EVERY WOMAN
EVERY CHILD
FOR HEALTHY AND EMPOWERED WOMEN,
CHILDREN AND ADOLESCENTS

OPERATIONAL FRAMEWORK

for the Global Strategy for Women's,
Children's and Adolescents' Health

SUSTAINABLE
DEVELOPMENT **G⬤ALS**

OPERATIONAL FRAMEWORK

for the Global Strategy for Women's, Children's and Adolescents' Health

May 2016

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INTRODUCTION

PART I

SUMMARY OF GLOBAL STRATEGY

The 2016-30 Global Strategy for Women's, Children's and Adolescents' Health (Global Strategy, launched at the Sustainable Development Summit in September 2015) sets out a bold new vision of, 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."

As a contributing strategy to guide efforts to address the Sustainable Development Goal (SDG) agenda, the Global Strategy builds on the successes of the previous 2010-2015 Global Strategy. These successes included political leadership and commitment, multi-stakeholder partnerships, a focus on accountability and scaling up innovations to improve health. Moreover, the Global Strategy identifies nine key action areas and also seeks to address ongoing challenges, namely to strengthen coordination and reduce fragmentation among various initiatives and funding efforts (both within the health sector and across other contributing sectors); to mobilize sufficient and effective financing for women's, children's and adolescents' health; and to ensure that country plans and priorities drive global collective action.

An overview of the Global Strategy is presented in Annex 1.

WHY AN OPERATIONAL FRAMEWORK?

This Operational Framework is intended to accompany the Global Strategy and to serve as a resource for national governments and the wide diversity of stakeholders within countries whose contributions are vital to improving the health and well-being of women, children and adolescents – including civil society, the private sector and development partners. It offers guidance and options for consideration as countries translate the Global Strategy into national and sub-national strategies and plans, starting with the period 2016-2020. These strategies can – and should – build on existing country-level processes and plans already underway.

This document is neither a prescriptive nor an exhaustive set of strategies. Instead, it presents objectives to implement the Global Strategy at country level around the nine action areas, including examples of country experiences. For each action area there is a corresponding "ingredient" for action:

1 **COUNTRY LEADERSHIP**
Country leadership

2 **FINANCING FOR HEALTH**
Aligning and mobilizing financing

3 **HEALTH SYSTEM RESILIENCE**
Strengthening health systems

4 **INDIVIDUAL POTENTIAL**
Establishing priorities for realizing individual potential

5 **COMMUNITY ENGAGEMENT**
Supporting community engagement, participation and advocacy

6 **MULTISECTORAL ACTION**
Enhancing mechanisms for multisectoral action

7 **HUMANITARIAN AND FRAGILE SETTINGS**
Strengthening capacity for action in humanitarian and fragile settings

8 **RESEARCH AND INNOVATION**
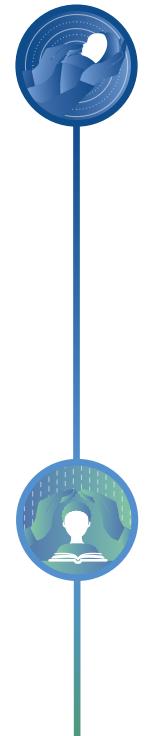Fostering research and innovation

9 **ACCOUNTABILITY**
Reinforcing global and national accountability mechanisms

The Operational Framework has been conceptualized as a "living document" with the potential to evolve as countries gain experience in translating the SDG agenda. It also provides an online central location to bring together tools and resources for implementation and to facilitate ongoing compilation and sharing of country experiences.

GLOBAL STRATEGY GOALS AND TARGETS

Survive, Thrive, Transform is the Global Strategy's call to action. Its over-arching goals are to end preventable mortality and enable women, children and adolescents to enjoy good health and thrive while being at the centre of transformative change and sustainable development (Table 1). The targets to be achieved by 2030 under each of the goals are drawn from related SDG targets.

SURVIVE:
End preventable deaths

THRIVE:
Ensure health and well-being

TRANSFORM:
Expand enabling environments

Table 1.
**Global Strategy goals and targets
(aligned with the SDGs and 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 1000 live births in every country

- *Reduce under-5 mortality*
  to at least as low as 25 per 1000 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 noncommunicable 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 adolescent girls, pregnant and lactating
  women and children*

- *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
  *free, equitable and good quality primary
  and secondary education*

- *Eliminate all harmful practices and all discrimination and violence*
  against women and girls

- Achieve universal and equitable access to
  *safe and affordable drinking water and to adequate 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

WHO IS THIS OPERATIONAL FRAMEWORK FOR?

This Operational Framework, like the Global Strategy, is applicable to all countries. The key audience is national governments in their role leading and driving country action, along with their partners in countries, including the important contribution of civil society (including adolescent, youth and health professional networks), the private sector, and global and regional development partners.

In addition, the document aims to inform the responsibilities of related global and regional initiatives (e.g. commissions, partnerships and agreed frameworks such as the Common African Position) that are aligned with, and supportive of, country level implementation. Examples of these responsibilities include quality technical assistance that is coordinated and aligned with national priorities; identification of a clear division of labour amongst the global/regional agencies that provide support; facilitating joint learning through the sharing of best practices and experiences in scaling interventions; increased efficiency of available funding flows along with increased overall funding; robust supra-national accountability mechanisms; increased investment in innovation, research and development; and advocacy, particularly with regard to equity and a rights-based approach.

HOW WAS THIS OPERATIONAL FRAMEWORK DEVELOPED?

The structure and content of this document have been developed with consideration to the written inputs received (from more than 7000 individuals and organisations) and the series of country consultations conducted to inform the Global Strategy (including in India, South Africa and the United Arab Emirates). Additional written inputs were sought and consultations were held in Tanzania, India, the United States, Mexico, Zambia, Uganda, Fiji and Bangladesh specifically for this Operational Framework. Finally, a draft of this document was made available online for public consultation in November 2015. These consultations represented a broad based, open and inclusive process with a wide range of stakeholders from governments, civil society, private sector and multilateral organizations.
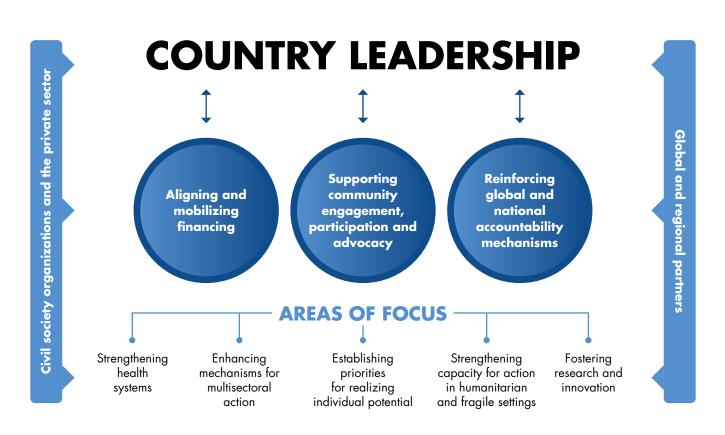
OPERATIONAL FRAMEWORK

INGREDIENTS FOR ACTION

This section describes key *ingredients for action* under each of the nine action areas set out in the Global Strategy. The objective is to highlight key considerations under each of the action areas, drawing on specific country experiences and providing links to further resources, with a view to guide countries as they operationalize the Global Strategy. Each ingredient for action is accompanied by implementation objectives, specific components to support each action area.

Country leadership is key among the Global Strategy's nine action areas, given that it is the overarching means that drives all implementation. **Financing, community engagement** and **accountability** are cross-cutting functions which are determined by and also contribute to country leadership. The remaining five action areas identified by the Global Strategy are focused on specific dimensions which country leadership needs to consider in operationalization: **health systems, multisectoral action, individual potential** (focusing on adolescents and early child development), **humanitarian settings**, and **research and innovation**.

While governments have the leadership and stewardship role for planning and implementation for all of the ingredients for action, true country ownership occurs when governments work with other stakeholders within and beyond government, including civil society organizations, networks for young people, associations of health care professionals, research and training institutes, as well as the private sector. Figure 1 presents a visual relationship of the nine ingredients for action.

Figure 1.
Operational Framework ingredients for action

1. COUNTRY LEADERSHIP

IMPLEMENTATION OBJECTIVES FOR THIS INGREDIENT:

- *A strong multi-stakeholder country platform for women's, children's and adolescents' health*

- *National and subnational SDG targets*

- *A single prioritized, costed, national plan for women's, children's and adolescents' health*

- *Effective stewardship and monitoring of implementation across sectors*

"The SDGs and targets are integrated and indivisible, global in nature and universally applicable, taking into account different national realities, capacities and levels of development and respecting national policies and priorities. Targets are defined as aspirational and global, with each government setting its own national targets guided by the global level of ambition but taking into account national circumstances. Each government will also decide how these aspirational and global targets should be incorporated in national planning processes, policies and strategies."

The 2030 Agenda for Sustainable Development

The first action area of the Global Strategy is country leadership – which encompasses all of the other action areas. As the above quotation from the 2030 Agenda for Sustainable Development notes, national governments will need to decide how to incorporate the SDG targets and Global Strategy action areas into their implementation efforts through national and subnational plans, strategies, policies and programming, in partnership with civil society, the private sector and development partners.

Facilitating country leadership is also an overarching ingredient for operationalizing the Global Strategy across its action areas. Countries will need to adapt and integrate existing plans for women's, children's and adolescents' health, themselves subsumed into existing national health plans and strategies, to incorporate the SDGs and the action areas of the Global Strategy, while developing new strategies for areas that are currently missing.

Challenges that have arisen with respect to planning in the MDG era need to be overcome. Some national plans for women's, children's and adolescents' health have been insufficiently integrated into national health sector plans and paid insufficient attention to the determinants of health, fostering fragmented implementation. Large portions have remained under-funded and critical aspects such as adolescent health, family planning, equity, or multisectoral dimensions were often overlooked. Accountability for results has varied both across and within countries. In addition, civil society engagement and mobilization around results remains nascent.

1.1 A strong multi-stakeholder country platform for women's, children's and adolescents' health

Led by the Ministry of Health, the process of improving national health plans is an in-depth stocktaking exercise in which policymakers, civil society (including adolescents), the private sector and technical experts review the situation of women, children and adolescents, identifying the high-impact interventions and fundamentally new strategies needed to accelerate results. This requires a strong multi-stakeholder country platform for women's, children's and adolescents' heath that brings together all essential stakeholders – government, communities, civil society, the private sector and development partners.

Country platforms can take different forms and should build on existing governance processes within countries. Country platforms need to:

• be transparent and inclusive of groups normally excluded from decision-making (including youth and adolescents)

• bring together crucial sectors for health beyond the health sector

• integrate with and build on existing mechanisms for planning and coordination, including other planning processes relevant to the SDGs

- be used for monitoring and reviewing progress in addition to initial planning

- have clear performance metrics and accountability mechanisms for their functioning, in line with International Health Partnership (IHP+) guidance and the Global Strategy accountability framework

- include consultations at subnational and local levels to strengthen coordination between different administrative levels within countries.

RESOURCES

1.2 SDG targets translated into national and subnational strategies and targets

The Global Strategy includes 17 key targets drawn from the SDGs which are crucial to the health of women, children and adolescents (see Table 1 above). SDG goals and targets require translation for countries' own contexts, with the setting of country-specific goals and targets, linked to national and global accountability frameworks through the following steps to be undertaken by the country platform:

1. Compare SDG targets to current targets already set in existing national plans and strategies

2. Analyse current progress against both national and SDG targets (for example, by analysing the distribution of reproductive, maternal, neonatal, child and adolescent health (RMNCAH) mortality and morbidity (including stillbirths) as well as underlying causes and determinants)

3. Establish country baselines for SDG targets related to RMNCAH, disaggregating data by key stratifiers to identify geographical areas and/or specific populations and communities of greatest need

4. Model the current national and subnational trajectory towards the 2030 SDG targets

5. Set or reaffirm national targets for 2030 for the SDGs related to the Global Strategy for joint monitoring of national health and RMNCAH strategies across different sectors

6. Identify subnational targets tailored to regional and local populations, focused on reducing inequities and gaps in data for monitoring these targets.

Figure 2 below outlines an example for a model of consultation on setting targets.

Figure 2.
Example of a Logical Framework for the Process of Setting Targets

(Source: adapted from UNICEF and WHO, 2010)

Like the MDGs, the SDG targets highlighted in the Global Strategy mostly focus on outcomes, rather than what is required to achieve them – this reflects that country contexts vary, and different paths will be required to achieve these targets to account for this diversity. Countries may find it useful to set additional targets, either on the key interventions and strategies in health and other sectors required, or intermediary milestones (e.g. for 2020 and 2025) to guide progress towards the 2030 deadlines.

RESOURCES

+ UNITAR National Briefing Package
http://www.unitar.org/thematic-areas/capacity-agenda-2030

Scanning the landscape of existing strategies and plans: UNITAR Module 6, slides 55-60 and Comparative analysis of SDGs and existing goals (goal level): UNITAR Module 6, slide 64

+ Landscape Synthesis of Reproductive, Maternal, Newborn, and Child Health Life-Saving Interventions and Commodities, Enumeration Manual, 2015
http://www.lifesavingcommodities.org/landscape-synthesis-enumeration-manual/

1.3 Strengthening prioritized, costed, national and subnational plans

Setting national SDG targets and considering the Global Strategy provides an opportunity for countries, via the country platform, to review existing strategies, identify and eliminate implementation constraints, prioritize interventions and consolidate plans into a single prioritized, costed strategy for women's, children and adolescents' health. Such a plan clearly focused on results ("investment case") aims to guide and attract additional financing from national and global partners over a three-to-five-year period, and can be further developed iteratively depending on the mobilization of resources. Consolidation and review of plans also provides an opportunity to prioritize key interventions in both health and non-health sectors, integrating with national strategies in key areas such as nutrition, education and social protection. Countries may draw from the overarching interventions presented in the Annexes of the Global Strategy and existing country programmes. Thus, priority interventions for scale-up can be identified, taking into account the country situation, coverage and human rights principles.

A prioritized, costed plan can drive agreement among key stakeholders on the set of priorities that can feasibly be implemented given the resources available. It can thus help shape the financing of such priorities. Such a plan should ideally be finalized as early as possible in the SDG era, drawing upon, integrating and clarifying existing planning processes and documents. Steps in the development process include:

1. agreement on what basis and what form the investment case should take

2. situation analysis (taking into account modelling undertaken in setting national targets)

3. selection of interventions and strategies

4. assessment of costs, cost-effectiveness of strategies and mapping of available resources

5. definition of priorities

6. agreement on who will finance each part of the plan among national and global partners (for more detail see section on "Aligning and Mobilizing Financing")

7. publication and dissemination of draft plan to seek feedback

8. finalization of plan

9. implementation.

RESOURCES

+ **Business Plan for the Global Financing Facility (World Bank 2015)**
http://www.worldbank.org/content/dam/Worldbank/document/HDN/Health/Business%20 Plan%20for%20the%20GFF,%20final.pdf

+ **Detailed guidance for investment cases for the GFF (under development)**

+ **Equist** *http://www.devinfo-cloud.info/equist/*

+ **Joint Assessment of National Health Strategies (JANS) Tool & Guidelines**
http://www.internationalhealthpartnership.net/en/tools/jans-tool-and-guidelines/

+ **One Health Tool** *http://www.who.int/choice/onehealthtool/en/*

+   *Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence (OHCHR, WHO, SIDA 2011)* http://www.ohchr.org/Documents/Publications/HRandGenderEqualityinHealthSectorStrategies.pdf

+   *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 (OHCHR 2012)* http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf

+   *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 (OHCHR, 2014)* http://www.ohchr.org/Documents/Issues/Children/TechnicalGuidance/TechnicalGuidancereport.pdf

+   *Summary Reflection Guide on a Human Rights-Based Approach to Health: Health Policy Makers (OHCHR et al 2015)* http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/RGuide_HealthPolicyMakers.pdf

1.4 Effective stewardship and monitoring of implementation across sectors

Country leadership extends beyond planning - even more important is stewarding and coordinating effective implementation across key sectors. Other parts of this Operational Framework consider key aspects of this, in particular the crucial contribution of an accountability framework that enables rapid action to address data revealing poor progress on national plans and strategies, or unforeseen consequences.

Strengthening of subnational platforms, similar to the country platform, is required for subnational coordination and monitoring the plan's implementation. Decentralized implementation may also improve its responsiveness to marginalized communities.

Effective implementation also requires strengthening of management capacity in health and other social services, particularly at the decentralized level, including:

- building local level evidence for investing in the health and opportunities for women, children and adolescents

- engaging decision-makers at subnational level on the need to adequately finance and implement interventions that improve the health and wellbeing of women, children and adolescents.

Nigeria's Saving One Million Lives Initiative:
A case study of country leadership to achieve results

The Saving One Million Lives (SOML) Initiative was launched in Nigeria by the President in October 2012, focusing on results and outcomes across six priority 'pillars': 1) strengthening RMNCH delivery platforms, 2) routine immunization coverage and polio eradication, 3) mother to child transmission of HIV, 4) access to essential RMNCH commodities, 5) malaria control and 6) child nutrition. In its original incarnation, SOML had a deadline of 2015 to match the MDGs as well as the 2015 presidential elections. The Federal government extended the initiative in 2015 with new World Bank funding for a linked four-year performance-based Programme for Results (P4R). Going forward, states will receive additional resources through P4R based on their performance on five process and outcome-related indicators.

SOML became a national priority initiative in Nigeria under the leadership of the Minister of State for Health. It has focused national attention on the basics of a primary health care approach, articulated strategic priorities for the Federal government and the health sector, and re-oriented service delivery discussions to results rather than inputs.

Further, the SOML team at the Federal level emphasized frequent and robust monitoring. Ongoing programme success was tracked using service coverage rates and related estimates of changes in mortality. A national scorecard was developed to compare states and encourage improvements. The Nutrition and Health Survey (NHS), which originally focused solely on northern Nigeria, was expanded to cover the entire country, explore additional RMNCH-related services and produce state-level data on an annual basis. This survey is now the main source of data for the new P4R to determine state financial incentives.

The Federal government also undertook specific actions to coordinate existing programmes to achieve better results. This national level coordination encouraged various state-level actors across HIV and maternal care programmes to use resources more effectively to make progress in PMTCT. The SOML team also worked to bolster accountability of managers and health workers through engagement, encouragement and incentives. In addition, the Federal SOML office put together coalitions of private sector companies and philanthropies to support the initiative. Compared to the usual focus on public services only, this emphasis on partnerships was an innovation to accelerate progress towards results. The Ministry of Health also tapped into special Federal accounts with resources to fund and manage large scale programmes outside of the regular Ministry of Health budget.

Programme areas that the country leadership prioritized and that have shown promising results include polio eradication, malaria control, routine immunization (particularly in northern Nigeria) and community management of acute malnutrition.

Sources: John Quinley; Loevinsohn BP (2015) *Nigeria - Programme to Support Saving One Million Lives : P146583 - Implementation Status Results Report: Sequence 01.* Washington, DC: World Bank Group. Federal Government of Nigeria and World Bank (2014) *Saving One Million Lives. Programme for Results. Brochure*

2. ALIGNING AND MOBILIZING EQUITABLE FINANCING

IMPLEMENTATION OBJECTIVES FOR THIS INGREDIENT:

- *Identification of funding requirements and mobilization of all potential sources and support for funding*

- *Coordination of funding flows*

- *Strengthened financing capacity at decentralized level*

There was an estimated funding gap in 2015 of US$33.3 billion in 63 high burden low- and lower middle-income countries for RMNCAH, or $10 per capita. All countries face either funding gaps or gaps in disbursement to realize the vision of the Global Strategy. As described in the Global Strategy and the Global Financing Facility (GFF) Business Plan, closing these deficits requires an increase in domestic and international funding, increased efficiency of existing investments and strengthened national health financing strategies. A sustainable response to this challenge will require combining external support, domestic financing, the private sector and innovative sources for resource mobilization and delivery, while minimizing out-of-pocket expenditure and eliminating user fees.

National health financing strategies need to consider both current needs and deficits, as well as model requirements through the SDG period to 2030, keeping in mind the target of achieving universal health coverage and ensuring financial risk protection. In humanitarian and fragile settings, increasingly the context for the majority of maternal, newborn and child mortality and stillbirths, intensified efforts are required to increase financing, which will mostly be required from external sources throughout the SDG era. Within countries, funding needs to be prioritized for the worst off to help reduce inequities.

2.1 Identification of funding requirements and mobilization of all potential sources and support for funding

Financing for RMNCAH should be integrated into core national planning processes for health financing, without duplication or undertaking parallel exercises, for example in the development of prioritized, costed plans described in the section on country leadership. Once developed, progress requires monitoring of implementation at both national and sub-national levels, including scale-up of interventions and mobilization of resources. Resource mapping can be used to identify all potential forms of funding, both domestic and external (including viable options of revenue reform measures, such as fuel subsidy reform or taxes on consumption of harmful substances), to meet country health financing needs. The aim should be to develop a national health financing strategy. Key steps in this process include:

1. estimating resource needs, using tools such as "OneHealth"

2. resource mapping to estimate financing flows from all sources

3. estimating overall resource gaps

4. identifying potential sources to close gaps (including innovative financing measures, development partners and private sector)

5. mobilizing sources of funding

6. monitoring and transparent publication of disbursement and funding flows

7. establishing a multi-stakeholder review process to review disbursement and funding flow data, and address shortcomings.

RESOURCES

+ *GFF Business Plan* http://www.worldbank.org/content/dam/Worldbank/document/HDN/Health/Business%20Plan%20for%20the%20GFF,%20final.pdf

+ *GFF detailed guidance on national health financing strategies (under development)*

+ *Global Investment Framework* http://www.who.int/maternal_child_adolescent/news_events/news/2013/global-investment-framework/en/

+ *World Health Report 2010 Country case studies* http://www.who.int/healthsystems/topics/financing/healthreport/whr_background/en/

+ *One Health Tool* http://www.who.int/choice/onehealthtool/en/

2.2 Coordination of funding flows

Even when funding is available, inefficiency in funding flows between different administrative levels and entities can be obstacles to effective service delivery. Key steps to address these challenges include:

1. mapping financing flows for health and health-related services within countries, in particular focusing on the flow between national and subnational levels

2. identifying where funding channels do not exist for key services

3. surveying facility based service delivery to assess what funds are actually spent

4. identifying and aligning financing flows for key non-health interventions (for example interventions for nutrition, education and gender equality)

5. developing funding formulas that take into account the burden of mortality and morbidity in disbursing funds between different subnational jurisdictions (that is, allocating higher per capita levels of funding to high needs areas)

6. delivering funds at the start of implementation cycles with greater predictability and reliability

7. aligning funding mechanisms that flow from national to subnational levels with funding sources at the subnational level.

RESOURCES

+ **GFF Business Plan** *http://www.worldbank.org/content/dam/Worldbank/document/ HDN/Health/Business%20Plan%20for%20the%20GFF,%20final.pdf*

+ **GFF detailed guidance on national health financing strategies (under development)**

+ **IHP+ Financial Management Harmonization and Alignment Guidance Note** *http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Tools/ Financial_Management_Assessment/Session%206%20FM%20Executive%20Summary%20 _%20Dec%202012.pdf*

2.3 Strengthened capacity at decentralized level for financing

Health and health-related services are delivered in communities and often managed at decentralized levels. However, even when bottlenecks are understood at this level, there is often insufficient agency and capacity on the part of those managing services at district or community level to adjust plans due to centralized financing. To address this challenge, countries can consider:

- increasing the flexibility of managers at subnational levels to reallocate resources when adjusting strategies on the basis of monitoring data and evidence

- training at national and subnational level in decentralized planning and budgeting and results-based financing approaches (where appropriate)

- complementary measures to strengthen public expenditure and financial accountability standards

- tracking investments to ensure that budget allocations are well spent, building capacity to analyse and track budgets where such skills are lacking or inadequate.

Achieving sustainable financing in a fragile context

The Democratic Republic of the Congo has faced repeated conflicts over the past two decades that have weakened institutions and led to millions of deaths (particularly among women and children), largely as a result of preventable diseases and malnutrition. Health expenditure in the country is low, at only half the average of low-income countries. A recent public expenditure review revealed that addressing this low expenditure does not require complicated new revenue generation measures, which are likely to be challenging to implement in a context in which institutions are still recovering from prolonged conflict. Instead, a combination of straightforward interventions could more than double the domestic resources currently available for health.

Increasing general tax revenues through better enforcement and administration of existing taxes and new levies from the natural resources sector could increase government health spending by 0.4% of gross domestic product (GDP). Increasing the share of the government budget that is allocated to health could increase spending by 0.3% of GDP. Better execution of budgets –from making appropriate allocations, to establishing controls to assure proper use of funds as well as monitoring and reviewing funds to ensure that limits are not exceeded – could increase spending by 0.6% of GDP. Recent economic growth in the country has exceeded 7% per year, which creates an important opportunity to increase resource mobilization for health.

At the same time, partners in the country such as GAVI, the Global Fund, UNICEF and the World Bank, are harmonizing their approaches and aligning their work to support the Ministry of Public Health's objective of reducing fragmentation among partners. The partners are jointly supporting a large-scale programme that aims to improve the delivery of an essential integrated package of RMNCAH services through performance-based financing and by addressing key bottlenecks in the health system.

Source: GFF Business Case

3. SUPPORTING COMMUNITY ENGAGEMENT, PARTICIPATION AND ADVOCACY

IMPLEMENTATION OBJECTIVES FOR THIS INGREDIENT:

- *A supportive environment for community engagement, participation and social accountability*

- *Strong advocacy and communication platforms*

- *Integration of service delivery by communities into national systems*

The vision of the Global Strategy cannot be realized without the central role of local communities as agents of change, demanding and delivering the quality services to which they are entitled. The Global Strategy calls for strong community engagement to "[harness] the power of partnerships and [strengthen] advocacy through coalitions at all levels." Stakeholders include communities, the private sector, women's groups, human rights defenders, trade unions, adolescent networks, faith-based organizations and national and international civil society organisations, among others.

Governments and partners can work together to strengthen community engagement and align around a common effort with a diverse but mutually reinforcing set of messages, processes, tools and tactics. Civil society groups and community members themselves can lead community engagement, participation and advocacy efforts. Media, including participatory citizen's media, can complement this. Although often overlooked, adolescents and youth constitute a key group that can actively engage as agents of social change to contribute to more effective policies and programmes to promote their own health and well-being. The private sector can also contribute to advocacy efforts, for example to strengthen supply chains, while explicitly stating their interests and avoiding any conflicts therein.

The Global Strategy also calls for community participation in service delivery, where communities are active providers of services and not mere recipients. Communities can deliver quality services with great impact, but these services need to be integrated into national plans and systems.

3.1 A supportive environment for community engagement, participation and social accountability

With a multi-stakeholder country platform, governments and civil society organizations can work together to identify and support agents of change in communities. Engagement and participation efforts can also provide communities themselves with opportunities for decision-making, planning, budgeting and contributing to accountability mechanisms. Examples include:

- identifying local individuals working on or supportive of RMNCAH issues

- providing resources necessary to support community engagement and participation, including capacity building and ensuring those most affected are able to engage (youth and women's groups should be prioritized for support)

- supporting existing social movements within countries to share information and monitor and demand access to affordable, acceptable and good quality health and social services without discrimination

- integrating civil society participation and social accountability into national accountability frameworks, allowing citizen-generated information to be part of the processes for monitoring, review and remedial action

- publicly funding the tools and costs of civil society engagement, with dedicated budget lines for this in national budgets

- building mechanisms for public participation, including taking advantage of technological platforms (e.g. mobile phones and social media) to facilitate community advancement of problem identification, prioritization and solutions

- recognizing community groups, particularly those most affected and those often excluded, with an equal platform to other traditional stakeholders such as professional associations

- institutionalising the monitoring and evaluation of community engagement with specific indicators.

RESOURCES

> **+** ***Institutionalize, Resource and Measure: Meaningful Civil Society Engagement in Global and National Health Policy, Financing, Measurement and Accountability*** *http://www.lifesavingcommodities.org/wp-content/ uploads/2015/11/Institutionalize-resource-measureF.pdf*

3.2 Strong advocacy and communication platforms

There is a continuing need for advocacy on RMNCAH issues, especially identifying and supporting existing national, sub-national and community-based partnerships, coalitions and activists. National, sub-national and local advocacy and communication platforms can enable individuals and communities to enact change in behaviours. Demand-driven communication for development strategies, based on sound analyses of social and behavioural determinants, can be used to 1) promote preventive practices and uptake of services, especially among those most marginalized, and 2) challenge discrimination and harmful social norms and stereotypes (particularly by engaging community leaders).

Advocacy and communication platforms can also facilitate social and community mobilization to create momentum and garner support to address health needs, particularly when they are driven by communities and used to promote participation and dialogue between people and service providers. In this way, decision-makers can be linked to community realities, creating space for dialogue, discussion and planning for evidence-based interventions. Such platforms can also be used to disseminate information on accountability mechanisms e.g. complaints procedures within health systems, and to support coordination among civil society and sharing of lessons.

Mapping existing resources that support people-centred advocacy for RMNCAH can help identify gaps in capacity, investments, data and information. A plan with national (and sub-national, if warranted) targets and milestones for community-engagement, partnerships and advocacy efforts can then be prepared to address these. Communities and other partners can be engaged to publicly monitor progress on capacity building, investments and related outcomes resulting from partnerships and advocacy work at agreed intervals.

RESOURCES

- ***A Promise Renewed Call to Action** – http://www.apromiserenewed.org*

- ***Every Newborn Action Plan** – http://www.everynewborn.org*

- ***Family Planning 2020** – http://www.familyplanning2020.org*

- ***Ending Preventable Maternal Mortality** – https://www.usaid.gov/sites/default/files/documents/1864/MH%20Strategy_web_red.pdf*

- ***Scaling up Lifesaving Commodities for Women, Children and Newborns – an Advocacy Toolkit** http://www.lifesavingcommodities.org/advocacy-working-group-workshop-brief/*

- ***Adaptable Communication Strategies for Nine Life-Saving Commodities** http://www.lifesavingcommodities.org/?s=adaptable+communication+strategy&showOnly=%20TkE9PQ%3D%3D*

- ***Demand Generation I-kit for Underutilized, Life-Saving Commodities** http://sbccimplementationkits.org/demandrmnch/*

3.3 Integration of service delivery by communities into national systems

Recognition and integration of the services provided by communities (including "task-shifting" and individual local private providers) into national systems requires:

- explicitly recognizing community provision of service delivery as a resource rather than as a "stop-gap" measure

- integrating community service provision into national plans and strategies

- implementing quality support, supervision and referral for community provided services to other parts of national systems (e.g. secondary and tertiary health facilities)

- providing remuneration and financial support from national and sub-national budgets for community provided services

- integrating community-based workers into national workforce strategies and providing training and career development pathways

- strengthening the linkages between health facilities and communities, through the use of technology for improved long-term follow-up and increased involvement of community leaders and local organizations

+ *An Inventory of Tools to Support Household and Community Based Programming for Child Survival, Growth and Development –*
http://www.unicef.org/nutrition/files/Inventory_of_community_tools_UNICEF.pdf

The community response to Ebola in Lofa County, Liberia

Lofa County in northern Liberia shares porous borders with both Sierra Leone and Guinea. In March 2014, the first cases of Ebola Virus Disease (EVD) appeared in Lofa County; within several months the county registered 724 cases, including 451 deaths. Key challenges included the limited knowledge of Ebola dangers and prevention among community members which led to stigma, fear and resistance, as well as the limited involvement of local leaders in the initial phase of the response.

In Barkedu Town in Lofa County, working in partnership with local authorities, religious leaders started a resilient and creative community response in July 2014, devising measures to stem the epidemic:

- *The community set up an 18 member Ebola task force comprised of youth, women, and community leaders. They organized their own rapid response system, identifying the suspected cases, isolating families and individuals, quickly carrying out safe and dignified burials and dispelling rumors by going door to door and organizing community dialogues.*

- *To facilitate negotiation of safe burials, 11 young trusted community members volunteered to be on the burial team.*

- *The town opened an isolation center for EVD cases since health centers had been deserted by health care workers.*

- *The community traced and monitored all newcomers. When in quarantine, the population patrolled the borders and restricted access.*

- *Quarantined families were closely monitored and provided with the necessary support they needed (food and non-food items as well as psycho-social support).*

- *Traditional leaders suspended all secret society ceremonies to avoid secret burials.*

- *Religious leaders prepared specific sermons addressing questions and resistance.*

Government and its partners aligned their responses with the community, encompassing multiple activities that enabled Lofa County to tackle the epidemic while creating momentum and buy-in from the community members at all levels, and setting a precedent for the rest of the response. This formal engagement with religious and traditional leaders was the first of its kind in Liberia's EVD response and proved to be critical in the resolution of the crisis. With this community leadership and community-based approach, Lofa County contained the epidemic in September 2014, with no further cases seen beyond this date.

Source: UNICEF (June 2015) Communication for Development: Responding to Ebola in Liberia. Lofa County: Communities took the matter in their own hands.

4. REINFORCING GLOBAL AND NATIONAL ACCOUNTABILITY MECHANISMS

IMPLEMENTATION OBJECTIVES FOR THIS INGREDIENT:

- **Robust accountability processes**

- **Effective civil registration and vital statistics systems**

Accountability is the process of monitoring, review and remedial action to achieve results and ensure the respect, protection and fulfilment of human rights. Global accountability will need to be built up from country-level measures and milestones. The Global Strategy calls for "robust country-led, multi-stakeholder accountability; independent review and unified reporting; and follow up action at all levels for women, children and adolescents." To realize this vision, the Global Strategy Unified Accountability Framework will build and strengthen accountability frameworks at subnational, national, regional and global levels, building on existing initiatives and aligning with SDG reporting.

This includes building on the work of the Commission on Information and Accountability for Women's and Children's Health (CoIA), supporting and promoting the use of the Global Strategy Indicator & Monitoring Framework (included in the resource list below) and linking with the SDG follow-up and review processes. It also includes reflecting on the findings of the Independent Accountability Panel (IAP), a nine-member technical body responsible for producing the annual "State of Women's, Children's and Adolescents' Health" report on progress on the Global Strategy. There is also a need to monitor the impact of the Global Strategy itself through review of progress on agreed milestones.

4.1 Robust accountability processes

Inclusive, transparent, diverse and regular reviews of plans, resource utilization and results are key to accountability. Country platforms (discussed in the section on country leadership) can play an important role in undertaking reviews, publishing their outcomes and acting on their results. Key steps include:

1. determining when and how often to conduct reviews

2. ensuring broad stakeholder engagement in the process

3. identifying key data, evidence, source documents, and processes to review

4. relating findings from reviews to SDG-related commitments for health, human rights, gender and equity, including the incorporation of sectoral reviews into the National Voluntary Reviews of the High-level Political Forum on Sustainable Development

5. taking remedial actions as necessary.

Mechanisms to strengthen accountability include:

• parliamentary committees

• citizens/ public hearings and inquiries

• use of national human rights and judicial institutions and their processes

• action by professional associations, such as health workers

• standardisation of user-friendly scorecards, updated frequently with locally-available disaggregated data providing insights into progress at national and sub-national levels

• citizen-led, social accountability platforms such as U Report, social audits and citizen report cards in addition to briefings or town hall meetings on tracking of results.

Health systems require particular attention in order to strengthen accountability, across the functions of monitoring, review and action. Data to inform reviews need to be disaggregated by sex, age, disability, race, ethnicity, mobility, or economic or other status, as nationally relevant, to identify women, children and adolescents facing discrimination in access to healthcare and other entitlements and services that affect their health and human rights. Regular internal review of health service coverage is required at national and sub-national levels to monitor availability, accessibility, acceptability and quality of services. This should inform the design and approach to implementation strategies.

RESOURCES

+   ***Global Strategy Indicator & Monitoring Framework*** *http://www. everywomaneverychild.org/news-events/news/1333-launch-of-new-global-strategy-monitoring-framework*

+   ***Terms of Reference, Independent Accountability Panel*** *http://www.who.int/pmnch/media/news/2015/iap_tors.pdf*

+   ***Integrated RMNCH Dashboard*** *http://www.lifesavingcommodities.org/wp-content/uploads/2015/05/Dashboard-Activity-Overview-20-April-2015.pdf*

+   ***U report*** *https://www.rapidsms.org/projects/ureport/*

+   ***UN Commission on Information and Accountability for Women's and Children's Health (CoIA)*** *http://www.everywomaneverychild.org/resources/archives/coia*

+   ***Global Collaborative on Performance Measurement and Accountability:*** *http://ma4health.hsaccess.org/docs/support-documents/the-roadmap-for-health-measurement-and-accountability.pdf?sfvrsn=0*

+   ***Country Accountability Framework (CAF) assessment and roadmap tool*** *http://www.who.int/woman_child_accountability/about/caf_tool_web.pdf?ua=1*

+   ***Country RMNCH scorecards for example,*** *http://advancefamilyplanning.org/sites/default/files/resources/Tanzania%20RMNCH%20scorecard.pdf*

4.2 Effective civil registration and vital statistics systems

Improved systems for civil registration and vital statistics (CRVS) are an essential part of ensuring quality data for decision making and to fulfil the ambitions of the Global Strategy. This is reflected by the inclusion of the birth identity SDG target as one of the "Transform" targets. Key considerations in improving CRVS systems include:

- implementing policies that promote free, universal and accessible birth and death registration as soon as possible after the event

- removing fees for registration or late registration

- reducing barriers such as discrimination, harmful social norms, distance and complicated registration processes

- designing policies for non-residents, for example people with nomadic lifestyles or displaced persons

- expanding eligibility for those who can be notifiers and verifiers of births and deaths (while taking into account the particular technical challenges of death verification)

- creating user-friendly forms in relevant languages

- protecting confidentiality

- removing criteria that hinder registration such as the presence of both parents

- using community-based providers and resources to promote birth and death registration

- documenting the cause of death using standard definitions, e.g. for maternal deaths ICD-MM, to allow countries to plan, prioritize, and implement strategies targeted to preventing deaths from those causes

- ensuring public availability, free and open access to regularly updated CRVS data to inform accountability mechanisms

- developing guidelines on the integration of CRVS data into policy-making processes in various sectors and policy levels

- digitizing CRVS systems and scaling up the use of mobile health applications.

An RMNCH Scorecard and political accountability for health service improvement in Tanzania

In May 2014, the Tanzanian Ministry of Health and Social Welfare created a "Reproductive, Maternal, Newborn and Child Health" (RMNCH) Scorecard to promote accountability for improved health services. The national scorecard provides information on 18 different indicators for each of Tanzania's 25 regions. Regional scorecards display the same indicators by district. Nearly all data included come from the routine health information system, enabling quarterly updates. Scorecards are color coded, representing indicators that are on track (green), somewhat below targets (yellow) or poorly performing (red). This colour-coding makes interpretation easy for those not familiar with specific health programmes or indicators.

As such, use of the Tanzanian scorecard is not limited to use by health officials, but is shared regularly with political leaders: the Prime Minister, President, regional commissioners and health teams. At the launch of the first scorecard by the President to an audience including regional commissioners, members of parliament, multisectoral government officials, civil society and others, he stated: "These are your working tools. We will use them to track your commitment, leadership and accountability for the lives of mothers and children at national and regional levels."

A January 2015 review found that most commissioners hold meetings at least quarterly with their regional and district health staff to review the scorecards and encourage them to find ways to improve their health programmes and scores. The regions, in turn, meet with district health teams who create specific action plans for targeted programmes and indicators. Following the first year of implementation, information system reporting rates (and the timeliness of reporting) increased substantially. The scorecard has been incorporated in Tanzania's new One Plan II for RMNCH and in the Health Sector Strategic Plan IV (2016-2020) (HSSP IV). The HSSP IV also calls for the creation of "community scorecards" to encourage accountability at the health facility level.

Source: John Quinley, A Promise Renewed Secretariat, incorporating information included in a PowerPoint presentation made by Clement Kehinga from the Tanzania MOHSW during the Uganda scorecards meeting.

5. STRENGTHENING HEALTH SYSTEMS

*IMPLEMENTATION OBJECTIVES
FOR THIS INGREDIENT:*

- *A strong health workforce*

- *Reliable supply, access and availability of commodities*

- *Effective health management information systems*

- *Quality health services delivered at scale with resilience*

Strengthening health systems is fundamental to achieving universal health coverage and developing the resilience of societies to withstand, respond and adapt effectively to health threats and shocks. Doing so requires considering all of the WHO building blocks for health systems (workforce, commodities, information systems, service delivery, financing and governance) to support delivery of the suite of interventions listed in Annexes 2 and 3 of the Global Strategy. It also requires attention to the links between these building blocks - and between health systems and other sectors. Issues relating to financing and governance are addressed in the corresponding sections of this Operational Framework. In addition, governments need to put in place appropriate policies and legal frameworks to enable access to services and steward the range of providers in public, private and civil society sectors. Considerations on the other four building blocks are outlined below.

5.1 A strong health workforce

In adapting the Global Strategy to their context, countries should consider the health system and workforce implications of its targets. Specifically, national commitments, plans, investment decisions and related accountability efforts that are developed should contribute to sustainable and long term strengthening of common service delivery platforms.

A strong health workforce that effectively addresses RMNCAH is one that emphasizes delivery at the primary care level, emphasizing prevention as well as treatment. The health RMNCAH workforce should include well-trained, supervised, equipped and incentivized health workers from the community to the referral level. District health managers should be equipped with or trained to develop technical, fiscal management and administrative capabilities.

Pre-service training for providers should be based on international norms, and deployment strategies should be based on identified needs to redress pre-existing inequities. Mechanisms to ensure supportive supervision of providers should also be in place.

To design and implement an enhanced workforce agenda responsive to RMNCAH needs, national institutions need to develop the capacities to collect, collate and analyse workforce data and labour economics; lead short and long term health workforce planning and development; advocate for better employment and working conditions for health workers; design, develop and deliver enhanced pre-service and in-service education and training for health workers; support health professional associations; facilitate collaboration with, and regulation of, private sector educational institutions and health providers; oversee the design of fair and effective performance management; and monitor and evaluate human resources for health interventions.

RESOURCES

+   ***A Toolkit for Implementing Health Services*** *http://www.lifesavingcommodities.org/ wp-content/uploads/2015/08/Toolkit-for-Health-Services-2.pdf*

+   ***The Newborn Resuscitation Toolkit*** *http://www.lifesavingcommodities.org/category/ knowledge-library/newborn-toolkit/*

+   ***Health Care Provider Training Tools Mapping Summary (Emergency Contraception)*** *http://www.lifesavingcommodities.org/health-care-provider-training-tools-mapping-summary-emergency-contraception/*

5.2 Reliable supply, access and availability of commodities

The UN Commission on Life-Saving Commodities highlighted how supply of essential commodities for health services remains a major barrier to service delivery. Countries can continue to implement the recommendations and use tools of the UN Commission (see Resources, below). Key issues for focus include, but are not limited to:

- strengthening public sector and private supply chains (e.g. in tendering and inspection, manufacturing processes, audit standards, warehousing, personnel and transport)

- implementing better commodity tracking systems

- improving regulatory mechanisms (e.g. harmonization of guidelines, support for joint manufacturer inspections and prioritization and fast track registration of WHO prequalified commodities)

- fiscal space and national supply financing assessments

- timely release of funding to prevent procurement delays

- enhanced quality assurance efforts to enhance post-market surveillance and pharmacovigilance

- preparedness for surge capacity

- establishment of clinical protocols.

The private sector and NGOs have expertise to strengthen supply chains, especially when it comes to reaching the last mile and developing effective interfaces between different segments of the supply chain. Efforts here might include providing technical support to strengthen supply chains, developing innovative models to overcome challenges and providing training in cutting-edge forecasting and inventory practices.

RESOURCES

+ **UN Commission on Life-Saving Commodities** – *http://www.lifesavingcommodities.org*

+ **Promising practices in supply chain management series**
  http://www.lifesavingcommodities.org/?s=promising+practices&showOnly=TkE9PQ%3D%3D

+ **Recommended indicators to address in-country supply chain**
  http://www.lifesavingcommodities.org/wp-content/uploads/2015/02/IndicatorsSCBarriersrev1.pdf

+ **Healthy Markets for Global Health: A Market Shaping Primer**
  http://www.lifesavingcommodities.org/wp-content/uploads/2014/10/USAID-CII-Market-Shaping-Primer-Fall-2014.pdf

+ **Scaling up Lifesaving Commodities for Women, Children and Newborns – an Advocacy Toolkit** *http://www.lifesavingcommodities.org/advocacy-working-group-workshop-brief*

5.3 Effective health management information systems (HMIS)

Health systems in all countries require valid and disaggregated data on components and performance to facilitate improved coverage. Countries can assess the quality and completeness of facility- and community-based health management information systems. They can also implement strategies to address reported shortcomings (e.g. training, revisions of forms or reporting mechanisms) and/or to take advantage of electronic reporting via SMS, tablets or the internet, depending on the country context (e.g. cell phone coverage, current HMIS platform).

One priority will be to build the capacity of district health management teams and programme staff to utilize HMIS data for timely management decisions on resource allocation and service delivery. Countries can review existing sector-specific assessment tools and management information systems to better capture information on under-represented groups, such as adolescents and minorities. They can also utilise technological platforms and innovations to improve data availability, quality and timeliness. To do so, there is a need to establish standards, common terminologies and minimum data sets, promoting the interoperability of systems. Policies can be developed on health-data sharing to ensure data protection, privacy and consent, and SMS-based technologies can be used to improve accuracy and timeliness of data and information reporting. The work of

the Health Data Collaborative resulting from the 2015 *Measurement 4 Health Summit* will be a key resource.

Other priorities include developing and using geographic information systems to map health system resources (including health workers), community needs and priority areas (not just limited to health sector considerations e.g. prioritizing areas with severe malnutrition or poor development indices); and optimization of HMIS data collection and use for quality improvement, performance measurement, and reporting/accountability.

RESOURCES

+ **Health Data Collaborative** *http://www.healthdatacollaborative.org*

+ **DHIS 2 -–** *https://www.dhis2.org/overview*

+ **Digital Health in Demand Generation for RMNCH Toolkit** *http://www.lifesavingcommodities.org/wp-content/uploads/2015/11/demand_generation_rmnch.pdf*

+ **Digital Health RMNCH Toolkit** *http://www.lifesavingcommodities.org/wp-content/uploads/2015/11/digital_health_rmnch.pdf*

+ **Considerations for the Integration of HMIS and LMIS** *http://www.lifesavingcommodities.org/wp-content/uploads/2014/08/14-126-Considerations-for-the-Integration-of-HMIS-and-LMIS_format.pdf*

5.4 Quality health services delivered at scale with resilience

Of the many innovations and advancements in RMNCAH, only a sub-set has been implemented "at scale" to reach large percentages of target populations and/or geographic areas within countries. In spite of this, it is increasingly recognized that scaling up quality services is fundamental for reducing discrimination and inequities; meeting the health needs of the most vulnerable, marginalized and excluded; and achieving overarching targets.

Country governments and their partners can support scale up of quality services with attention to both a transparent, inclusive, systematic, evidence-based decision-making process and a participatory, rights-based policy process. Specific issues for particular attention include:

- establishing evidence of effectiveness and efficiency of the intervention(s)

- building capacity of sub-national government and partners to implement the intervention(s)

- identifying existing bottlenecks and barriers to effective implementation (considering enabling environment, supply, demand and quality of care determinants of coverage)

- monitoring and reporting on progress and impact as the intervention(s) are replicated and expanded

- adapting global service delivery standards and protocols to country conditions

- developing policies, strategies and systems for quality improvement and sustainability at national and subnational levels

- measurement of health service outcomes and quality and client satisfaction

- developing and supporting use of tools and quality assurance methods e.g. perinatal or near-miss audits and tools for monitoring quality of care

- implementing guidelines, training and monitoring mechanisms for the provision of respectful and compassionate care, in particular for stigmatized and marginalized groups

- providing essential services to health facilities, including clean water, sanitation and energy.

Despite increasing attention to the need to make health systems more resilient, the exact measures required to do so, particularly in weak health systems, need further consideration. One priority is to strengthen the resilience of community health systems – where most people receive health services. Particular attention should be paid to strengthening supply chains, empowering and protecting health workers who deliver services in the community and ensuring they are recognized and institutionalized into national health systems. Key influencers in communities should be identified and trained in advance for roles in disease outbreaks.

RESOURCES

✚ **ENAP Bottleneck Analysis Tool –** *http://www.everynewborn.org/every-newborn-toolkit*

✚ **Consultation on improving measurement of the quality of maternal, newborn and child care in health facilities** *http://apps.who.int/iris/bitstream/10665/128206/1/9789241507417_eng.pdf?ua=1*

✚ **Roadmap for Health Measurement and Accountability and the Five-Point Call to Action** *http://ma4health.hsaccess.org/roadmap*

✚ **Treatment of Childhood Pneumonia at the Community Level with Amoxicillin DT** *http://www.lifesavingcommodities.org/wp-content/uploads/2014/08/Copy-of-Amox-Advocacy-Brief-eng.pdf*

✚ **Demand Generation for 13 Life-Saving Commodities: A Synthesis of the Evidence series** *http://www.lifesavingcommodities.org/?s=spotlight&showOnly=TkE9PQ%3D%3D*

✚ **Demand Generation Evidence Framework for Child Health** *http://www.lifesavingcommodities.org/demand-generation-evidence-framework-for-child-health/*

✚ **Service Standards for Sexual and Reproductive Healthcare January 2013** *http://www.lifesavingcommodities.org/wp-content/uploads/2014/09/Service-Standards-Sexual-Reproductive-Healthcare-2013.pdf*

✚ **Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health** *http://www.lifesavingcommodities.org/wp-content/uploads/2015/03/essential_interventions_18_01_2012-1.pdf*

✚ **WHO statement on The prevention and elimination of disrespect and abuse during facility-based childbirth** *http://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/*

✚ **A Guide for Advocating for Respectful Maternity Care, WRA, USAID, Health Policy Project** *http://whiteribbonalliance.org/wp-content/uploads/2013/10/RMC-Guide_FINAL.pdf*

Bottleneck analysis to support district health systems strengthening in Uganda

In 2011, the Ugandan Ministry of Health (MOH) initiated district health systems strengthening activities in several districts. Along with their in-country partners, the MOH brought together District Health Management Teams (DHMTs) to assess local data, identify supply-side bottlenecks and their causes and develop solutions appropriate to decision and fiscal space limits. Community interviews explored perceptions on financial and social barriers to accessing health services to better understand the causes of demand-side bottlenecks.

Using the information gathered, participating DHMTs identified key barriers to health, nutrition and water and sanitation interventions at the facility, outreach and community levels of service delivery, as well as their underlying causes. These included illegal fees and bribes demanded of mothers for services that are supposed to be free; persistent stock-outs of antimalarials and zinc; lack of community awareness of hand-washing and sanitation practices; lack of familiarity with pneumonia, malaria and diarrhoea danger signs among both mothers of children under five and community health workers; and insufficient outreach sessions. Using data from a Lot Quality Assurance Sampling (LQAS) household survey, inter-district differences in immunization were identified. These data indicated that several rural districts faced chronic staff shortages due to low staff retention, while more urban districts had better staffing. In part, this resulted from inequitable investments, with some districts receiving more financing for human resources. Another factor was illegal user fees, which community members in all five districts identified as one of the greatest barriers to use of services, particularly in the case of poorer households.

Based on these and other findings from the bottleneck analysis exercises, the DHMTs developed locally tailored interventions they identified as feasible, such as improving initial utilization and effective coverage through radio spots, village health team quarterly meetings chaired by local political and community leaders, increased messaging via churches/mosques, implementation of the SMS-based and community-empowering "uReport" monitoring system, expanded use of an SMS-based 'mTrac' system to report human resources and stock shortfalls and complete birth registration for children under five. In addition, DHMTs developed a plan for each facility to be assessed regularly by managers and community members (via SMS-based community oversight) to ensure the fee schedule was visible and complete and that staff members wore name badges to improve accountability for the care they provided.

6. ENHANCING MECHANISMS FOR MULTISECTORAL ACTION

IMPLEMENTATION OBJECTIVES FOR THIS INGREDIENT:

- *Governance to enable multisectoral action*

- *Structures to support multisectoral collaboration*

- *Joint monitoring across sectors*

Multisectoral action on the determinants of health is essential to realize the vision of the Global Strategy, in particular to reduce inequities. Even for health outcomes highly sensitive to health service delivery, such as maternal, neonatal and child mortality and stillbirths, the actions of the health sector on its own are insufficient. For example, it is estimated that over half of the improvement in under-5 mortality from 1990 to 2010 was a result of efforts beyond the health sector.

The importance of multisectoral action for health has long been recognized, including being highlighted in the Declaration of Alma Ata in 1978 and more recently in the 2011 Rio Political Declaration on the Social Determinants of Health. Yet working across sectors has proved difficult in practice, needing to reconcile differences in culture, language, epistemology and accountability. The health sector has often struggled to understand the interests of other sectors and to articulate why other sectors should consider health impacts and their contribution to health. There has also been a lack of functional convergence between sectors with different strategies that impact on women's, children's and adolescents' health, leading to poor implementation.

The SDGs present a more integrated agenda for development than the MDGs, and therefore provide an opportunity for countries to take a more multisectoral approach to health. In doing so it is important to distinguish between different types of multisectoral action on determinants of health:

- addressing structural forces and social and gender norms that affect all of society, including those that drive disparities. These require wide ranging cross sectoral legislation and policies driven by heads of government and championed by key societal agents of change

- supporting actions within single sectors that form their core business (such as ensuring children attend school and learn well for the education sector, access to safe water for the water and sanitation sector, or access to clean power for the energy sector)

- ensuring the health sector recognises its own role in generating health disparities (such as discrimination and abuse, provision of differential quality of care to different groups, and inadequate water and energy supplies to health facilities) and maximises its key role in primary prevention

- identifying, promoting and co-financing actions that require collaboration between two or more sectors (intersectoral work) to produce joint or "co-benefits" and to maximise health benefits (such as the use of cleaner stoves to reduce indoor air pollution or comprehensive sexuality education in schools).

Further work on the governance, financing and monitoring of multisectoral action is underway under the auspices of Every Woman Every Child, with the aim of providing further resources and technical guidance for countries to implement a multisectoral approach to women's, children's and adolescents' health.

6.1 Governance to enable multisectoral action

Multisectoral action for health rarely occurs spontaneously. Countries that have had success with multisectoral action have seen political leadership and commitment from heads of government to drive and coordinate different sectors and actors to work together with joint accountability. Whether at national or subnational level, it is essential to have political leaders, to whom multiple sectors report, drive any multisectoral initiative, persistently articulating the case for why the inputs of different sectors are required. But such leadership is only the first step. Additional steps required for implementation can be summarized as follows, allowing that each country will need to adapt this for their own context:

1. Create a policy framework and an approach to health that are conducive to multisectoral action.

2. Emphasize shared values, interests and objectives among partners and potential partners.

3. Raise political support; build on positive factors in the policy environment.

4. Engage key partners at the very beginning, including civil society; be inclusive.

5. Enable appropriate horizontal linking across sectors as well as vertical linking of levels within sectors.

6. Invest in the alliance-building process by working towards consensus and accountability mechanisms at the planning stage.

7. Focus on concrete objectives and visible results.

8. Organize for leadership, accountability and rewards to be shared among partners.

9. Build stable teams of people who work well together, with appropriate support systems.

10. Develop practical models, tools, mechanisms and accountability frameworks to support the implementation of multisectoral action.

11. Facilitate public participation; educate the public and raise awareness about health determinants and multisectoral action.

12. Mobilize sufficient financial and interdisciplinary human resources for implementation.

RESOURCES (APPLICABLE ACROSS THIS INGREDIENT)

+ *Graham J, Amos B, Plumptre T. Principles for good governance in the 21st century. Policy brief no.15. New York, UNDP, 2003.* http://unpan1.un.org/intradoc/groups/public/documents/UNPAN/UNPAN011842.pdf

+ *Kickbusch I, Buckett K, eds. implementing Health in all Policies: Adelaide 2010. Adelaide, Department of Health, Government of South Australia, 2010.* http://www.who.int/sdhconference/resources/implementinghiapadel-sahealth-100622.pdf

+ *Crossing sectors - experiences in intersectoral action, public policy and health. Ottawa, Public Health Agency of Canada, 2007.* http://www.phac-aspc.gc.ca/publicat/2007/cro-sec/index-eng.php

+ *Health equity through intersectoral action: an analysis of 18 country case studies. Ottawa, Public Health Agency of Canada and WHO, 2008.* http://www.who.int/social_determinants/resources/health_equity_isa_2008_en.pdf

+ *Adelaide Statement on health in all policies. Adelaide, WHO and Government of South Australia, 2010.* http://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf

+ *Health in all Policies Training Manual, Geneva, WHO, 2015.* http://who.int/social_determinants/publications/health-policies-manual/en/

+ *PMNCH policy compendium* http://www.who.int/pmnch/media/news/2014/compendium/en/

6.2 Structures to support multisectoral collaboration

Multisectoral collaboration depends on shared understanding and interests, driven by supportive and joint accountability. Structures by themselves cannot ensure the success of multisectoral efforts, and the creation of structures, absent the necessary supportive environment, often generates redundancy.

At the same time, in the context of a supportive environment, there are a number of structures and tools that can be useful to implement multisectoral work. These include:

- inter-ministerial and interdepartmental committees

- cross-sector action teams

- integrated budgets and accounting

- cross-cutting information and evaluation systems

- integrated workforce development

- community consultations and Citizens' Juries

- partnership platforms

- health and health equity lenses

- impact assessments

- legislative frameworks.

6.3 Joint monitoring across sectors

The Global Strategy itself provides an impetus for joint monitoring across sectors, as its targets are multisectoral. These are concentrated in the "Transform" dimension, but are also integral to achieving the "Survive" and "Thrive" dimensions. Taking this cue, national strategies can monitor the inputs to health across key sectors, harnessing existing monitoring initiatives in other sectors—such as nutrition, water and sanitation—to deliver joint information and accountability while facilitating cross sectoral analysis and prioritization for investment and implementation. For example, national health strategies should consider rates of enrollment and attendance of adolescent girls in education as much as they consider adolescent pregnancy and immunization coverage rates. This does not mean that the health sector should be responsible for monitoring outcomes outside its purview. Nor does this does mean that the responsibility for education of adolescent girls lies with the health sector. Instead, all sectors need to consider their accountability for contributions to health and monitor their impact on health outcomes. National strategies on the health of women, children and adolescents should convene the key sectors who contribute to impact, for which ministries of health can play a convening role.

Tools and methods are available for analyzing health and equity risks and benefits associated with policies implemented across and within different sectors (such as "health in all policies" and health impact assessment) and to review specific determinants (such as gender assessments and audits and gender responsive planning and budgeting).

Chile's Crece Contigo Programme:
A case study on effectively using multisectoral action to improve early childhood development

Chile is a middle-income country with low infant mortality (8.3 per 1000 live births) and broad health coverage, but Chile still faces important inequities in education, wealth distribution and health. In the 1990s, with sustained political commitment to equity, Chile began to strengthen social policies to address inequities in living conditions of the people. In that decade, specific equity-oriented programmes on education, health and housing proliferated, but programmes were often limited to their own sector and missed opportunities to harmonize and augment other programmes. By the 2000s, Chile recognized the need for a multisectoral action to effectively tackle complex social and health inequities. New policy strategies maintained the explicit focus on equity and prioritized expanding the sectors that needed to participate in social interventions; the President lent strong political support to this work. At the same time, in 2005, Chile underwent health system reform. The shift in policy focus from the 1990s to the 2000s, the explicit policy focus on equity and health system reform effectively set the stage for the landmark social protection system to foster early childhood development, Chile Crece Contigo (ChCC).

ChCC is a human rights- and evidence-based social protection system aimed at eliminating socioeconomic differences between children from gestation through pre-kindergarten. From its start, a presidential council sought regional, national and international input from experts, civil society and community actors across sectors. By 2007, new initiatives were introduced, providing universal access to parental protection, nursery and pre-school, improved prenatal care, birth with paternal participation and improved well child care, all with added support for vulnerable families.

This ambitious agenda was feasible only through multisectoral action. The first stage of implementation began with creating a Coordinating Team (part of the Social Determinants of Health and Health Equity Secretariat) within the Ministry of Health. ChCC continues to be characterized by close collaboration between the Ministries of Planning and Health, sustained political support and municipal implementation through local inter-sectoral networks. Specifically, in 2009, ChCC was made mandatory in all municipalities. An accompanying decree established a Committee of Nine Ministers, including the Ministers of Planning, Health, Education, Justice, Women's National Service, Finance, Presidency, Labor and Housing. The national technical committee was expanded to include all public services related to children, and a permanent working group was established. Implementation at the Regional level is coordinated by a Regional Cabinet and led by the Regional Ministerial Secretary of Planning, while the Director of each municipal Health Service Unit serves as territorial manager of the Local Intervention Network (the primary care center serves as the entry point for families).

The Registry Monitoring and Reference System (SDRM) was established with participation of all sectors in order to monitor and evaluate every child from entry in prenatal care to four years of age, measuring process, intermediate results and impact. SDRM's software is accessible to all actors linked to the programme, facilitating immediate access to benefits. Since its inception, more than 650,000 pregnant women entered into ChCC, and in 2012, more than 638,000 home visits were made to vulnerable families. Since 2009, every child born in Chile receives a set of basic childcare aids. In response to its own aspirations for child development, Uruguay launched Uruguay Crece Contigo in 2012, modeled after ChCC.

Source: Vega J. Steps towards the health equity agenda in Chile. Chile Crece Contigo. http://www.crececontigo.gob.cl/

7. ESTABLISHING PRIORITIES FOR REALIZING INDIVIDUAL POTENTIAL

IMPLEMENTATION OBJECTIVES FOR THIS INGREDIENT:

- *An evidence and planning base for programming*

- *Participation of adolescents*

- *Priorities for adolescent programming*

- *Priorities for early childhood development programming*

Supporting every woman, child and adolescent to realize their individual potential requires specific attention to programming for adolescents and for early childhood development – two areas that are often neglected in national strategies. Optimizing the demographic dividend from the world's 1.2 billion adolescents (aged 10-19) requires investment in strategies to prevent adolescent deaths ("Survive"), support improved adolescent health ("thrive") and expand enabling environments ("transform") for programming for and with adolescents. An estimated 200 million children younger than 5 years are not achieving their developmental potential. Much greater investment in early childhood development is required with inputs from all key sectors. Care and nurture during the first 1000 days of life is a core intervention that promotes healthy development, linking both the targets for "Survive" and "Thrive."

7.1 An evidence, advocacy and planning base for programming

Given the relative lack of attention to areas around individual potential, national partners should consider a number of strategic steps to build the evidence, advocacy and planning base for action including:

- a situation analysis, focusing on demographic, epidemiologic, social and other health and well-being indicators (for example, to define the most at risk adolescent and early child groups, gaps and opportunities)

- identifying the mix of health, non-health and structural interventions (policies and laws) required

- developing national plans and programmes to implement interventions with efficient coordination and monitoring mechanisms

- building data systems and implementing disaggregation by age and sex (including separating early and late adolescence), starting with secondary analysis of available survey data to obtain age-disaggregated estimates and supporting special studies (including modelling)

- advocating for investment using local data as well as evidence and good practices from other countries, also highlighting the costs of inaction

- leveraging partnerships with civil society, adolescent and youth groups to enhance commitment of national governments across sectors

- forging partnerships with private sector groups willing to participate in reporting and accountability frameworks

- securing the technical expertise needed by governments to identify priority issues and plan appropriate interventions

- committing publicly to action, mobilizing resources and commencing action.

RESOURCES

+ *Health for the world's adolescents* – *http://www.who.int/maternal_child_adolescent/documents/second-decade/en/*

+ *Global standards for quality health-care services for adolescents* – *http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/*

+ *Adolescent Health. The Lancet Series, April, 2012.* *http://www.thelancet.com/series/adolescent-health-2012*

+ *Progress for Children. A report card on adolescents. 2012, UNICEF* *http://www.unicef.org/media/files/PFC2012_A_report_card_on_adolescents.pdf*

7.2 Participation of adolescents

Adolescents are agents of their own development and can influence movements for social change. Initiatives that involve the meaningful participation of adolescent girls and boys in their design, implementation and evaluation tend to be more relevant and effective. To that end, mobilizing adolescents and engaging them in the formulation and roll out of the national health plan will help ensure that their issues are adequately represented at country and community level. This involves:

• establishing adolescent-responsive structures and processes to institutionalize adolescent participation in relevant public policy dialogue and programme implementation

• empowering adolescents and youth by providing them with the information and skills needed to enable their meaningful participation and contribution, as well as raising awareness of their rights and avenues for redress

• supporting fora for adolescents to share their experiences, good practices and models of successful adolescent-led interventions.

7.3 Priorities for adolescent programming

Priorities for adolescent programming include:

• addressing the common determinants underlying key health problems for adolescents, including legal, policy, environmental and behavioural elements as well as harmful social norms and gender stereotypes, across sectors

- providing comprehensive sexuality education for adolescent girls and boys

- developing health systems with provision of adolescent- and youth-responsive health information and integrated health services (including sexual and reproductive health services, linked with HIV services, immunization and psychosocial support)

- tackling financial and legal barriers to health care

- promoting partnerships between schools, health centres, adolescent and youth groups to enhance commitment and understanding of adolescent needs

- eliminating harmful practices such as early and forced marriage, female genital mutilation and violence against women and children

- controlling exposure to unhealthy products including tobacco, alcohol, illegal substances and unhealthy foods and beverages

- improving the nutritional status of adolescent girls, with adequate assessment of status and research to assess needs and interventions

- assessing and treating mental health and preventing suicide.

RESOURCES

➕ **Marrying too young – UNFPA** *https://www.unfpa.org/sites/default/files/pub-pdf/ MarryingTooYoung.pdf*

➕ **Save the Children: Adolescent Nutrition. Policy and Programming in SUN+ Countries** *http://www.savethechildren.org.uk/sites/default/files/images/Adolescent_Nutrition.pdf*

➕ **'Together for Girls' data and resources –** *http://www.togetherforgirls.org/data-and-resources/*

➕ **'All In' to end adolescent AIDS –** *http://allintoendadolescentaids.org/wp-content/ uploads/2015/02/ALL-IN-Launch-Document.pdf*

➕ **Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings, UNFPA, Save the Children.** *https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ ASRHtoolkit_english.pdf*

7.4 Priorities for early childhood development programming

Priorities for early childhood development programming include:

- addressing greater integration between sectors to promote nurturing care and protection for every young child to improve developmental outcomes

- recognizing and advocating for solutions to the emerging issue of children at increased risk of neurodevelopmental and social-emotional difficulties

- addressing the common determinants underlying poor child-rearing practices in the first years of a child's life (including stressors affecting the caregiver's ability to promote child health and development)

- promoting packages of core interventions aimed at vulnerable adolescent parents including improved quality prenatal care and support and counselling through the 2nd year of life of their children

- promoting local demand for parent/caregiver support services and early childhood development services.

RESOURCES

+ ***Investing in Young Children: ECD Guide to Policy Dialogue and Project Preparation –*** *http://www-wds.worldbank.org/external/default/WDSContentServer/ WDSP/IB/2012/05/24/000333038_20120524234213/Rendered/ PDF/578760REPLACEM053783B09780821385265.pdf*

+ ***Care for Child Development –*** *http://www.unicef.org/earlychildhood/index_68195.html*

+ ***Promoting Care for Child Development in Community Health Services. A Summary of the Pakistan Early childhood development Scale-up (PEDS) Trial: Main findings, delivery strengths and the path forward*** *http://www.unicef.org/ earlychildhood/files/3_PEDS_Trial_Summary_Report.pdf*

+ ***Building Better Brains: New frontiers in early childhood development –*** *http://www.unicef.org/earlychildhood/files/Building_better_brains____web.pdf*

+ ***Thinking Healthy: Manual for psychological management of perinatal depression –*** *http://apps.who.int/iris/bitstream/10665/152936/1/WHO_MSD_ MER_15.1_eng.pdf?ua=1&ua=1*

India: Adolescent Health Strategy for Sustainable Inclusion and Growth

Recognizing the potential of adolescents for a demographic dividend, in 2014 the Government of India launched a national strategy, "Rashtriya Kishor Swasthya Karyakram" (RKSK) that proposes a multi-level, multisectoral solution to enhance adolescent health. Based on the principles of participation, rights, inclusion, gender equity and strategic partnerships, RKSK takes a comprehensive approach to adolescent health and wellbeing and situates adolescence in a life-span perspective within dynamic sociological, cultural and economic realities. While building linkages to a wider RMNCAH agenda through the continuum of care and health systems strengthening, it represents a shift from a clinical approach to effective community-based health promotion and preventative care.

In 2013, the Government of India shepherded a multisectoral process with the Ministries of Health, Youth, Education, and Women and Children to develop a holistic adolescent health programme that goes beyond clinical services. The process engaged young people from diverse backgrounds to share their needs and concerns from existing programmes, and proposed solutions to address the gaps. The Ministry of Health and Family Welfare worked with leading NGOs and young people to develop detailed implementation plans for the strategy's launch and rollout.

The strategy prioritizes six areas of adolescent health identified through a situation analysis: nutrition; sexual and reproductive health; mental health; injuries and violence; substance misuse; and non-communicable diseases. The interventions are planned at distinct layers in the adolescent universe: individual, family, school and community thus entailing integrated action of different sectors. Though the strategy is within the Ministry of Health and Family Welfare, engagement of other sectors is ensured through multisectoral steering committees that operate on national, state, district and village levels. One of the innovations to increase accountability was to use participatory monitoring where the adolescents themselves are involved. The monitoring mechanism also complements data gaps in the HMIS which has limited age-disaggregated, adolescent-specific data.

Given its planned scope (total 676 districts), the RKSK programme is being implemented in a phased manner. After the first year of implementation in 213 districts, the programme improved access to health services and counselling, strengthened outreach and referrals through peer educators, enhanced nutrition by iron/folic acid supplementation and supported menstrual hygiene management. During the programme's second year in 2015, an estimated 84 million adolescents will be reached.

Source: Global Strategy Adolescents Working Group

8. STRENGTHENING CAPACITY FOR ACTION IN HUMANITARIAN AND FRAGILE SETTINGS

IMPLEMENTATION OBJECTIVES FOR THIS INGREDIENT:

- *Humanitarian and fragile settings as core business of national health and social systems*

- *A core emphasis on neonatal survival and sexual and reproductive health in humanitarian and fragile settings*

- *Emphasis on human rights*

The worst mortality and morbidity rates for women, children and adolescents occur in humanitarian and fragile settings that are caused by, and create, breakdowns in governance, rule of law and support systems. Such settings can be a result of conflicts or natural disasters but can also stem from ongoing political crises and systematic weaknesses. These settings are characterized by destruction or absence of public infrastructure including health facilities, massive population displacement, insecurity and a collapse of the social contract. For example, hostilities may be actively directed at stigmatized populations, and governments may become hostile to displaced populations. And, while climate change threatens everyone, it has become increasingly evident that it brings differential impacts to women, children and adolescents. This requires specific actions putting women, children and adolescents at the centre of humanitarian response and climate change adaptation and mitigation strategies.

In response to these challenges, national health and social systems need to link development and humanitarian programming, seeing both as "core business". This requires investments in preparedness, local systems building and service provision (including investment in civil society delivery), and community resilience. Governments should also consider how responses to emergencies might strengthen existing systems and/or build capacity where it does not exist, particularly in fragile settings.

A five year implementation plan is being developed for supporting implementation of the Global Strategy in humanitarian and fragile settings; a description is included in the resource list below.

8.1 Humanitarian and fragile settings as core business of national health and social systems

Key steps for positioning humanitarian and fragile settings as core business of national health and social systems include:

- integrating action in humanitarian and fragile settings into national strategies for health and other sectors, with a single planning, monitoring and accountability framework, with inputs from affected communities

- ensuring clarity on jurisdiction and accountability between different ministries and sectors, clearly assigning overall leadership and roles, particularly during humanitarian emergencies

- using assessment tools such as multi-hazard health sector risk assessment (including gender and conflict sensitivity analysis, risk of epidemics and pandemics, and climate-related risk) to understand vulnerabilities in health and social systems

- using a risk-informed programming approach in country development plans, including risk assessments, risk mitigation, disaster planning and contingency funding

- investing in the capacity to absorb shocks to build resilience, through simulations, preparedness and planning for reconfiguration of resources (e.g. workforce), with strategies for response to sudden reduction in capacities

- acknowledging the potential impact of emergencies on proximal and distal health service coverage determinants and outcomes, such as diversion of resources, public security, communications infrastructure, geographic isolation, staff desertion and population movement

- strengthening capacity and data availability to undertake situation analyses in emergencies

- recognizing that capacity building and data strengthening should not only revolve around emergency preparedness, but should also include the perhaps limited but existing local, district and county health data systems.

RESOLURCES

From Principles to Practice: reproductive, maternal, newborn, child and adolescent health: life-saving priorities in all settings: Implementing the Global Strategy for Women's Children's and Adolescents' Health Everywhere http://www.everywomaneverychild.org/news-events/news/1332-everywhere-five-year-plan

PAHO/WHO Health Sector Self-Assessment Tool for Disaster Risk Reduction http://www.preventionweb.net/files/15881_pahoselfassessmenttooloct2010.pdf

WHO Framework for Safe Hospitals 2015 http://www.who.int/hac/techguidance/comprehensive_safe_hospital_framework.pdf

WHO Safe Hospital Index 2015 http://www.who.int/hac/techguidance/hospital_safety_index_evaluators.pdf?ua=1

WHO Toolkit for assessing health system capacity for crisis management 2012 http://www.euro.who.int/__data/assets/pdf_file/0008/157886/e96187.pdf

WHO Operational Framework for Building Climate Resilient Health Systems http://apps.who.int/iris/bitstream/10665/189951/1/9789241565073_eng.pdf?ua=1

Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties 2011 http://www.who.int/ihr/IHR_Monitoring_Framework_Checklist_and_Indicators.pdf

8.2 A core emphasis on neonatal survival and sexual and reproductive health in humanitarian and fragile settings

The circumstances of humanitarian and fragile settings are marked by an absence of health workforce and services, significant constraints on service provision, and heightened risks of violence against women and children. Prioritization of health services to be scaled up is therefore essential. In particular, efforts to increase service delivery should maintain a core emphasis on neonatal survival and sexual and reproductive health by:

• prioritizing provision of the Minimum Initial Service Package (MISP) for reproductive health in both national plans and systems as well as in the efforts of external partners in emergencies and crises

• undertaking objective assessments of needs and vulnerabilities; addressing these through an integrated package of health, HIV/AIDS, nutrition and WASH services; and transitioning programmes responsibly across the emergency to

development spectrum

- ensuring the safety of health facilities and health worker safety as part of efforts to provide essential services.

RESOURCES

+ **Minimum Initial Service Package** *http://www.unfpa.org/resources/what-minimum-initial-service-package*

8.3 Emphasis on human rights

Human rights and the use of human rights principles and approaches are at the heart of the Global Strategy. Humanitarian and fragile settings require particular attention to human rights including:

- Focusing on respect and the delivery of services and interventions without coercion, violence or discrimination in accordance with international human rights law

- Taking into account the specific needs and rights of different sex and age groups

- Anticipating, preventing and responding to the major threats to health and wellbeing that often worsen in humanitarian and fragile settings, such as gender-based violence

- Protecting the safety of affected groups in humanitarian and fragile settings during the collection of data and advocacy efforts and ensuring confidentiality.

RESOURCES

+ **Interagency Standing Committee Resources** *https://interagencystandingcommittee. org/resources/iasc-products*

Prioritizing humanitarian settings: Turning disaster into an opportunity for resilient quality improvement in essential intrapartum and newborn care (EINC) services in the Philippines

Being affected by 20 major typhoons every year, flash flooding, volcanoes and earthquakes, the Philippines is considered the third most disaster-prone country in the world. In November 2013, Super Typhoon Haiyan hit parts of the Philippines affecting over 18 million people and causing infrastructural damage of an estimated US$1.5 billion. The hardest hit geographic areas belonged to the most deprived regions in the country with 40% of children living in poverty. Rapid assessments conducted 16 weeks following the typhoon revealed that health services infrastructure, logistics and human resources were severely impacted. In addition, existing service standards and provider skills were inadequate. Re-establishment of health services for mothers and children, particularly primary and secondary care for obstetric emergency, was identified as a top priority by the Department of Health (equivalent to the Ministry of Health).

In a first stage, emergency stakeholders conducted a multi-stage vulnerability analysis to identify priority areas for the humanitarian response. Based on preliminary data from the Philippines National Disaster Risk Reduction and Management Council and the United Nations Office for the Coordination of Humanitarian Affairs, 120 most affected cities and municipalities were identified. Criteria used included 1) 95% and above affected population, 2) category of typhoon signal and 3) highest potential for storm surge. In a second stage, additional data such as poverty incidence were analysed and a simple index and weighted averages to fine-tune area prioritization created. In a third stage, the status of existing and planned interventions across five sectors namely health, nutrition, education, child protection, and water, sanitation and hygiene, were categorized into high, medium and low convergence areas (high – all 5 sectors present; medium – 4 sectors; and low – less than 4 sectors).

In a fourth and final stage, the top 40 priority municipalities covering all high and some of the medium and low convergence areas were identified based on cumulative affected populations that would yield optimal coverage in relation to strategic response plan targets.

With technical support from the Philippines-based non-governmental organization Kalusugan ng Mag-Ina, UNICEF provided Essential Intrapartum and Newborn Care (EINC) trainings, Training of Trainers (TOTs), Cascade Quality Assurance workshops and supervisory visits in 40 priority municipalities. While trainings were based on updated guidelines endorsed by the World Health Organization for utilization in post-disaster areas, the content of each training session was tailored to the local context, taking into account gaps identified in previous rapid assessments. Gaps identified included Breastfeeding, Kangaroo Mother Care, Infant and Young Child Feeding in Emergencies, Basic Newborn Resuscitation, administration of magnesium sulfate, and postnatal care of mother and newborn.

In addition, two independent post-training evaluations were undertaken comprising of field visits to 56 facilities in the target areas. These evaluations revealed that 1) key commodities were now readily available at health facilities (e.g., magnesium sulfate from 38% to 94%, bag and masks from 0% to 88%-100% across the regions) and 2) service standards (partograph use, delivery room temperature and delivery records) had substantially improved. Dramatic increases in antenatal steroid use and Kangaroo Mother Care were also observed and recorded. Less progress was observed for handwashing, companion of choice during labor, BCG birth doses and monitoring of postnatal care.

This experience shows that post-disaster settings can provide opportunities to strengthen health systems and make them more resilient for future emergencies. The rapid restoration of EINC was a key entry point to quality improvement and health systems strengthening in this post-disaster setting.

9. FOSTERING RESEARCH AND INNOVATION

IMPLEMENTATION OBJECTIVES FOR THIS INGREDIENT:

- *Strengthened implementation research capacity*

- *An effective global innovation marketplace*

Innovation and research are essential to accelerate attainment of targets under the SDGs and the Global Strategy - increasing domestic capacity for innovation and research is key. This capacity traditionally has been supported to a large degree by global research and innovation funders, and this needs to continue in the SDG era. At the same time, there is an increasing need for greater domestic support for building this capacity to stimulate a pipeline of innovations for testing and taking successful products or approaches to scale. Country plans also need to consider how they will incorporate local and global innovations to help accelerate their targets.

9.1 Strengthened implementation research capacity

While increased research capacity is required in a number of areas (including basic and clinical research), implementation research is particularly important to improve the delivery of services and interventions, producing knowledge to overcome obstacles that are context and system specific. Strengthening implementation research capacity requires:

- Understanding of the value of implementation research by policy-makers, funders and implementers within countries

- Dedicated domestic and global funding pools for implementation research

- Training in methodology for implementers and national researchers in implementation research

- Technical support from global and regional partners to help implementers use the findings of implementation research to improve service delivery.

RESOURCES

+ ***The Child Health and Nutrition Research Initiative*** *http://www.chnri.org/*

+ ***Implementation Research in Health: A Practical Guide*** *http://www.who.int/ alliance-hpsr/resources/implementationresearchguide/en/*

+ ***Implementation research toolkit*** *http://www.who.int/tdr/publications/topics/ir-toolkit/en/*

9.2 An effective global innovation marketplace

The Every Woman Every Child Innovation Marketplace aims to provide a mechanism and a conducive environment—backed by a global partnership of stakeholders—to curate the pipeline of innovations, identify the most promising, and broker investment to accelerate their path to scale, sustainability and impact. The goal is to transition at least 20 investments to scale by 2020 and to see at least ten of these innovations widely available and producing significant benefits for women, children and adolescents by 2030. Functions of the Innovation Marketplace include:

- maintaining a network of curators with deep expertise in different health segments who maintain prioritized lists of most promising innovations using common criteria

- assessing applications for transition to scale from various stakeholders against common criteria and lists of most promising innovations in relevant health segment

- developing funding partnerships among stakeholders including common application forms for transition to scale

- developing funding partnerships around specific deals with multi-national corporations and other private sector entities engaged in research and innovation

- attracting investments for individual deals from high net-worth individuals and family offices, sometimes in partnership with investment banks

- linking these activities to global funding modalities.

RESOURCE

+ **The Innovation Marketplace** *http://www.bmj.com/content/351/bmj.h4151*

Research and Innovation: Building Global Partnerships for Research and Innovation Through Grand Challenges Ethiopia

Ethiopia has largely achieved the MDG targets through a robust primary health care approach. To consolidate this achievement, the Government of Ethiopia finalized a 20-year envisioning exercise aimed at achieving health-related targets comparable to the best performing middle-income countries by 2035. The country targets are also coherent with the SDG targets, particularly ending all preventable deaths of mothers and children by 2030.

The velocity of the current progress is not sufficient to attain bold and ambitious targets stipulated in Ethiopia's targets and SDGs. As a consequence, it is of paramount importance to accelerate existing efforts by stimulating domestic innovation and research. It will be particularly important to measure the possible population-level impacts and implementation cost of early stage innovations based on empirical data and mathematical modelling in order to determine which innovations are best suited to transition to scale.

In order to stimulate new innovations within Ethiopia, swiftly import relevant innovations that have been developed elsewhere in the world and ensure the worldwide dissemination of domestic research and best practice information, the Ministry of Health of Ethiopia has established Grand Challenges Ethiopia (GCE). The programme focuses on funding innovations in maternal and newborn health, early childhood development and health services. It will focus on funding innovations demonstrating clear linkages to desired population-level impacts under Ethiopia's Health Sector Transformation Plan and which are tailored to pastoralist communities within the country. Innovations that demonstrate sustained contributions to ending preventable maternal and child deaths will be transitioned to national or sub-national scale.

Importantly, the innovation and research efforts of Grand Challenges Ethiopia will tap into surging momentum for innovation at global level. Grand Challenges Ethiopia plans to harness global and regional partnerships— for example by engaging with the Every Woman Every Child Innovation Marketplace, Saving Brains and other global initiatives —to share and import best practices, stimulate research and innovation and eventually ground all health interventions in innovation. Such investments will help Ethiopia attain the Global Strategy's "Thrive" objectives, as well as its own Health Sector Transformation Plan objectives.

Source: Federal Ministry of Health of Ethiopia 2015. The Health Sector Transformation Plan (HSTP), 2015/16-2019/20. Addis Ababa, Ethiopia.

ROLE OF PARTNERS

Civil society

"Civil society" is a broad term which has varying definitions but can cover a number of different actors within countries including local community groups, non-governmental organizations (NGOs), faith-based organizations, women's groups, adolescent and youth groups, social movements, trade unions, professional associations and academia. Civil society organizations (CSOs) perform a number of different functions described in other sections in this Operational Framework, including in the sections on community engagement, accountability and health systems. In doing so they directly contribute to all of the ingredients for action of this Operational Framework.

Key functions include, but are not limited to:

- advocacy and political participation

- social mobilization for both participation in governance and behaviour change

- direct provision of health and other social services

- raising financial and other resources

- engagement and outreach to marginalized populations in difficult environments

- social accountability

- social innovation

- undertaking research and analysis

- providing training and capacity building

- challenging legal or commercial interests where these conflict with health.

However, the contribution of civil society within countries is often under-recognized and/or poorly aligned with health efforts by other stakeholders. While part of the essential nature of civil society is to challenge existing policy and programmes to better serve communities, better engagement with the diverse range of CSOs can help to improve health outcomes.

Supporting civil society engagement in multi-stakeholder platforms (including country platforms for women's, children's and adolescents' health) is crucial to realizing the potential of CSOs to contribute to the health of women, children and adolescents. Increased resources, support and technical assistance are required to build the capacity of civil society to meaningfully engage in multi-stakeholder country platforms, to support social accountability and to ensure active citizen engagement in available and created spaces. Lack of political will and funding remain barriers to significant civil society engagement and successful citizen empowerment in many countries.

One model for increased CSO funding at country level is the Multi-Partner Trust Fund (MPTF), utilized for strengthening country engagement as part of the SUN Movement (see box). Funded at just over US$10 million by three donors (DFID, Irish Aid and the Swiss Agency for Development and Cooperation), the SUN Movement MPTF has provided support for civil society engagement and activities, learning across countries as well as monitoring and evaluation.

The Multi-Partner Trust Fund: A catalytic instrument to support SUN efforts

The Scaling Up Nutrition (SUN) Movement Multi-Partner Trust Fund (MPTF) was established in March 2012 to provide catalytic grants for the development and implementation of actions for scaling up nutrition. It was a fund open to governments, UN agencies, civil society groups, other SUN partners and support organizations, but the vast majority of funds was allocated to support civil society participation and catalytic actions for scaling up nutrition.

Since 2012, donors have contributed to the SUN Movement MPTF with a total deposit of USD 10,072,740. As of December 2014 the Management Committee of the SUN Movement MPTF allocated a total of USD 8,951,172 (approximately 89% of the total deposits) to 3 'Windows':

- *Window I - Support for initial SUN actions at country level: USD 642,000 for a project to develop a learning and sharing programme across stakeholders of the SUN Movement*

- *Window II - Catalytic programmes for countries: USD 7,393,172 for 23 projects to support in-country civil society participation and actions for scaling up nutrition and USD 856,000 to support the costs of the Secretariat of the SUN Civil Society Network*

- *Window III - Support for global SUN strategic efforts: USD 60,000 for one project to develop the Monitoring and Evaluation Framework of the SUN Movement.*

The SUN Movement MPTF support for civil society engagement at country level is aligned with a detailed logframe and Theory of Change behind a goal of 'sustained public, political and financial commitment and action to effectively tackle undernutrition in SUN countries.'

The Independent Comprehensive Evaluation of the SUN Movement, published in 2015, while not an in-depth evaluation of the MPTF, concluded that the projects funded through the SUN Movement MPTF have been highly relevant to the four strategic objectives of the SUN Movement. Several challenges of the SUN Movement MPTF were also highlighted by the evaluation team, mainly regarding its efficiency and sustainability. However they concluded that there may be a continued need for a global fund for some time to come. This is mainly due to the barriers and inadequate bilateral funding opportunities currently available for Civil Society Alliances (CSAs) in country. There is an evaluation of the MPTF currently underway.

Source: UNDP. 2014 Annual Report of the SUN Movement Multi-Partner Trust Fund

Private sector

The private sector has a vital role in reaching the targets of the Global Strategy and supporting the implementation measures outlined in this Operational Framework by contributing to each of the nine ingredients for action. The Global Strategy itself calls for the business community to:

- support government policies aimed at universal health coverage, better nutrition, healthier foods and cleaner energy

- identify and address with partners the external consequences of business actions that might harm the health of women, children and adolescents

- protect and promote the health and well-being of employees and their families

- support efforts to improve access to good-quality health services and life-saving commodities

- explore new drugs, technologies and interventions to improve health in resource limited settings, address emerging global challenges, such as antimicrobial resistance, and bring the most promising innovations to market

- use business expertise to create and scale up interventions that promote health, such as essential interventions and education on sanitation and hygiene and access to improved nutrition.

The private sector is comprised of many different types of organizations with widely varying characteristics, including:

- small and medium sized enterprises (SMEs) operating at a local or national level, including individual vendors, service providers and social enterprises

- regional enterprises

- multinational enterprises operating on a global basis

- privately owned and publicly traded (shareholder owned) companies.

The business activities and industry characteristics of companies also vary widely and include: employers that provide health services and/or health insurance to employees and their families; private health sector providers; pharmaceutical and medical technology companies that supply essential drugs, vaccines, diagnostics and technologies; financial services companies that invest in health service delivery and digital operators that use mHealth services to promote health delivery; and communications companies that can help drive positive health-seeking behaviour.

With the launch of the SDGs, there are higher expectations of the private sector to help address global problems and unmet societal needs. Over the past several decades a number of varying mechanisms have evolved that promote cross-sector collaboration with the private sector. These include:

Corporate Philanthropy: *Providing donations of cash or 'in-kind' products and services.* An example is donation of pharmaceuticals to prevent or address particular health needs, such as river blindness. In-kind donations need to comply with international standards and guidelines such as those developed by the Partnership for Quality Medical Donations. Philanthropic donations must not be linked with commercial business gain such as increased sales or profits.

Corporate Social Responsibility (CSR): *Deploying business resources and core competencies to achieve positive societal impact.* CSR initiatives help address unmet societal needs and often also aim to enhance the sustainability of companies by reducing business risks and/or achieving reputational benefits. CSR activities are generally not directly linked to commercial sales generation.

Creating Shared Value (CSV): *Utilizing commercial business models to simultaneously achieve positive societal and business outcomes.* An example is developing new commercial innovations that reduce child mortality, such as insecticide-treated bed nets or affordable technologies for low-resource settings. CSV initiatives, by definition, engage with the core business operations of a company and are intended to support growth in sales and profits. One factor distinguishing CSV from Corporate Philanthropy and CSR is that there is no inherent limitation to the scale that can be achieved since investments are mainstreamed into the core business of the company.

Aligning Policies, Standards and Practices: *Aligning advocacy and policy initiatives from companies, both internally and externally, to be consistent with broader societal policies, standards and goals.* This can include progressive workforce policies to encourage healthy behaviors among employees. The private sector can also utilize its influence to encourage national and international laws, guidelines and regulations that support achievement of goals reflected in the Global Strategy and the SDGs.

While the former two categories are most discussed in terms of private sector contribution to health, the latter two categories are more substantial in terms of impact and potential. The private sector is an integral part of all economies; in many countries, the private sector represents the majority of the health sector. Therefore, more substantive engagement is required in policy and programming, with explicit identification of interests, contribution and potential for real harms. Governments also need to build their capacity to steward private sector engagement, including through regulation.

Since the launch of Every Woman Every Child in 2010, over 80 private sector commitments have been made, with some common principles for best practices emerging:

- private sector commitments need to be well aligned with the health and development goals prioritized by national governments, including specific priorities represented by SDG targets and initiatives

- commitments need to be specific in terms of intended populations served and health impacts, and include projected indicators that will be utilized for measurement and accountability

- the majority of commitments will involve some form of cross-sector collaboration (such as public-private partnerships), for which it is important to establish common objectives among the partners. Collaboration requires trust, and care must be taken to choose partners, including companies, where motivations are well aligned

- these objectives and related action plans should be articulated in a formal document such as a Memorandum of Understanding, such that there is full transparency on each partner's interests, intent, role and contribution

- leaders of collaborative partnerships need to possess personal characteristics that are conducive to working across sectors while being respectful of the need for local, country ownership

- where conflicts or harms to health occur, clear arbitration mechanisms are required which adhere to the laws and democratic processes of countries and respect national sovereignty

- while the majority of EWEC commitments to date are in the category of Corporate Philanthropy and CSR, a growing number of companies are embracing shared value models that combine social and commercial impact. Increasingly, partnerships with companies leverage the expertise and core assets of business, rather than being limited to financial donations.

Eliminating disease spread due to injection device reuse in childhood immunization programmes

The Expanded Programme on Immunization (EPI) is among the greatest accomplishments in the history of global public health. However, by the late 1980s the agencies that administered the EPI became aware that disease was being spread from child to child in the EPI due to reuse of injection devices designed for single use and from improper sterilization of reusable devices. WHO and UNICEF reached out to industry to help address this problem by developing technical solutions that would not disrupt continued progress in expansion of the EPI.

Becton, Dickinson and Company (BD), working in collaboration with Program on Appropriate Technology in Health (PATH), was the first company to respond, through development of the first "auto-disable" immunization device, which locks and is rendered nonfunctional after a single use. This innovation was introduced into WHO field trials in 1988 and became commercially available in 1991.

It took eight years for these devices to achieve full scale deployment. Over this time, the key barriers to achieving full scale were addressed. These included policy changes (joint policy statement issued in 1998 requiring use of auto-disable devices for publicly funded immunization campaigns), funding (provided by GAVI and associated with the broader scale-up of global immunization), accessible technology (first generation designs were revamped to substantially reduce cost to a level comparable to standard injection devices) and mass deployment via disease elimination initiatives for maternal and neonatal tetanus (MNT) and measles.

In supporting the goal of eliminating disease spread during mass immunization programmes, BD implemented all four modes of private sector action:

- *Corporate Philanthropy – Provided substantial cash and in-kind donations to the MNT and Measles Initiatives, totaling over US$10 million*

- *Corporate Social Responsibility – Trained health workers on proper injection technique when using auto-disable technology, in support of the Measles Initiative*

- *Creating Shared Value – Established a sustainable business model for the development, production and supply of auto-disable syringes, ultimately supplying 6.5 billion of these devices over the MDG period*

- *Aligning Policy – Successfully advocated for changing national immunization policy in India, from use of reusable glass syringes to auto-disable syringes, "leapfrogging" standard disposable syringes.*

As a result of this effective multisectoral effort supported by international agencies, funding partners, policymakers and industry, BD helped to eliminate an entire category of disease spread among children.

Source: Cohen G, BD

Global and regional partners

The SDGs present a new, comprehensive and more integrated model of development. This should prompt an evaluation of how fit for purpose the global architecture is to deliver upon its targets, including those of the Global Strategy. The UN system agencies working on health will work together to implement the Global Strategy and support the application of this Operational Framework, as the H6 partnership, building on the progress during the MDG era of the H4+ partnership. But there is also a need to go beyond the UN to coordinate the efforts and impacts of the broad range of global and regional actors, including bilateral development partners, international NGOs and faith-based organizations, development banks and regional entities (such as the African Union, ASEAN, ECOWAS, SADC, MERCOSUR and SAARC).

Operationalizing the Global Strategy is critical to achieving the SDGs. In the process of aligning and coordinating global and regional support for the Global Strategy, there is an opportunity to recommit to the principles of the Paris Declaration, the Accra Accord and the IHP+ on aid effectiveness. Key principles that require greater adherence include:

- respecting country leadership in all activities both through national political leadership and the active engagement of civil society, the private sector and individual citizens

- reducing fragmentation and duplication of activities

- providing global and regional support in accordance with national planning timelines rather than external timelines

- prioritizing national use of data, and national accountability frameworks, for decision-making

- supporting rather than supplanting nationally-led efforts in systems strengthening.

In operationalizing the Global Strategy, global and regional actors can undertake a number of functions:

Technical assistance – across all ingredients for action, in particular in supporting, upon request, the convening of a country platform and the development of prioritized, costed plans. It is particularly important here that the above principles are adhered to. The GFF process will provide support for this work in "frontrunner" countries, but support is required in all countries, including funding for the process, support of consultation, evidence generation, modelling and costing, setting of numerical targets, and prioritizing interventions. The H6 should coordinate this support, potentially setting a timeline for plan development linked to countries' national planning cycles, and incorporation of SDG targets. New thinking will also be required to support the new areas of the Global Strategy, for example, in taking a multisectoral approach to health.

Financing – including continued provision of direct funding (aligning delivery of global sources of funding including the Global Fund, GAVI and bilateral development partners) and other forms of complementary financing (including loans), supporting financial management systems, providing technical assistance to support domestic financing and lending stewardship of private sector investment and impacts at the global level, including by transnational corporations.

Capacity building and sharing of experiences – in particular, supporting the development of institutions and expertise within countries to build capacity including management capacity and quality assurance. There is also a need to support in-country and inter-country exchange visits between key actors to facilitate learning and scale-up. The website for this Operational Framework will provide a place to document and share countries' experiences in implementing the Global Strategy.

Advocacy – there is a need for dissemination and advocacy for use of the Global Strategy (and this Operational Framework) itself, as part of SDG advocacy and support efforts. Its use by a large network of actors and country leaders needs to be encouraged, building awareness across the Every Woman Every Child movement. This is another task for the H6. More generally, global and regional advocacy networks can play a powerful role alongside country efforts in mobilizing resources and supporting national efforts, particularly those in high-burden countries where civil society advocates may be less visible, more likely to be marginalized or peripheral to the RMNCAH landscape.

Accountability - global actors have a specific role with respect to accountability for the Global Strategy in supporting the function of the Independent Accountability Panel (IAP). The Partnership for Maternal, Newborn and Child Health will house the secretarial for the IAP. Global and regional partners should also promote accountability and transparency through regional and global reporting, to enable progress to be compared across countries and regions. Further, global and regional partners can improve methods for global maternal and child mortality estimation and tracking, while technically supporting countries in their own national accountability processes and mechanisms. Regional bodies could play a greater role in accountability, for example through peer dashboards and scorecards or regional targets/milestones.

Multisectorality – global and regional actors can support a multi-sectoral approach by supporting joint global and national monitoring of interventions and targets across sectors (driven by the United Nations Secretary-General's office as part of SDG monitoring) and mobilizing financing (existing and new) in addition to incentivizing multisectoral collaboration and action through existing and new partnerships. Within countries, there is a need for support of governance, financing and monitoring capacity for cross-sectoral work.

Global public goods and market shaping – to this end, global partners can identify new high-impact commodities and the appropriate market shaping interventions; secure price reductions and pooled-procurement agreements beyond the initial set of commodities; develop product standards; and better capture the contribution of all sectors to commodity procurement.

To fulfil these functions, global and regional actors can:

Consider neglected areas or gaps that merit new Commissions – under the original Global Strategy, two UN Commissions were convened (one on commodities, a second on information and accountability). These commissions catalysed new financing, organization and collective action across agencies. Consideration should be given to new commissions in areas of particular challenge, for example, implementing the SDG agenda for health across countries at different income levels, or multisectorality.

Identify the differential support needs of countries at SDG baseline – For the Global Strategy targets, countries are starting at widely differing levels. For example, early modelling suggests that at current rates of progress, many countries have already achieved the maternal, neonatal and child mortality targets implicit in SDG 3.1 and 3.2, a further group of countries are likely to achieve these targets by 2030 at current trajectories, but over 40 countries will miss the under-5 target, and over 60 countries will miss the maternal and neonatal targets. This type of analysis could provide an informed basis for prioritization of support to countries. Similar analysis could inform allocation of resources and support within countries for high burden sub-national areas.

Reconceptualize the delivery of support within countries including better alignment of initiatives and coordination of activities – there is an urgent need for improved alignment of global, regional and national initiatives by different actors. This proliferation of initiatives is particularly marked for RMNCAH. A core aim of operationalizing the Global Strategy is addressing this. It is essential to improve alignment and communication among UN system agencies and other global actors at global, regional and country levels, enhancing efficiency by simplifying processes and reducing transaction costs.

Operationalizing the Global Strategy needs to bring together key initiatives launched during the MDG era to accelerate progress, including the Every Newborn Action Plan, the Global Vaccine Action Plan, A Promise Renewed, Family Planning 2020, Ending Preventable Maternal Mortality, and the Global Action Plan on Pneumonia and Diarrhoea. Countries who have engaged with these initiatives can sustain this momentum towards achievements of the SDGs under the umbrella of the Global Strategy, without needing to start again.

At the outset of the SDGs, countries should be supported to map the activities of partners and encourage rationalization. It is especially important that the activities related to the GFF are seen as core to implementation of the Global Strategy and aligned with existing global and national initiatives rather than becoming a parallel exercise. The H6 has a major role in ensuring this.

National consultations and workshops within countries are required to coordinate all actors on the SDGs and Global Strategy, and integrate existing global efforts with new initiatives like the GFF. The process of convening the country platform can be

central to this coordination. Finally, the H6 should coordinate and facilitate coherent delivery of health assistance at country level under the leadership of government counterparts and the UN Resident Coordinator, also taking advantage of the UN Development Assistance Framework.

ANNEX 1.

Overview of Global Strategy

The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)

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.

OBJECTIVES AND TARGETS aligned with the Sustainable Development Goals (SDGs)

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 free, equitable and good-quality primary and secondary education
- Eliminate all harmful practices and all discrimination and violence against women and girls
- Achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable 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

HIGH RETURN ON INVESTMENTS

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

ACTION AREAS

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

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

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

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

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

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

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

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

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

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

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.

EVERY WOMAN
EVERY CHILD

FOR HEALTHY AND EMPOWERED WOMEN,
CHILDREN AND ADOLESCENTS