TOWARD A COMMON APPROACH:
COORDINATING REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH-RELATED INITIATIVES
AUGUST, 2013
I. INTRODUCTION

As we approach 2015 there is a renewed sense of urgency to accelerate progress to achieve the Millennium Development Goals (MDGs), and an opportunity to more systematically focus on the needs of women and children, as outlined in the UN Secretary-General’s Global Strategy for Women and Children’s Health, and the Every Women Every Child (EWEC) Movement.

There are now less than a 1000 days left to achieve MDGs 4 and 5. Between now and December 31, 2015, we must all come together to avert the deaths of 4.4 million children and 200,000 women. There are significant resources at hand – both financial and technical; at global and country level – to help us achieve this goal and we must use these wisely and efficiently. But more will still be needed. According to preliminary estimates from the UN Special Envoy’s for Financing the Health MDGs, roughly US$ 1 billion will need to be incrementally raised to meet country needs and complement existing sources of financing globally and domestically just to cover core commodity and associated service delivery costs. This assumes that countries themselves will continue to increase their domestic contribution to health.

There is also an opportunity to ensure a partnership model for RMNCH initiatives at an operational level that puts goals and expected results up-front. Defining the right priorities needs to build on a complementary sequence of activities including a robust and up-to-date analysis of the burden of disease, improving access to an evidence-based package of interventions and commodities, and tackling the main delivery bottlenecks.

A common approach to reviewing, refining, shaping, sharpening and supporting RMNCH plans is urgently needed as various initiatives and funding mechanisms simultaneously target numerous countries. Working within the broader MDG framework, the goal of a taking a common and well-coordinated approach will be central in providing a major push towards reducing child mortality (MDG 4) and improving maternal and reproductive health (MDG 5). Efforts around MDG 6, which have already yielded significant results, must also be leveraged and factored into a more coordinated and holistic approach.

To further these goals the RMNCH Steering Committee has been established to align and coordinate the international RMNCH response under the Every Women Every Child banner, and to more effectively respond to country needs and gaps. The purpose of this short document is to present a set of common principles underlying this work. It also outlines a framework that seeks to bring together and makes sense of the numerous initiatives, funds, development partners, coordinating bodies, and implementing agencies that have been engaged over the last few years to better support country-led efforts. It clarifies the respective roles and responsibilities with regards to engaging with countries to sharpen national plans; and coordinating the efforts around RMNCH, including the recently established RMNCH Fund, the H4+ and implementation of the UN Commission on Life-Saving Commodities (UNCoLSC) recommendations.

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1 A Global Investment Framework for Women’s and Children’s Health is under preparation, which will provide a more comprehensive picture of the financing needs.

2 This document attempts to capture the complexity of the RMNCH landscape and articulate how the different pieces fit together. As such it is intended for an informed audience already familiar with the general context. Simplified version(s) of this paper may be produced to suit various audience, as needed.
II. REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH FRAMEWORK

Recent years have witnessed strong national leadership and increased priority for RMNCH in countries with the greatest needs. Recent announcements of ambitious programs and targets by the governments of Nigeria, India, South Africa, China, Malawi and Ethiopia are a few notable examples. Initiatives such as the National Health Mission in India, Saving One Million Lives in Nigeria and the Safe Motherhood programme in Malawi reflect efforts that are firmly anchored at the highest political level and demonstrate the type of bold leadership required to generate rapid gains towards the health MDGs.

Simultaneously, accelerated progress in diverse countries such as Rwanda, Nepal, Cambodia, Senegal, Kenya, Tanzania, Zambia and Bangladesh highlight what can be achieved in relatively short programmatic time frames. Furthermore, these national efforts are underpinned by a range of complementary global initiatives, including the G8 Muskoka Initiative, Family Planning 2020, A Promise Renewed, the Global Newborn Action Plan and the UN Commission on Life-Saving Commodities for Women’s and Children’s Health (UNCoLSC), and others. The World Bank’s Health Results Innovation Trust Fund and its associated International Development Association (IDA) support is also a key supportive initiative.

A number of major development partners are supporting MDGs 4 & 5 through these multilateral initiatives, through direct bilateral support to countries, as well as directly through implementing partners.

To further bolster these global efforts, the newly appointed UN Special Envoy for Financing Health MDGs is tasked with mobilizing additional resources. Financial smoothing mechanisms, which allow to front-load resources against future commitments or bridge funds to account for disbursement delays, are in place to resources can quickly reach countries. Decisions taken at a policy level by both GAVI and the Global Fund to base their support on national strategies, and accept joint assessments, complement the recent initiative by the World Bank President and G8 leaders to revitalize IHP+.

Technical support for these efforts is provided in large part by the H4+, a joint effort by WHO, UNAIDS, UNFPA, UNICEF, UN Women, and the World Bank to improve the health of women and children and accelerate progress towards achieving MDGs 4 and 5. The H4+ serves as the lead technical partner for the UN Secretary-General’s

### Box 1: Common Principles for RMNCH Engagement - as agreed at the October 2012 Meeting of the PMNCH Board

1. **Country leadership and ownership.** Adhere to the Paris Declaration principles of country-driven programme design and implementation, in the context of IHP+ compacts, where they exist, aligned with national Health Sector strategies and RMNCH plans, and with budget processes and cycles.

2. **Strategic and equity focus.** Scale up the highest impact, evidence-based services/intervention packages and related health systems strengthening (HSS) prioritising the disadvantaged in low-income, high-burden countries (such as reflected in the EWEC country list). Match allocations of funds to availability (“to live within one’s means”) and gaps in programming with the goal of delivering results for women and children.

3. **Simplicity, alignment and complementarity.** Focus on the comparative advantage of a coordinated financing mechanism and build on and align with existing initiatives, processes and mechanisms. Keep design simple in order to enable rapid start-up and effective delivery.

4. **Harmonization.** Adapt/Use the tools and processes developed by previous initiatives to support countries to sharpen their national plans including for the joint assessment of national health plans and strategies and improved aid effectiveness.

5. **Leverage.** Build on and catalyse actions by a broad range of partners committed to the EWEC effort.

6. **Mutual accountability.** Drive transparency and responsibility relating to resources and results. Monitoring and evaluating for results is key to sustain commitments and sustain efforts.

7. **Time-bound nature (until 2015).** Set a limited time horizon initially; then make a decision on continuation based on assessment of effectiveness, and continued need to address coverage gaps.

8. **Separation of functions.** Avoid conflict of interest by clearly separating the four functions of financial oversight, assessment of proposals, implementation and receipt of funds.

9. **Sustainability.** Co-financing with countries; phasing out as countries gain in economic development.

10. **Inclusiveness:** Both non-UN and UN actors are active in major initiatives across the RMNCH continuum, such as FP2020, A Promise Renewed, and the UNCoLSC. A common RMNCH approach includes UN and non-UN actors and will therefore extend where appropriate H4+ membership.
Global Strategy for Women’s and Children’s Health. These efforts are further supported by a range of RMNCH partners working in-country who provide technical, operational and financial support to complement domestic efforts to achieve MDGs 4 and 5. Bilateral partners, including but not limited to Canada, France, Norway, Sweden, the UK and the US are critical partners, providing significant financial and technical support at country level. The Bill and Melinda Gates Foundation, Clinton Health Access Initiative and other private foundations are also taking a leadership role in global initiatives and in-country support.

**Diagram 1: Towards a Common Approach for Reproductive, Maternal, Neonatal and Child Health**
There are other bodies that support a broader accountability and advocacy framework. The Partnership for Maternal, Newborn and Child Health (PMNCH), an alliance of more than 500 partners established to ensure that all women, infants and children are healthy and thrive, works at global, regional and country level as a key advocacy and policy forum to advance the overall RMNCH Agenda. The independent Expert Review Group, for its part, is playing an increasingly important role to monitor overall progress of these various initiatives, supported by Countdown to 2015 and other monitoring efforts.

This strong leadership and momentum at country and global levels has facilitated discussions about how all partners can support one comprehensive national health plan, with clear results and targets, one budget and one “system” framework. Improving the harmonisation and alignment of international resources and engagements with national plans, resources and processes would greatly contribute to the acceleration of progress towards the health-related MDGs and foster better coordination between development partners and implementers at global and country levels (Box 1). The Diagram 1 above attempts to depict the different pieces described above.

Bringing all this together is the RMNCH Steering Committee, supported by a Strategy and Coordination Team and an RMNCH Trust Fund. The Steering Committee is not a governing body in the strict sense of the term – it has, for example, no legal standing nor does it make binding decisions on its members. However, it does aim to be more than just an information sharing forum, by serving to more closely harmonise and coordinate funding streams and activities in response to RMNCH country plans.

Each main element of the diagram is further detailed below. A country matrix against which the various initiatives are mapped can be found in Annex 1.

**Country Leadership & Implementation to Accelerate RMNCH Results and Impact**

National leadership is essential for long term sustainability of programmes, as outlined in the Busan Partnership for Effective Development which continued the movement towards country ownership, inclusive partnership and a focus on results and accountability. Active support for the country engagement process is critical to perform necessary technical tasks such as analysing trends in epidemiological context in order to identify and prioritise strategic interventions, programs and strategies. For example, the Ministry of Finance can take an active role to facilitate alignment of any future funding with existing budgets and funds. Global stakeholders and funds can also help leverage local resources.

Ultimately the engagement process in a country should lead to a group of key stakeholders actively buying-in to the determination of priority gaps, strategies for action, catalytic funding opportunities, and the establishment of relevant monitoring and accountability systems. Country-level coordination mechanisms, where possible building on SWAp and Compacts, must be further strengthened.

In terms of process, in most countries the Ministry of Health initiates a national, evidence-based, multi-stakeholder process to assess and sharpen national RMNCH plans, generate funding proposals, and coordinate monitoring & evaluation (M&E) activities. In most countries, an over-arching national health strategic plan exists, though the level of detail varies. There are then multiple sub-plans for specific disease areas or health system building blocks. It is critical that the linkages between these plans are made clear. The same situation exists within the RMNCH space, where sub-plans for family planning, maternal health or child health usually exist, and where overlaps exist with other disease-specific plans. While these sub-plans may well be necessary,
too often they are not linked or coordinated leading to possible duplication of effort, of over or under costing needs, and of a blurred picture of actual resource gaps. The efforts some countries are under-going now within A Promised Renewed, the H4+ Initiative or the UN Commission on Life-Saving Commodities should be an opportunity to more clearer establish those linkages and better channel new resources to existing gaps – if such analyses have not already been done through IHP+ process or similar approaches.

This process should include not only traditional health stakeholders, but also other sectors and ministries, development partners, foundations, and civil society to ensure sustainability and accountability. Where possible deliberations should be aligned with existing national processes such as the Annual Health Review, Sector-wide Review and others. For example, the principles for national health planning, created as part of the International Health Partnership (IHP+) provide guidance and tools, while the Joint Assessment of National Health Strategies (JANS) is a relevant approach to assess the strengths and weaknesses of a national health plan.

The review of plans and development of concept notes will, in the first instance, be used to advocate for further domestic resources and funding from local development partners and funders. Indeed, in most instances domestic resources are the major source of funding for national health systems, yet in the vast majority of countries those remain woefully insufficient. The case for investing in health as a necessary ingredient to sustained growth and socio-economic development has been made clear. Most countries have indeed increased their health sector spending, but it remains insufficient. Different countries have different means and opportunities to increase their contribution so a one-size-fits-all may not be appropriate. But if we are to be successful by 2015 and beyond, a more deliberate and sustained effort must be made in all recipient countries.

The notes/plans would then also be shared through the RMNCH Steering Committee and with development partners at a global and regional level. The widespread completion of these national priorities and their collation at a regional or global level will help to identify areas where additional global support may be necessary (such as new product development or pooled procurement agreements).

Greater efficiencies and ‘more health for the resources’ must also be sought. Indeed, even if new resources are mobilized globally and domestically, they will likely not meet all the growing needs. Greater focus on accountability and results must be encouraged through such approaches as ‘Results Based Financing’. This represents not only a way to be more efficient and cost-effective, but also a fundamental shift in mind-set from a focus on inputs to one on outputs and results. Experience has shown that such a shift has also dramatically improved health information systems and the use of data for decision-making.

**GLOBAL STRATEGY FOR WOMEN AND CHILDREN'S HEALTH: EVERY WOMEN EVERY CHILD MOVEMENT (EWEC)**

Launched by UN Secretary-General Ban Ki-moon during the United Nations Millennium Development Goals Summit in September 2010, Every Woman Every Child aims to save the lives of 16 million women and children by 2015. It is an unprecedented global movement that mobilizes and intensifies international and national action by governments, multilaterals, the private sector and civil society to address the major health challenges.

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3 Investing in health for Africa: The case for strengthening systems for better health outcomes, Harmonization for Health in Africa, 2011
facing women and children around the world. The effort puts into action the Global Strategy for Women’s and Children’s Health, which presents a roadmap on how to enhance financing, strengthen policy and improve service on the ground for the most vulnerable women and children.

EWEC is an ‘umbrella’ effort, under the roadmap laid by the Global Strategy. As such it seeks to harness the role of partners at all levels recognizing that they each have a unique role to play and value-add. From these partners, commitments are drawn towards the Global Strategy, which can be in-kind, through direct financial support or other technical support. These commitments translate into action on the ground and results. To oversee this, accountability mechanisms have been strengthened including an independent Expert Review Group (iERG), which will be discussed below.

The UN Secretary-General champions the Every Woman, Every Child effort, both publicly and in bilateral opportunities. Key platforms for the personal engagement of the Secretary-General are closely coordinated with partners to maximise the communications and commitment – building potential of all opportunities. This high level strategic engagement is managed and led by the Office of the Secretary-General. The Secretary-General’s global health team is located in the EOSG Strategic Planning Unit, and broadly covers the following acts in relation to the Every Woman, Every Child effort. The broad work streams have been established for the period 2011-2015, namely: implementation work at the country and global level – translating financial, policy and service delivery commitments into reality and adding impact through innovation; global accountability for resources and results; and mobilizing and keeping momentum among world leaders and global stakeholders

- Ensuring 3 areas of work described above move forward quickly through overall leadership and outreach to partners via a joint work plan
- Strategic guidance and overall support to the Secretary General, Deputy Secretary-General and Assistant Secretary-General
- Policy coordination and strategic communications related to initiatives under the auspices of the Every Woman, Every Child effort
- Link-building across priority UN agendas (gender, youth, food security, sustainable development etc.) with agencies, member states and other stakeholders
- Senior representation at key events and in the process of securing new commitments
- Outreach and guidance to the top-level actors across the “membership” of the global effort
- Convening of partners to provide strategic advice and steer advocacy efforts at the highest level
- Engaging new partners and influential actors
- Convening an annual “Special Event” for Every Woman, Every Child

While some of the global initiatives pre-date EWEC, such as the Partnership for Maternal, Newborn and Child Health established in 2005 and the H4+ Initiative, many of the initiatives launched over the past 3 years in support of MDGs 4 and 5 – further discussed below – have come from this movement, including, the Commission on Information and Accountability (CoIA), the Innovations Working Group, the Commission on Life-Saving Commodities (UNCoLSC) and A Promise Renewed (APR).
**INFORMATION AND ACCOUNTABILITY**

As the diagram depicts, accountability is a fundamental pillar of the global and local RMNCH response. While there are specific initiatives or groups that focus on the issue of accountability it must be seen and understand as much more than that. Indeed, it cuts across all levels of the system, all actors and all programs. Accountability is needed against global and local commitments; it is need to track progress of results; and it is critical in the context of the use of resources. Accountability is built into the internal systems of the various stakeholders and supported by the monitoring and evaluation frameworks of individual initiatives, programs or strategies. Nevertheless, supplementary efforts have been put in place to further strengthen accountability across the system as we move closer to the 2015 MDG deadline.

The Global Strategy for Women’s and Children’s Health called for a process to ensure global reporting, oversight and accountability. In response, a time-limited *Commission on Information and Accountability for Women’s and Children’s Health (CoIA)* was convened by President Kikwete of the United Republic of Tanzania and Prime Minister Harper of Canada and delivered a report in 2011: “Keeping Promises, Measuring Results”, which put forth 10 recommendations to fast track results for women’s and children’s health in the 75 countries that account for 95% of maternal and child deaths in the world. WHO has the mandate to follow-up on the implementation of the Commission’s recommendations. As of May 2013, 58 countries have developed accountability frameworks or are in the process of completion and 36 have received catalytic funding of the magnitude of $250,000. Countries receiving support can be found in Annex 1 (under preparation). In-country follow-up to the recommendation is being facilitated by the World Health Organization. Countries are receiving support to strengthen their accountability mechanisms such as the Health Management Information System, National Health Accounts and other resource tracking mechanisms.

One of the recommendations proposed the establishment of a time-limited oversight body that will report regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission’s recommendations. The *independent Expert Review Group (iERG)* was established in 2012 and its Secretariat is hosted by WHO; its role has recently been expanded to also follow-up on the recommendations of the *UN Commission on Life-Saving Commodities* and commitments made at *Family Planning 2020* Summit. It also reports on progress against the *Scaling-up Nutrition* movement.

*Countdown to 2015* is also an important mechanism at country level to strengthen accountability and generate increase momentum. Established in 2005 as a multi-disciplinary, multi-institutional collaboration, *Countdown to 2015* is a global movement of academics, governments, international agencies, health-care professional associations, development partners, and nongovernmental organizations, with The Lancet as a key partner. *Countdown* uses country-specific data to stimulate and support country progress towards achieving the health-related Millennium Development Goals (MDGs). *Countdown* tracks progress in the 75 countries where more than 95% of all maternal and child deaths occur, including the 49 lowest-income countries. With a focus on MDGs 4 and 5, *Countdown* promotes accountability from governments and development partners, identifies knowledge gaps, and proposes new actions to reduce child mortality and improve maternal health.

**ADVOCACY**

Every Woman Every Child continues to gather momentum. The UN Secretary-General, together with Heads of State and Government, must continue to work to keep women’s and children’s health high on the global political agenda. Global advocates, heads of 3 health-related agencies, parliamentarians, CEOs and civil society leaders are working to sustain momentum, showcase progress and foster links with related regional and national initiatives.
Advocacy efforts are driven by a growing and diverse network of partners, and are highlighted in a monthly newsletter and on the Every Woman Every Child website, facilitated by the UN Foundation and PMNCH. These provide a platform for commitment makers to showcase implementation efforts and their stories of success. Communicating success stories is vital to ensure women’s and children’s health remains high on the agenda as we make the final push on the current MDGs and through the post-2015 discussions.

PMNCH has a unique role to play in support of the global RMNCH response. It was launched in 2005, and brings together the reproductive, maternal, newborn and child health (RMNCH) communities into an alliance of more than 500 members. In its 2012-2015 Strategic Framework, the Partnership defined three strategic objectives: broker knowledge and innovation for action; advocate to mobilize and align resources; and promote accountability for resources and results. As such, it cuts across, supports and complements many of the global and regional initiatives that are more oriented towards implementation. PMNCH is governed by a board of 23, made up of diverse group of stakeholders representing seven constituencies: academic/research/training institutions; developing countries, represented through the Ministry responsible for health; development partners; health care professional associations; multilateral organizations with a health mandate related to MDGs 4 and 5; and non-governmental organizations and the private sector.

PMNCH has its Secretariat in Geneva, hosted by WHO. In-country work is carried out through its network of partners. PMNCH is also a key partner in the follow-up to the COiA’s recommendations, notably by hosting the Countdown to 2015 secretariat. PMNCH also serves as the secretariat to the Innovation Working Group. Their yearly reports on the follow-up to the commitments made against the Global Strategy have been an important advocacy and accountability tool. PMNCH’s budget has grown significantly over the years, standing in 2013 at roughly US$14.7 million.

**RMNCH-related Initiatives, Financing Channels and Implementing Partners**

Over the past several years over a dozen various initiatives have been launched under the umbrella of Every Women Every Child. A few pre-date the Global Strategy, but most have been launched since. They are of a different nature, scope and purpose. Some are rallying points, global action plans, or processes to rally support at country and global levels. Others are financing mechanisms in support of country plans. While this may on the face of it create a seemingly fragmented effort, the diagram attempts to show how they are in fact complementary and mutually comprehensive. If coordinated effectively, the sum of these efforts can indeed be transformational. Each element of the diagram is further explained below.

**RMNCH-related initiatives**

In support of the Global Strategy, a number of initiatives, summits, call to actions, and commissions have been set-up across the RMNCH continuum of care. In most cases, modest resources have been made available to support country planning processes and global coordination, These are briefly described below.

**Family Planning 2020.** Family Planning 2020 (FP2020) is a global partnership that supports the right of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. FP2020 works with governments, civil society, multi-lateral organizations, development partners, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020. FP2020 is an outcome of the 2012 London Summit on Family Planning where more than 20 governments made commitments to address the policy, financing,
delivery and socio-cultural barriers to women accessing contraceptive information, services and supplies. Development partners also pledged an additional US$2.6 billion in funding. Led by an 18-member Reference Group, guided technically by Working Groups (Country Engagement; Performance Monitoring & Accountability; Rights & Empowerment; and Market Dynamics), operated daily by a Task Team and hosted by the United Nations Foundation, FP2020 is based on the principle that all women, no matter where they live should have access to lifesaving contraceptives. FP2020 is in support of the UN Secretary-General’s global effort for women and children’s health, Every Woman Every Child. There are currently 23 focus countries, chosen because they have made specific commitments at the FP2020 Summit and it is expected that new countries make additional commitments. The main sponsors of this initiative are the Bill and Melinda Gates Foundation and the UK, in close collaboration with UNFPA and USAID.

Child Survival Call to Action – A Promise Renewed. Committing to Child Survival: A Promise Renewed is a global effort to end preventable child deaths. Under the leadership of participating governments and in support of the U.N. Secretary-General’s Every Woman Every Child strategy, A Promise Renewed brings together public, private and civil society actors committed to accelerating the decline in under-five mortality. It emerged from the Child Survival Call to Action, convened in June 2012 by the Governments of Ethiopia, India and the United States. A modelling exercise presented at the high-level forum demonstrated that the world can accelerate progress by scaling-up the full continuum of care for women and children. All countries can lower child mortality rates to 20 or fewer deaths per 1,000 live births by 2035. Achieving 20 by 2035 represents an important milestone towards the ultimate goal of ending preventable child deaths. What emerged from the Call to Action was a rejuvenated movement for child survival. Under the banner of A Promise Renewed, 176 governments have signed a pledge, renewing their commitment to save greater numbers of children from dying of preventable causes. More than 400 civil society and faith-based organizations signed their own pledges of support. Each signature represents a renewed commitment to give every child the best possible start in life. The Governments of Ethiopia, India, Zambia, DRC, Bangladesh, Senegal and Liberia are already translating their commitments into practical actions by sharpening country plans, setting measurable benchmarks, and strengthening national accountability for child survival. Similar efforts are underway in countries such as Uganda and Malawi. UNICEF serves as Secretariat for this Movement.

Global Action Plan for Newborns – Every Newborn. Set to launch in May 2014 in conjunction with World Health Assembly with implementation in 2014 and beyond by all stakeholders, Every Newborn will contribute to the Global Strategy for Women’s and Children’s Health and, provide a roadmap and joint action platform for the reduction of preventable newborn mortality. It will define the role and responsibilities of stakeholders, setting out a vision, targets and objectives, with recommended key actions to implement based on proven strategies for change and the latest evidence on effectiveness, costs and expected impact of interventions. Every Newborn is being developed through a series of consultation meetings throughout 2013, facilitated by the Core group chaired by UNICEF and WHO. Twenty countries have been identified to start analysing their situation in preparation for more detailed planning.

Global Action Plan for Nutrition – Scaling-up Nutrition Roadmap (SUN). Developed in 2009 and launched in 2010, SUN is a movement that brings organizations together across sectors to support national plans to scale up nutrition by helping to ensure that financial and technical resources are accessible, coordinated, predictable and ready to go to scale. 40 countries across Africa, Latin America and Asia have committed to scaling-up efforts under this movement. To improve coherence, provide strategic oversight, improve resource mobilization and ensure collective accountability a Lead Group
was established in 2012 made up of senior leaders from countries, development partners, civil society, business, and UN system organization. The movement is coordinated by the UN Special Representative for Food Security and Nutrition and chaired by the Executive Director of UNICEF.

**Global Vaccine Action Plan.** The Global Vaccine Action Plan (GVAP) was the product of the Decade of Vaccines Collaboration, under the leadership of the Bill & Melinda Gates Foundation, GAVI Alliance, UNICEF, United States National Institute of Allergies and Infectious Diseases and WHO. In May 2012 GVAP was endorsed by the 194 Member States of the World Health Assembly. The Plan provides a framework to prevent millions of deaths by 2020 through more equitable access to existing vaccines for people in all communities and aims to strengthen routine immunization to meet vaccination coverage targets; accelerate control of vaccine-preventable diseases with polio eradication as the first milestone; introduce new and improved vaccines and spur research and development for the next generation of vaccines and technologies. It covers a ten year period until 2020 and its development and implementation is advised by the Strategic Advisory Group of Experts (SAGE) on Immunization of the WHO. GVAP’s accountability framework follows the Global Strategy’s accountability framework, which is submitted with other reports to the independent Expert Review Group (iERG) for inclusion in its annual report to the SG.

**Global Action Plan for Pneumonia and Diarrhoea (GAPPD).** Led by WHO and UNICEF, partners launched in April 2013 the integrated Global Action Plan for the prevention and control of Pneumonia & Diarrhoea (GAPPD), which proposes a cohesive approach to end preventable child deaths (29% of all under-five children’s deaths) from these diseases by 2025. It brings together critical services and interventions to create healthy environments, promote practices known to protect children from diseases and ensures that every child has access to proven and appropriate preventive and treatment measures. The goal of the GAPPD is to reduce deaths from pneumonia to fewer than 3 children per 1000 live births, and from diarrhoea to less than 1 in 1000 by 2025. The global momentum and road map exist but the challenge is to put this knowledge and support into action. The Diarrhoea & Pneumonia Working Group, co-chaired by the Clinton Health Access Initiative (CHAI) and UNICEF, consists of representatives from more than 20 development agencies, development partners, NGOs, and the private sector provides technical assistance, resource mobilization, and monitoring and evaluation support to organizations and governments working to scale-up zinc, ORS, and amoxicillin in 10 high burden countries—Bangladesh, DRC, Ethiopia, India, Kenya, Niger, Nigeria, Pakistan, Tanzania, and Uganda.

Another set of global initiatives have had a more cross-cutting nature, including the Innovation Working Group, the UN Commission on Information and Accountability (already described in the previous section) and the UN Commission on Life-Saving Commodities.

**UNSG Innovation Working Group.** Launched in 2010 as the Global Strategy for Women’s and Children’s health hub on Innovation, the IWG is an informal gathering of organizations and individuals interested in promoting technological, organizational or social innovations towards faster progress for women’s and children’s health. Members come from governments, multilateral agencies, academia, civil society and businesses. The IWG fosters cooperation among organizations to develop and scale up innovations under country leadership, promotes greater private sector participation, supports the development of Private-Public Partnerships and establishes thematic task forces; for example on Sustainable Business Models, Checklists, Medical Devices and Innovative Finance. There are work streams on global health diplomacy, e- and m-health coordination and a practical guide to engage the private sector. The IWG is supported by the Norwegian Agency for Development Cooperation (NORAD), with the secretariat
hosted by the Partnership for Maternal, Newborn & Child Health (PMNCH). The IWG Asia chapter was recently launched, with the secretariat hosted by World Vision in Malaysia.

**UN Commission on Life-Saving Commodities (UNCoLSC).** Launched in March 2012, the UN Commission on Life-Saving Commodities for Women and Children was led by Co-Chairs President Goodluck Jonathan of Nigeria and Prime Minister Jens Stoltenberg of Norway. The Commission developed ten key recommendations which aim to increase access to thirteen life-saving medicines and health supplies for the world’s most vulnerable women and children. The recommendation called for building consensus around priority actions for increasing availability, affordability, accessibility and rational use of essential commodities for women’s and children’s health, including regulatory issues and market dynamics. Twenty two working groups are working with countries and partners to implement the Commission’s recommendations and eight ‘pathfinder’ countries are setting the example in addressing the implementation bottlenecks at the country level. The RMNCH Strategy and Coordination Team (SCT), hosted by UNICEF, provides support and oversight on the implementation, while the RMNCH Trust Fund, hosted by UNFPA and supported by Norway, is providing catalytic resources for global interventions as well as country gaps to rapidly increase access to life-saving commodities. (Both the RMNCH SCT and the Trust Fund are further discussed below, as their mandate extends beyond the follow-up to the UNCoLSC).

**UNSEO and 1,000 Days of Action.** In April 2013, the UN Secretary General called for 1,000 days of action in the race to meet the MDGs, stating “we all have a responsibility to make the most of the next 1,000 days and fulfill the millennium promise to the world’s poorest and most vulnerable people.” At that time, the newly appointed UN Special Envoy for the Financing of the Health Millennium Development Goals and Malaria (UNSEO) shared an analysis that revealed a need to avert the deaths of an additional 4.4 million children and 230,000 mothers by the end of 2015 in order to successfully achieve MDGs 4 and 5. In alignment with the UN Commission on Life-saving Commodities for Women and Children (UNCoLSC) the UNSEO has championed a campaign for the final 1,000 days to ensure that a sufficient number of essential commodities are made available in the countries bearing the greatest number of deaths. These commodities must be supported by large-scale “demand creation” efforts and improved delivery systems. Further, the UNSEO is working with partners to track progress against the targets, in the fewer than 850 days remaining until the 2015 deadline. One particular focus is to understand the cumulative impact of combined partner programs and country plans, with the goal of assessing whether these collective efforts are “on track” or “off track” in achieving the 2015 targets, and to identify where extra support or coordination may be needed. The UNSEO is working in close collaboration, amongst others, with the newly established RMNCH Strategy and Coordination Team.

**Financing channels/mechanisms**

Funding to support country plans and priorities – that align with and/or adapt these global plans and recommendations – flows through a variety of different channels. The diagram above provides a simplified picture of these flows, which are often more nuanced. This fragmentation can sometimes create confusion and a lack of transparency at the country level. Yet, it would be unrealistic to expect these could be merged or integrated; while some consolidation may be expected over time, they first and foremost need to be better coordinated both at the country level and globally.

The vast majority of funds in support of RMNCH plans and interventions are channelled bilaterally to countries, This means a development partner, funding agency or foundation channels resources directly to a specific country or set of countries. These are sometimes channelled directly to governmental institutions with varying
degrees of earmarking. Sometimes they are channelled to a UN agency or else to an NGO that is implementing a country program.

Significant resources are also channelled to countries through large global multi-donor financing mechanisms like GAVI and the Global Fund to Fight AIDS, TB and Malaria. These are extremely relevant to the RMCNH response given the overlaps in target populations, the synergies that could be had between HIV, TB and malaria programs with RMNCH interventions, and their system strengthening perspective.

A third channel is though multilateral agencies that have significant country presence. These agencies provide direct support to countries or channel their resources at country level to governmental institutions or other implementing partners. Two examples are the H4+ Muskoka Initiative of France and the World Bank’s Health Results Innovation Trust Fund.

**H4+ Muskoka Initiative (France).** As part of the government of France commitment at the G8 Summit in Muskoka to step up efforts to achieve MDG4 and 5, the French Ministry of Foreign and European Affairs (MAEE) is supporting H4+ efforts in twelve countries: Benin, Burkina Faso, Central African Republic, Chad, Cote D’Ivoire, Democratic Republic of the Congo, Guinea, Haiti, Mali, Niger, Senegal, and Togo. The total amount of grant approximates $120 million for a five year period until 2016. The focus of the grant is to improve RMNCH outcomes through a health systems approach. A first progress report covering the period up to December 2012 was submitted in May 2013. Funding is routed from the MAEE to each H4+ agency based on an agreed annual plan, to be channelled to countries.

**World Bank Health Results Innovation Trust Fund (HRITF).** The HRITF is a multi-donor trust fund supported by Norway and DFID and managed to implement Results-Based Financing (RBF) approaches in the health sector for achievement of the health-related MDGs – particularly MDGs 4 and 5. The country financing is linked to funding from the International Development Association (IDA). In total US$550 million in funding from HRITF is linked to 1.2 billion in IDA financing, supporting 34 countries. A considerable number of countries are in the process of scale up. All programs are accompanied by impact evaluations. The results published in the recent progress report are showing RBF programs are increasing coverage and quality of maternal and child health services. Evidence also suggests that well designed RBF programs have a positive impact on key health systems functions, making them more efficient and more accountable—all critical factors to reduce maternal mortality and improve child health and reaching MDGs 4 and 5. In several countries, the Results Based Financing approach has become an effective platform for joint prioritization, purchasing of a package of services and stronger harmonization of development partner financing. This can be further expanded through effective collaboration with the initiatives above.

Yet another mechanism used to channel some resources has been through a UN-based multi-donor trust fund. In these cases, funds are channelled to one UN agency who administers the resources on behalf of sister agencies. These are channelled to UN Agencies globally or in-country, who then hold responsibility and are accountable for the use of resources. These resources can be further channelled to implementing partners such as government institutions, NGOs, etc. Several such funds are currently managed by UNFPA.

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**H4+ Initiative (Canada).** Implementing a commitment made at the G8 Summit in Muskoka in 2010, the Canadian International Development Agency (CIDA) is supporting the H4+ in five priority countries with high rates of maternal and newborn mortality: Burkina Faso, DRC, Sierra Leone, Zambia, and Zimbabwe. The H4+/CIDA initiative aims to provide joint technical assistance and support to the national scale-up of reproductive, maternal, newborn and child health (RMNCH) interventions. CIDA is providing CAD $50 million over five years until December 2015. Funding is channelled through UNFPA, which serves as the Administrative Agent, to the responsible H4+ Agencies, and then to countries. The first year progress report covering up to December 2012 was submitted to CIDA in April 2013. The governance of this initiative is done in coordination with the SIDA H4+ support.

**H4+ Initiative (Sweden).** The Swedish International Development Cooperation Agency (Sida) is collaborating with the H4+ in six African countries, including Cameroon, Cote d’Ivoire, Ethiopia, Guinea-Bissau, Liberia and Zimbabwe. The USD $52 million grant covers the period from December 2012-December 2015 and focuses on supporting national health plans in the areas of reproductive, maternal, newborn and child health through strengthening health systems. Country implementation started in mid-2013. Similarly to the CIDA H4+ support, resources are channelled through UNFPA. The governance of this initiative is done in coordination with the CIDA H4+ support.

**Thematic Trust Fund for Maternal Health.** The Maternal Health Thematic Fund, known as the MHTF, was launched in 2008 and currently includes UNFPA’s flagship programme in midwifery and the Campaign to End Fistula. It is supporting activities in 43 countries. It has grown over the years and currently manages over US$30million per year. Its main funders are Norway, Sweden, the Netherlands and Luxemburg. Funds are primarily used to support UNFPA country programs, but also support global and regional initiatives.

**Global Programme to Enhance Reproductive Health Commodity Security.** The Global Programme to Enhance Reproductive Health Commodity Security works closely with the governments of 46 countries to ensure access to a reliable supply of contraceptives, condoms, medicine and equipment for family planning, prevention of HIV and other sexually transmitted infections and maternal health. Launched in 2007, the Global Programme provides financial and technical support for countries to procure and manage supplies of reproductive health commodities and strengthen their health systems. In 2012, the fund managed US$181million, principally from the European Commission, the Netherlands and the UK.

**Implementing Partners**

As described in the various initiatives or funding channels, implementing partners and technical agencies have an incredibly important role to play in support of country plans and programs. In all EWEC countries, there are a number of implementing partners working hand-in-hand with local governments and ministries of health. The most widely and most consistently present in the RMNCH arena are the UN technical agencies, known collectively as the H4+. There are also numerous civil society organizations, including international and local NGOs that play a very important role in support of government policies and priorities. The private sector is playing an increasingly important role, in particular in areas around access to life-saving commodities and the introduction of innovative technologies in support of health programs.

**The H4+ Agencies**

While there are global initiatives described above that pertain to the H4+ agencies, the H4+ is much more than that. As the constituency with the most extensive reach in low-income/high burden countries, the H4+ agencies
WHO, UNICEF, UNFPA, World Bank, UN Women and UNAIDS) have committed to facilitate and support implementation of the commitments made to the Global Strategy in all EWEC countries. The H4+ with national teams have worked over recent years to identify gaps, develop joint action plans, conduct joint technical support missions when needed, and provide coordinated support. In the context of the RMNCH response, the H4+, in partnership with other stakeholders, continue to work together with the following functions:

**At the country level,** specific modalities of work among the H4+ agencies are defined within each context by country agency leadership and covers, amongst others, the following areas:

- Support countries to conduct needs assessments to identify systems constraints to improved RMNCH, and ensure that health plans are MDG-driven and performance-based.
- Develop and/or cost RMNCH and related components of national health plans, and rapidly mobilize new or additional resources.
- Support countries to scale up RMNCH programs in line with domestic priorities, and strengthening health systems including procurement, regulatory and supply chain management systems; skilled health workers, particularly midwives, and other related personnel, including community health workers; and strengthen M&E systems to ensure timely, accurate, and reliable data on RMNCH outcomes.
- Support countries to address demand-side barriers and strengthen community engagement, particularly among marginalized and vulnerable groups.
- Tackle the root causes of maternal mortality and morbidity, including gender inequality, gender-based violence, human/SRH rights violations, low access to education (especially for girls) and rights-based family planning services, child marriage, and adolescent pregnancy.

The H4+ work closely with existing regional mechanisms such as Harmonization of Health in Africa (HHA) and through the agencies’ existing regional structures.

**At the global level:**

- Technical review – The H4+ provide expert review and advice to countries on an as-needed and as-requested basis to support implementation of RMNCH plans, program and activities. This work includes: expert review of country plans and programs in collaboration with national governments; review and support of technical proposals from strategic partners, including development partners and the private sector; engagement with global research and knowledge forums to facilitate information sharing; convening appropriate regional and country workshops to develop aspects of the H4+’s technical agenda/work plan, and share lessons learned.
- Monitoring and evaluation and implementation of the country level work and similar support to countries as they engage in their work plan activities.
- Global advocacy and communications – The H4+, alongside many others, including PMNCH, UNF, etc advocate on behalf of relevant RMNCH issues, under the umbrella of the Every Woman, Every Child movement.

The H4+ requires inter-agency coordination and this function will continue as it is presently with the appointed lead agency for a term of 1 year. The coordinating responsibilities include:

- Oversight and monitoring of the implementation of H4+ global level strategic Work Plan through regular teleconferences among the H4+ agencies, and/or any other means.
- Liaising with external partners on behalf of the H4+, including prospective development partners or other strategic partners (including the private sector) involved in RMNCH programming and/or funding.
Further liaison work with specific external audiences can be assigned to other agencies on an ad-hoc basis once initial contact has been established.

- Liaising with country offices, or providing a platform through which regular communication with country offices can occur
- Promotion of the H4+ activities and high-level advocacy on behalf of the H4+, including the development of appropriate communication materials and updates on the H4+ website and through other media, on an as-needed basis.

The lead agency co-ordinates technical and programming support before and after H4+ meetings, technical analysis and fact findings to support decision making; and collect country inputs, and ensure coordination among agencies for H4+ initiatives at country and global levels, including having technical discussions with each H4+ agency when necessary. It is also be the entry point for dialogue with new potential development partners interested in supporting H4+.

**NGOs, civil society, private sector**

Without getting into the detailed roles and responsibilities of the various groups of actors and stakeholders, it is important to recognize the crucial role that civil society – international and local NGOs and associations – and the private sector play. In many instances, international NGOs can perform similar functions than those of the H4+ agencies, complementing their capacity and expertise. The private sector needs to be increasingly engaged with at all stages of the response: during the up-stream planning phases as well as during implementation. They have already demonstrated in numerous instances the value they can add to the global response by for example, agreeing to make available certain commodities at reduced prices, by sharing their organizational and managerial expertise to strengthen program implementation, by leveraging new technologies, and by supporting critical advocacy and resource mobilization efforts.

**Mechanisms to ‘smoothen’ funding flows**

Within these initiatives and along the funding flow-chain, a number of potential delays and financial bottlenecks may exist and hamper rapid implementation. To address this reality, two specific mechanisms have recently been established: the US Fund for UNICEF’s Bridge Fund, and the Pledge Guarantee for Health.

**US Fund for UNICEF Bridge Fund.** The Bridge Fund was launched in early 2012. Often, significant delays occur between a development partner’s pledge, agreement or grant and the actual disbursement of funds from the development partner to the recipient. Therefore, to minimize programmatic delays which may result in lives lost, the fund can provide advance funding for country programs against a firm development partner guarantee. When funds are disbursed from the development partner, the amount that was advanced by the Bridge Fund gets reimbursed by the development partner directly. This mechanism leverages $14.3M of net worth grants up to three and one-half (3.5) times to acquire $50M in program-related investment and below market-rate loans. The mechanism has been deployed to accelerate the provision of RUTF and Oral Polio Vaccine in sub-Saharan Africa. In Nigeria, for instance, a US$6M bridge grant strengthened the impact of a World Bank’s $95M total commitment for 2013 OPV purchase.

**Pledge Guarantee for Health.** The USAID-Sweden-UN Foundation Pledge Guarantee For Health (PGH) was also recently launched. This mechanism has secured a 5 year $50M guarantee from USAID and SIDA ($25M each). By USAID and SIDA providing a direct guarantee to an Institutional Investor, PGH will be able to secure a 5 year $100M Revolving Credit Line to address cash flow bottlenecks and accelerate program implementation. For example, in a malaria-related transaction with the World Bank, UNICEF,
and the government of Zambia, the PGH accelerated the delivery of 800,000 malaria bed nets ahead of the peak rainy season, saving thousands of lives; with PGH, the WB was able to finance and procure in just 6 weeks - 27 weeks faster than the normal process. In another example, a PGH direct guarantee for Ethiopia accelerated the purchase of over 600,000 reproductive health implants, twice the amount that could be purchased without PGH.

**THE RMNCH STEERING COMMITTEE, FUND, AND STRATEGY AND COORDINATION TEAM**

This complex, yet potentially highly impactful architecture, requires innovative governance.

**RMNCH Steering Committee**

In order to more effectively respond to country needs and to align the international RMNCH response more closely with the implementation of the EWEC strategy and country plans, a Steering Committee has been established. The RMNCH Steering Committee is unique in that it cuts across all the RMNCH-related global initiatives under the EWEC banner. Its purpose is to accelerate and align the international response to the implementation of *Every Woman Every Child* strategy. As such, it is operationally oriented, basing its deliberations on how the sum of global support represented in the Steering Committee – multilateral and bilateral, financial and technical – can best respond to country needs and gaps.

Naturally, the primary and most important locus of dialogue between countries and development partners is at the country level. The RMNCH SC seeks in no way to circumvent on-going efforts to further strengthen such interactions within countries; on the contrary it seeks to strengthen and support country-level dialogue by

<table>
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<th>Box 2: Composition of the RMNCH Steering Committee</th>
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<td>The composition of the RMNCH is driven by its core function, which is to serve as a global coordination body to harmonize and align different initiatives and funding streams to better support countries. It is geared toward implementation. The total size should not exceed 25 in order to keep it manageable. As such the proposed make up is as follows:</td>
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The PMNCH Board will nominate these 3 representatives on a two-year basis, starting in 2014.
allowing common implementation challenges or outstanding needs and gaps that cannot be addressed at the country level to be expressed at a global level and in a forum that brings together key decision-makers and representatives of global initiatives, institutions and countries themselves.

Building on IHP+ principles, its orientation is towards supporting country plans and specific gaps expressed therein, which may very well vary in scope or form depending on the country context. The Steering Committee will therefore essentially serve two functions:

- Provide a platform for alignment of major initiatives related to RMNCH as described above;
- Based on country plans or concept notes, reviewing countries’ priorities, gaps, bottlenecks and needs in order to be able to ensure an effective response in terms of support for service delivery, including of life-saving commodities and technical support.

To ensure productive and effective deliberations, the Steering Committee will remain relatively limited in size. It is important, however, that all the initiatives or financing mechanisms described in the sections above are part of the Committee. The Steering Committee currently includes senior representatives from Nigeria, Ethiopia, Indonesia, Senegal, Tanzania, US, UK, Canada, Sweden, Norway, France, UNFPA, UNICEF, WHO, World Bank, Gates Foundation, CHAI, PMNCH, the UN Foundation, the Office of the Special Envoy for Financing the Health MDGs. GAVI and the GFATM have also been invited to join. The Executive Office of the Secretary-General will participate as observers. The make-up of the Steering Committee is not meant to be exclusive and it will likely change over time (See Box 2). The main concern is to keep it focused on strategic and operational implementation issues, and not slide into a forum for policy and normative debate. It has already been recognized that having all RMNCH-related constituencies represented would be duplicative of the PMNCH Board; instead the RMNCH SC will seek complementarity with the work and scope of the PMNCH Board. Each SC member should be supported by one senior aide to ensure swift follow-up, as necessary, of decisions that will have been made at the meeting.

The RMNCH Steering Committee will convene at least four times a year, alternating telephone/video conferencing with face-to-face meetings. Face-to-face meetings will last one day, allowing sufficient time to examine and discuss a number of country plans. If possible, these face-to-face meetings should happen in one of the countries being considered by the SC. During those discussions, it is expected that SC members will strive to identify how they or the initiatives they are supporting can support the country gaps, as well as discuss the most strategic uses of the RMNCH Fund towards these gaps. Firm funding decisions, at least for the time being, will not be collective but will remain the prerogative of each individual development partner based on the deliberations of the Steering Committee.

In support of its coordination function, the RMNCH Steering Committee will be supported by a RMNCH Fund and a RMNCH Strategy and Coordination Team (SCT), both described further below.

Individual governance mechanisms of specific initiatives such as, for example, the FP2020 Reference Group, or the H4+/CIDA/SIDA Technical Steering Committee will continue to function alongside the broader RMNCH Steering Committee, but will aim to take forward within their respective spheres the orientations provided during RMNCH SC discussions.

**RMNCH Trust Fund**

The RMNCH Fund will support the EWEC movement by providing additional resources and matching resources to gaps. This will help ensure country-led implementation of national plans for reproductive, maternal, newborn and child health.
It is important at the outset to distinguish the RMNCH Fund from the RMNCH Steering Committee described above. While the RMNCH Fund will support the efforts of the RMNCH Steering Committee, the Steering Committee is in itself much broader than the Fund, and can exist independently of the Fund. Likewise, the RMNCH Fund is not structurally or legally dependent on the RMNCH Steering Committee. Both are, however, mutually reinforcing.

In line with on-going debates on the most effective and efficient means of supporting country plans, and building on previous discussions around RMNCH financing, including through the PMNCH Board discussions, the RMNCH Fund seeks to avoid creating a new institution that would inevitably set-up parallel financing and reporting structures. Instead, it builds and strengthens existing financial and technical support systems. It will not seek to finance large-scale service delivery interventions, but rather draw on a dedicated funding pool from a range of development partners to (co-)finance the catalytic scale-up of high-impact RMNCH intervention packages and health systems strengthening investments, including commodities and associated delivery systems. Indeed, while the RMNCH Fund will support country plans, or parts thereof, directly it will also seek to leverage other multilateral or bilateral funding mechanisms in support of these same plans in a complementary fashion. This is why linking the RMNCH Fund to the RMNCH Steering Committee – which is broader than the actual Fund – is so important.

UNFPA is the fiduciary agent for the RMNCH Fund. To ensure greater value for money, the Trust Fund will favor pooled funding that can be deployed against approved country plans. As the fiduciary agent UNFPA will periodically submit financial reports to the development partners contributing to the Fund on expenditures and outstanding funding needs. These will also be shared with the Steering Committee. UNFPA will set up the necessary systems to make quick disbursements when instructed. The funds will be allocated and disbursed in response to Government prioritization of funding gaps, expressed through national plans or ‘Concept Notes’.

While the Steering Committee will as a group make recommendations on the optimal use of the RMNCH Fund in support of country plans or other global-level activities, decisions on the specific uses of the RMNCH Fund will be made by the specific development partners that are directly contributing into the RMNCH Fund,

The RMNCH Fund will:

- Provide financial support to countries and technical partners to assess, revise and sharpen their national RMNCH plans.
- Provide financial support for innovative service delivery scale-up for the RMNCH continuum of care (cash support linked to expected performance).
- Finance support for improving availability and access to life-saving commodities. This will include filling transformational gaps in the service delivery of life-saving commodities for EWEC countries – especially those that benefit from global and local market-shaping mechanisms that will achieve the best value for money.
- Support technical cooperation in countries to facilitate the implementation of evidence-based policies and service delivery, including demand-side factors to accelerate progress in improving RMNCH.
- Provide support to the H4+ and UNCoLSC working groups to perform global public good activities including but not limited to activities to implement the UNCoLSC recommendations.
- Provide support to evaluate and document the impact of the investments made by the Fund.
**RMNCH Strategy and Coordination Team (SCT)**

A Strategy and Coordination Team (SCT) has been established, hosted by UNICEF. This is a multi-agency team, with seconded staff from UNICEF, UNFPA and WHO. The SCT is responsible for providing administrative and technical support to the Steering Committee and Champions Group. The SCT will not implement activities; this will be done by Governments, and implementing partners co-ordinated by the H4+. The functions of the SCT are coordination, oversight, tracking and reporting to the Steering Committee. It will also be specifically supporting activities stemming from the report of the UN Commission on Life-Saving Commodities. Specifically, the SCT’s role includes:

**Governance and financial oversight**
- Support the work and meetings of the SC, the Champions Group, and UNCoLSC WGs
- Develop procedures for identification and peer review of country needs and plans
- Identify funding needs to the Steering Committee and other partners
- Based on Steering Committee deliberation and on specific directions from development partners to the RMNCH Trust Fund, instruct the Trust Fund fiduciary agent (UNFPA) on fund disbursements.

**Planning and coordination**
- Liaise with the H4+ to ensure up-to-date technical information and analysis on RMNCH initiatives, priority countries and gaps in country plans
- Identify partners as needed to support national RMNCH responses
- Coordinate the follow-up to UNCoLSC recommendations

**Performance monitoring**
- In the context of EWEC and the CoIA recommendations, and working with other partners such as the UN Special Envoy’s Office for Financing the Health MDGs, ALMA and others, setting benchmarks and targets
- Tracking progress and providing feedback to grantees

**Communication and reporting to Steering Committee**
- Monitoring and reporting on financial flows, outcomes and results achieved by the RMNCH Fund
- Synthesizing information into clear messages to support advocacy activities and information sharing as requested by the SC

The RMNCH Steering Committee will review and approve the Strategy and Coordination Team’s workplan and budget, communication strategy, and monitor its progress in executing adopted plans; including review of periodic financial reports from the RMNCH Fund on expenditures and outstanding financial needs.

### III. Towards a Common RMNCH ‘Country Engagement’ Process

A common RMNCH approach to the country engagement process could be more efficient and effective. It is proposed to use a similar process to what has recently been established by the Global Fund to fight AIDS, TB and Malaria. The diagram below (Diagram 2) summarizes this ‘country engagement’ process. In short, countries will be encouraged to develop ‘full expressions of demand’ based on their (existing) national plans or sub-plans; this will vary from country to country based on what they already have. First, countries would carry out an analysis of their current situation – a landscape synthesis. This would include reviewing existing strategies and sharpening national plan(s), as needed; synthesizing and reviewing latest epi-data and progress to date; and better understand status of the RMNCH enabling environment and key bottlenecks. This would be followed by
an in-country dialogue to confirm this analysis and identify and align relevant on-going initiatives, as well as map available and projected domestic and external resources at the national and sub-national level. All efforts should be undertaken to address gaps and priorities at the country level. The final step in establishing the ‘full expression of demand’ and the unmet need would be to articulate this gap analysis into a Concept Note on priority needs to accelerate progress and ‘bend the curve’ of MDGs 4 & 5. Throughout this process, which should take no more than a few months, the H4+ agencies, bilateral partners and well as relevant local and international NGOs would be actively engaged to provide timely and relevant technical assistance, as requested by governments. While this support should primarily come from available in-country resources and expertise, countries would also be able to draw upon global technical expertise through the H4+ partners, members of the UNCoLSC Technical Reference Teams, and other partners. The RMNCH Strategy and Coordination Team can also help facilitate this exchange. Furthermore, the analytical work underpinning the Concept Note and the Concept Note themselves would not be developed just for the RMNCH Fund; it could be used more than once – for different initiatives, financing channels, development partners, etc.

**Diagram 2: Towards a Common RMNCH ‘Country Engagement’ Process**

![Diagram 2: Towards a Common RMNCH ‘Country Engagement’ Process](image)

The Concept Notes will then be discussed at the global level. The RMNCH Strategy and Coordination team would then vet the funding requests, by checking for example, whether the submission adequately profiles the current national RMNCH situation; whether the submission reviews specific contextual barriers in relation access to
RMNCH services and commodities; whether it clearly identifies national RMNCH priorities and linkages; whether it captures the contribution of available domestic and international technical and financial resources to support these priorities and ensuing gaps; whether a realistic logical framework and implementation time line is included; and whether proposed budgets are appropriately and reasonably linked to the objectives and timelines. The SCT would then present these plans to the Steering Committee for consideration and help identify potential financing options to meet the gaps including through, but not limited to, the RMNCH Fund. Feedback will be provided to countries, including indicative funding envelopes and requesting specific funding requests to be made. In order to minimize administrative burden on countries, where possible, these will build on existing grant requirements and structures already in place. During this stage of the process and throughout the actual implementation, the H4+ agencies and other partners will be providing technical assistance and needed and as requested.

Given the short timeline to the 2015 deadline and the general urgency to make rapid progress against RMNCH targets, light but frequent monitoring of progress will be needed at country level.

IV. CONCLUDING REMARKS

Despite its complexity, and its many constantly moving parts, the framework depicted above forms a coherent whole. It is complex, no doubt, but that is probably necessary. Our responsibility is to harness that complexity and make it work towards our common goals, and rapidly save the lives of millions of children and women between now and 2015, and indeed beyond 2015. While we must keep our focus on the MDG deadline, which is now less than 1000 days away, we must also work towards an architecture that can continue to thrive, be effective and help us collectively accelerate progress towards a world where maternal deaths and children mortality in low income countries is on par with rates seen in high income countries.

This is a process in constant evolution. We must remain flexible and adapt to changing needs and circumstances. As such, the roles and responsibilities of various stakeholders, global initiatives, coordination mechanisms, etc. must also evolve and adapt as circumstances dictate. Most importantly, we must always ensure that the way we organize and manage the global response to country needs and gaps reduces complexity, duplication, and silos and lessens the transaction costs and administrative burden on countries.
**ANNEX 1: MAPPING OF RMNCH-RELATED INITIATIVES AGAINST COUNTRIES (1/2)**

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### ANNEX 1: MAPPING OF RMNCH-RELATED INITIATIVES AGAINST COUNTRIES (2/2)

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