method, see <http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html> (accessed 26 August 2015).
 23. This includes all annual PMNCH accountability and progress reports produced since 2011.
 24. The PMNCH 2011 Accountability Report: Analyzing Commitments to Advance the Global Strategy for Women's and Children's Health. Geneva, PMNCH, 2011.
 25. The PMNCH 2012 Accountability Report, Analyzing Progress on Commitments to the Global Strategy for Women's and Children's Health. Geneva, PMNCH, 2012. The PMNCH 2013 Accountability Report: Analyzing Progress on Commitments to the Global Strategy for Women's and Children's Health. Geneva, PMNCH, 2013.
 26. The PMNCH 2014 Accountability Report: Tracking Financial Commitments to the Global Strategy for Women's and Children's Health. Geneva, PMNCH, 2014.
 27. EWEC: Saving Lives, Protecting Futures, Progress Report on the Global Strategy for Women's and Children's Health 2010-2015. New York, United Nations, 2015, http://www.everywomaneverychild.org/images/EWEC_Progress_Report_FINAL_3.pdf (accessed 26 August 2015).
 28. The analysis in this report is focused on commitments that were listed on the EWEC website, <http://www.everywomaneverychild.org/commitments/all-commitments> (accessed 26 August 2015).
 29. The 34 new commitment-makers that have joined EWEC since May 2014 include 12 stakeholders from the private sector, 10 foundations, 6 NGOs, 3 academic and research institutions, 1 low-income country (LIC), 1 high-income country (HIC), 1 multilateral organization and 1 health care professional association. In total, the Every Newborn Action Plan (ENAP) catalyzed 40 new commitments for women's and children's health, showing once more the power of high-level events to catalyze new commitments, <http://www.everywomaneverychild.org/commitments/all-commitments> (accessed 26 August 2015).
 30. These findings are based on an analysis of the financial commitment statements from the EWEC website, <http://www.everywomaneverychild.org/commitments/all-commitments> (accessed 26 August 2015). Since May 2014, nine additional financial commitments have been made to the Global Strategy. Because the timeframes of these commitments occur mainly in the post-2015 period, they are not included in the overall commitment amount for 2011-2015.
 31. See Appendix 5 for details.
 32. This represents 15-19% of the US\$88 billion funding gap for reproductive, maternal, newborn and child health (RMNCH) for 2011-2015 as laid out in the Global Strategy.
 33. Disbursement rate of double-counting free funding calculated as the share of the median of double-counting free commitments of US\$44.5 billion (range: US\$41.4 billion – US\$45.2 billion).
 34. For instance, the United Kingdom (UK) reported disbursements until March 2015 and disbursement data for Gavi is available until June 2015. While most commitment-makers made commitments for the period 2011-2015, some stakeholders started implementing their commitments in 2010, in accordance in with their fiscal year, including the UK, Canada, Australia and other major donors.
 35. Countdown priority countries account for more than 95% of global maternal and child deaths. The 49 Global Strategy countries are a subset of the 75 Countdown countries. For a complete list of the Countdown priority countries, please refer to: <http://www.countdown2015mnch.org/country-profiles> (accessed 31 July 2015).
 36. This is the strongest annual growth rate since 2008/2009 and is substantially higher than in 2011 and 2012, when RMNCH ODA increased by 0.2% and 10.9% for the Global Strategy countries and by 0.5% and 7.8% for the Countdown countries, respectively. In addition to RMNCH ODA by public donors, private foundations and NGOs provided substantial financial resources for RMNCH. In 2013, the Bill & Melinda Gates Foundation provided US\$0.9 billion in private grants for RMNCH interventions in the 75 Countdown to 2015 countries.
 37. Arregoces L et al. Countdown to 2015: changes in official development assistance to reproductive, maternal, newborn, and child health, and assessment of progress between 2003 and 2012. *Lancet Global Health*, 2015; 3: e410-421.
 38. Institute for Health Metrics and Evaluation. Financing Global Health 2014: Shifts in Funding as the MDG Era Closes. Seattle, IHME, 2015.
 39. The different initiatives also focus on different groups of recipients: Countdown tracks RMNCH ODA to Countdown priority countries as well as global RMNCH ODA funding flows. IHME tracks development assistance for maternal, newborn and child health to all LIC and MIC (as defined by the World Bank), including funding from private donors such as the Bill & Melinda Gates Foundation. Our methodology focuses on RMNCH ODA to 49 Global Strategy and 75 Countdown countries.
 40. According to OECD DAC data. See: OECD Development Co-operation Directorate. CRS Database, <https://stats.oecd.org/Index.aspx?DataSetCode=CRS1> (accessed 16 March 2015).
 41. HIV-related RMNCH funding includes the proportion of financing for activities related to HIV/AIDS prevention, treatment and care programs that is estimated to benefit children and women of reproductive age (as per the Muskoka method). See <http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html> (accessed 26 August 2015).
 42. Funding for maternal and newborn health (MNH) has increased by a total of 53% (to US\$1.3 billion in 2013) for the Global Strategy countries and by 39% (to US\$1.7 billion) for the Countdown countries. While RMNCH funding targeting HIV/AIDS continues to be the largest funding

- area with disbursements reaching US\$2.6 billion in the 49 Global Strategy Countries and US\$3.3 billion in the 75 Countdown Countries in 2013, respectively, growth rates are low at 8% and 5% from 2010 and 2013 across the two country groups. Funding for immunization receives the second most RMNCH funding: Disbursements for immunization to the 49 Global Strategy countries increased by 45% between 2010 and 2014 (more recent data provided by WHO, UNICEF and Gavi) and by 38% for the 75 Countdown countries. Malaria funding, on the other hand, is on the rise again after declining in 2011. Disbursements towards malaria burden to the 49 Global Strategy countries and to the 75 Countdown countries grew by 27% and 17% between 2010 and 2013. Funding for nutrition, which is an integral component of two of the six GIF packages (MNH and child health), similarly increased, especially between 2012 and 2013. Overall, disbursements to both country groups have almost tripled since the launch of the Global Strategy.
43. External funding was excluded by discounting the mean share of external resources of total government expenditures for health received by the 49 Global Strategy and the 75 Countdown countries in the period 2009-2013.
 44. Global Strategy Finance Working Group. Background paper for the Global Strategy for Women's and Children's Health: Financial estimates in the Global Strategy. New York, United Nations, 2010.
 45. These 12 countries are: Benin, Burkina Faso, Cambodia, Cote d'Ivoire, Democratic Republic of the Congo, Gambia, Niger, Sierra Leone, Tajikistan, Tanzania, Togo, and Uganda. See: Lie. G. et al. Financing women's, children's, and adolescents' health. *BMJ*, 2015; 351: h4267.
 46. Xu K et al. Protecting households from catastrophic health spending. *Health Affairs*. 2007; 26(4): 972-83. See also Fan V, Glassman A. Going local. *Finance and Development*. 2014; 51(4): 12-15, <http://www.imf.org/external/pubs/ft/fandd/2014/12/pdf/fan.pdf>
 47. Jamison DT et al. Global health 2035: A world converging within a generation. *Lancet*. 2013; 382: 1898-955.
 48. UNGA, Human Rights Council, Annual Report of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality (2 July 2012) UN Doc A/HRC/21/22, http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf (accessed 26 August 2015); WHO and OHCHR, Human Rights and Economic and Social Issues Section & Millennium Development Goals Section. A Human Rights-Based Approach to Health, Health Information Sheet.
 49. Lie. G. et al. Financing women's, children's, and adolescents' health. *BMJ*, 2015; 351: h4267.
 50. A human rights-based approach (HRBA) requires the goals of the updated Global Strategy to be linked to the progress of a range of Sustainable Development Goals (SDGs), including Goal 5, to achieve gender equality and empower all women and girls. This goal extends to eliminating discriminatory and harmful practices like gender based violence and early marriage, as well as to improving economic opportunities, among other things, and therefore necessarily implicates other SDGs such as SDGs 2, 3, 4, and 8.
 51. Previous PMNCH Accountability reports acknowledged this to some extent through its analysis of overall RMNCH funding trends, which highlighted donor contributions more comprehensively.
 52. This decrease in the response rate was accompanied by an increasing number of commitment-makers. In 2013, still 120 stakeholders completed the survey. In 2014, no web-survey was conducted. However, for the first time, the seven largest bilateral donors provided up-to-date disbursement data.
 53. See WHO. Health Accounts. Health Accounts methodology, <http://www.who.int/health-accounts/methodology/en/> (accessed 26 August 2015), and http://www.who.int/health-accounts/platform_approach/en/
 54. Another problem was the costing of non-financial commitments: It has not been possible to estimate the significant financial value of all the policy, advocacy, service delivery and other commitments that were not expressed in explicit financial terms, and which also contribute to narrowing the financing gap.
 55. Access to Medicine Index, <http://www.accesstomedicineindex.org/ranking> (accessed 26 August 2015); Access to Nutrition Index, <https://www.accesstonutrition.org/> (accessed 26 August 2015).
 56. The iERG 2014 report mentions human rights as a central piece of the accountability framework for the post-2015 era, recommending establishing a Global Commission on the Health and Human Rights of Women and Children to propose ways to protect, augment, and sustain their health and wellbeing. See EWEC: a post-2015 vision: The Third Report of the iERG on Information and Accountability for Women's and Children's Health. Geneva, WHO, 2014.
 57. EWEC: SURVIVE, THRIVE, TRANSFORM - The Global Strategy for Women's, Children's and Adolescents' Health. New York, 2015.
 58. EWEC: SURVIVE, THRIVE, TRANSFORM - The Global Strategy for Women's, Children's and Adolescents' Health. New York, 2015.
 59. Bustreo F et al. Women's and Children's Health: Evidence of Impact of Human Rights. World Health Organization, 2013, http://apps.who.int/iris/bitstream/10665/84203/1/9789241505420_eng.pdf (accessed 26 August 2015).
 60. The PMNCH. Knowledge Summary 23: Women's and Children's Health. Human Rights and Accountability. PMNCH, 2013, http://www.who.int/pmnch/topics/part_publications/KS23_human_rights.pdf?ua=1 (accessed 26 August 2015).
 61. UNGA, Human Rights Council, Annual Report of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality (2 July 2012) UN Doc A/HRC/21/22, http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf (accessed 26 August 2015); UNGA, Human Rights Council, Annual Report of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (30 June 2014) UN Doc A/HRC/27/31, <http://www.ohchr.org/Documents/Issues/Children/TechnicalGuidance/TechnicalGuidancereport.pdf> (accessed 26 August 2015). The Technical Guidance on under-five mortality is the result of close collaboration between a range of human and child rights actors, including OHCHR, WHO, UNICEF, civil society and independent experts—and provides guidance on the application of a HRBA to the

- implementation of policies and programs to reduce preventable mortality and morbidity of children under 5 for a greater audience. This document complements the previous technical guidance on the application of HRBA to the implementation of policies and program to effectively reduce preventable maternal mortality and morbidity.
62. Two guides were published in 2014: "A Reflection Guide for Health Policymakers" and "A Reflection Guide for National Human Rights Institutions"; another for the judiciary and one for health service providers are to be published in 2015. These guides are based on the assumption that to effectively integrate a HRBA to ensure RMNCAH depends on multiple actors and target four different professional constituencies integral to the guarantee of human rights at the national level and engage in a series of questions around key issues from their perspective, to look closely at the policy cycle influencing RMNCAH outcomes. See OHCHR et al. Summary Reflection Guide on a Human Rights-Based Approach to Health, Application to sexual and reproductive health, maternal health and under-5 child health: Health Policy Makers (2014), http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/RGuide_HealthPolicyMakers.pdf (accessed 26 August 2015); OHCHR et al. Summary Reflection Guide on a Human Rights-Based Approach to Health, Application to sexual and reproductive health, maternal health and under-5 child health: National Human Rights Institutions (2014), http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/RGuide_NHRIInsts.pdf (accessed 26 August 2015).
 63. Yet, while local and traditional courts play an important role in addressing rights violations and tend to be more accessible and culturally acceptable compared to the formal court system in some places, thereby increasing community engagement, they can also be sites of human rights violations themselves. See Center for Reproductive Rights. The Role of Human Rights-Based Accountability in Eliminating Maternal Mortality and Morbidity. New York, Center for Reproductive Rights, April 2011, <http://www2.ohchr.org/english/issues/women/docs/responses/CenterforReproductiveRights.pdf> (accessed 26 August 2015). In Sierra Leone, for example, local courts were found to be handing down decisions inconsistent with human rights standards, especially with regards to women's rights. This underlines the need for appropriate integration of a human rights into not only the national policy framework, but also into the governance of mechanisms meant to monitor and provide recourse of violations. See International Center for Transitional Justice. Sierra Leone. Submission to the Universal Periodic Review of the UN Human Rights Council 11th Session: May 2011. November 1, 2010, <http://www.hrcsl.org/sites/default/files/ICTJ-SierraLeone-Periodic-Review-2010-English.pdf> (accessed 14 August 2015).
 64. Björkman, M, Svensson, J. Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda. The Quarterly Journal of Economics, 2009. 124(2): 735-769.
 65. The White Ribbon Alliance, The Citizens' Hearings 2015, <http://whiteribbonalliance.org/campaigns2/citizens-hearings-2015/>
 66. For example, Afghanistan; Bangladesh; Burkina Faso; Cambodia; Ethiopia; Ghana; Guinea; India; Indonesia; Kenya; Lesotho; Malawi; Mali (May 4); Mauritania (May 4); Nepal (March 30); Niger (May 11); Nigeria (March 19); Pakistan (July 24); Senegal (June 30); Sierra Leone (May 19); South Africa (June 10); Tanzania (March 26); Uganda (March 7 & 27); Zambia.
 67. Key informant interview. Civil society organizations capacitated by the Partnership to track and monitor budget and implementation at the local level are able to provide information and statistics that parliaments cannot obtain on their own, leading to better policies for RMNCAH.
 68. PMNCH et al. Enhancing Capacity of Civil Society, Parliamentarians and the Media for Budget Analysis; Advocacy for Women's and Children's Health 27-30 August 2014, Nairobi, Kenya. Meeting Report, http://www.who.int/pmnch/media/events/2013/workshop_report.pdf (accessed 14 August 2015). The workshop, "Enhancing Capacity of Civil Society, Parliamentarians and the Media for Budget Analysis and Advocacy for Women's and Children's Health," took place from 27 -30 August 2013, in Nairobi, Kenya. Over sixty representatives of national parliaments, civil society, ministries of health, media and development agencies from Kenya, Liberia, Sierra Leone, Tanzania, and Uganda participated. The workshop was designed to build their capacities to engage with budgets and undertake budget advocacy for improved women's and children's health.
 69. The workshop in Dakar, Senegal, took place 6-9 May 2014, and was a multi-sectoral, regional budget-tracking workshop to build the capacity of stakeholders to understand how to undertake health budget advocacy; foster greater collaboration among stakeholders from different constituencies who influence budget processes in countries; and support the development of budget advocacy strategies that build on the advocacy plans of existing RMNCH or CSOs active in health-related issues. PMNCH, Multisectoral budget tracking workshop for Francophone Africa kicks off in Dakar 6-9, MAY 2014, Dakar, Senegal, <http://www.who.int/pmnch/media/events/2014/dakar/en/> (accessed 14 August 2015).
 70. For information on the Harare, Zimbabwe, workshop, see Healthy Newborn Network. A multi-stakeholder approach to health budget advocacy, <http://www.healthynewbornnetwork.org/blog/multi-stakeholder-approach-health-budget-advocacy?page=9>
 71. Enhancing Capacity of Civil Society, Parliamentarians and the Media for Budget Analysis and Advocacy for Women's and Children's Health, Nairobi, Kenya, August 27-30, 2013. Meeting Report, http://www.who.int/pmnch/media/events/2013/workshop_report.pdf (accessed 14 August 2015).
 72. In Senegal, 75 representatives of national parliaments from health and budget committees, civil society, ministries of health and finance, media and development agencies from Burkina Faso, Democratic Republic of Congo, Mali, Niger and Senegal came together. The participating partners are still developing their budget advocacy work plans. In Zimbabwe, teams from Ghana, Malawi, Nigeria, Zambia and Zimbabwe were invited, representing budget CSOs, health CSOs, the media, parliamentarians and Ministries of Health and Finance.
 73. PMNCH provided USD 20,000 in catalytic funding for the implementation of these plans. PMNCH, Progress Report, Budget advocacy for improved women's and children's health: experiences from national civil society organizations. PMNCH, 2014, http://www.who.int/pmnch/media/events/2013/progress_report.pdf (accessed 26 August 2015).
 74. Other activities undertaken include: trainings for media and civil society on budget processes and accountability in Liberia and development of policy briefs, elaborating on key RMNCH issues, requiring increased consideration by the Ministries of Health (MOH). PMNCH. 2013 Progress Report, Budget advocacy for improved women's and

- children's health: experiences from national civil society organizations. PMNCH, 2014, http://www.who.int/pmnch/media/events/2013/progress_report.pdf (accessed 26 August 2015).
75. Key informant Interview; PMNCH. Strengthening National Advocacy Coalitions for Improved Women's and Children's Health. PMNCH, 2013, http://www.who.int/pmnch/knowledge/publications/cso_report.pdf?ua=1 (accessed 27 August 2015).
76. Reports and briefs can be downloaded from the Mamaye website <http://www.mamaye.org/>
77. PMNCH. 2013 Progress Report, Budget advocacy for improved women's and children's health: experiences from national civil society organizations. PMNCH, 2014, http://www.who.int/pmnch/media/events/2013/progress_report.pdf (accessed 26 August 2015). The CSO coalition in Sierra Leone, the Budget Advocacy Network (BAN), whose primary remit is budget advocacy, focused their efforts in 2014 on identifying key bottlenecks around late disbursement of funds to the health sector and the resulting impact on the quality of health service delivery for women and children. BAN also worked to ensure government accountability on a 2012 presidential commitment to increase funding for health, and used its research findings to inform ongoing advocacy for timely quarterly disbursement of funds in 2014.
78. The White Ribbon Alliance (WRA), Tanzania Midwifery Association (TAMA). Report of the "Be In Science Choose Midwifery" Campaign Among Secondary School Youths in Tanzania (2013).
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80. WRA. Tanzania, Campaigning for emergency care, <http://whiteribbonalliance.org/national-alliances/tanzania/> (accessed 21 August 2015); The White Ribbon Alliance. White Ribbon Alliance Campaign Update, June 24, 2014, <http://whiteribbonalliance.org/opinions/white-ribbon-alliance-2014-campaign-update/> (accessed 14 August 2015).
81. Key stakeholder Interview; World Vision, Uganda. Opportunities could include, for example, the WHA. In Uganda, the alliance sent the MOH to the WHA (2012) having identified the event as an opportunity to increase literacy and capacity of the MOH around RMNCAH accountability. Further, in Uganda the alliance has identified the following as critical to the implementation of the Acceleration Plan: advocating for better equipment for RMNCH; combating systemic budgetary challenges; and working with local governments to integrate the Acceleration Plan.
82. http://www.who.int/pmnch/media/events/2013/progress_report.pdf
83. PMNCH, Progress Report Budget advocacy for improved women's and children's health: experiences from national civil society coalitions.
84. These ten countries are: Bangladesh, Burkina Faso, Ethiopia, Ghana, India, Indonesia, Kenya, Nigeria, Tanzania, and Uganda. A total of \$35,000 in catalytic funds was given to each country.
85. PMNCH. Strengthening National Advocacy Coalitions for Improved Women's and Children's Health. PMNCH, 2013, http://www.who.int/pmnch/knowledge/publications/cso_report.pdf?ua=1 (accessed 27 August 2015).
86. EWEC. Africa Coalition on Maternal, Newborn and Child Health, <http://www.everywomaneverychild.org/commitments/all-commitments/africa-coalition-on-maternal-newborn-and-child-health> (Accessed 14 August 2015).
87. These constraints include poor health system governance, insufficient budget allotment or improper distribution of funds, ineffectual policies, among other things. Political will is needed, however, to address these constraints and parliamentarians can provide the dynamic leadership to generate such will and ensure necessary actions. Parliaments have the potential to promote global accountability for commitments by supporting the implementation of the recommendations of the COIA at the national level.
88. Inter-Parliamentary Union. Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children. 2012.
89. These lessons have been informed by previous accountability reports and stakeholders consulted for this current report.
90. Stenberg K, Axelson H, Sheehan P, et al. Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. *Lancet* 2014; 383(9925): 1333-54.
91. Jamison DT, Summers LH, Alleyne G, et al. Global health 2035: a world converging within a generation. *The Lancet* 2013; 382(9908): 1898-955.
92. Guttmacher Institute. Adding it Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014. 2015/05/04 2014; <https://http://www.guttmacher.org/pubs/AddingItUp2014.html>
93. Heckman J. 4 Big Benefits of Investing in Early Childhood Development. 2015; <http://heckmanequation.org/content/resource/4-big-benefits-investing-early-childhood-development>
94. World Health Organization. Health for the world's adolescents: a second chance in the second decade. Geneva: World Health Organization, 2014.
95. In the context of the health system, this shift also means that citizens (as individual beneficiaries of a healthcare system) are recognized as rights holders, and improving health is not reduced to merely its economic or developmental benefits, but acknowledged as a fundamental obligation.
96. Only 25 of the 27 LIC committed to increase their government health expenditure as part of their Global Strategy commitment and are therefore included in this figure.
97. For background on the Muskoka method, see <http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html> (accessed 31 July 2015).
98. Institute for Health Metrics and Evaluation. Financing Global Health 2014: Shifts in Funding as the MDG Era Closes. Seattle, IHME, 2015.
99. For further details on Countdown's approach, see Arregoces L et al. Countdown to 2015: changes in official development assistance to reproductive, maternal, newborn, and child health, and assessment of progress between 2003 and 2012. *Lancet Global Health*, 2015; 3: e410-421.

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Advisory Group

The Advisory Group of PMNCH Partners played an important role in the development of the report. Its objectives were: (1) to comment and advise on the proposed methodology; (2) to review initial and emerging findings and drafts of the report; (3) to ensure that the voices of the Partnership's key stakeholders are captured; and (4) to advise on how to maximize the impact and reach of the report's findings and lessons learned.

The members of the Advisory Group were: Christopher Armstrong, Government of Canada; Zulfiqar Bhutta, Aga Khan University; Aleksandra Blagojevic, Inter-Parliamentary Union; Josephine Borghi, London School of Hygiene & Tropical Medicine; Lola Dare, Chestrad; Leith Greenslade, MDG Health Envoy; Betsy McCallon, White Ribbon Alliance; Jennifer Requejo, Countdown to 2015; Jyoti Sanghera, Office of the High Commissioner for Human Rights; Rotimi Sankore, Africa Health, Human & Social Development; Lale Say, World Health Organization

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