

The Global Campaign for
the Health Millennium
Development Goals 2010

Putting the Global Strategy
for Women's and Children's
Health into action



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We acknowledge with gratitude the individual and collective contributions by the global and international leaders listed above.

The Global Campaign for the Health Millennium Development Goals brings together a number of actions and initiatives, all aimed at fulfilling the promises given by world leaders ten years ago.

The report of 2010 provides an update on the efforts being made by countries and institutions in putting the Global Strategy for Women's and Children's Health into action. The Global Strategy was launched at a special event during the MDG summit in September by the Secretary-General of the United Nations.

For more information: www.un.org/sg/globalstrategy.shtml and www.norad.no/globalcampaign

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Entering a new era for the health of women and children

The Secretary-General of the United Nations
Ban Ki-moon

FOREWORD TO GLOBAL CAMPAIGN REPORT 2010

In September 2010, I was joined at the United Nations by leaders from around the world to launch the Global Strategy for Women's and Children's Health. Our special event during the MDG Summit was called "Every Woman, Every Child" and carried in its name an important message: that every woman, whether she lives in a wealthy urban centre or remote village, should have access to the basic health services she needs; and that every child has the right to a healthy future. This is a matter of fundamental equity. It is also easily within our grasp with often simple solutions that are available today.

The Global Strategy marks a distinct departure from business as usual. Previous efforts have generated progress but tended at times towards the piecemeal. The Global Strategy is truly comprehensive: it addresses the full range of issues that affect the health of women and children; it brings all the key actors together under one umbrella; and it integrates what they are doing – their objectives and programmes – into one coherent approach.

Developed and endorsed by a wide range of actors – Governments, international organizations, philanthropic institutions, civil society, the business community, health workers, professional associations, academic and research institutions – and welcomed by all 192 Member States, the Strategy gives us, for the first time, an agreed game plan that stresses the need for investment, innovation and measurable results.

Significant financial commitments accompanied the launch; further contributions are expected as we move forward. These new resources, and the impact they make, will be highlighted on everywomaneverychild.org. Increased transparency is among the hallmarks of the initiative.

Our success will depend on all global stakeholders coming together to support countries as they implement their plans. The United Nations and other multilateral organizations have a particularly important role in this regard and will work in partnership, village by village, community by community, country by country.

Already, efforts on the ground are accelerating. Some governments have committed to firm timelines for increasing budgetary allocations and improving service delivery. Private companies have promised to expand their investment portfolios in ways that will benefit women and children in developing countries. These are other steps show a vibrant and growing support base for the Strategy.

Promising changes will buttress our work. A rich reform agenda is emerging as countries and multilateral organizations increasingly demand more from their efforts and investments. New communications technologies have the potential to profoundly change the way we approach some of our most pressing challenges. The development of a robust and accessible accountability framework will allow all partners to track progress and ensure that promises are kept.

As we seek to usher in a new era for the health of women and children, let us be flexible in our approaches; let us learn from what works and what doesn't; and let us challenge ourselves and others to deliver. This publication showcases what our partners will do to move from commitments to action. I commend it to a wide global audience and to all involved in our shared mission to build a safe and healthy future for every woman and every child.

Analysis of Country Commitments

Countries around the world have responded generously to the Global Strategy by committing an additional US\$40 billion to improve the health of women and children. This chapter details the commitments made, who made them and where they can make a difference.

Country commitments are focused on three areas: reducing financial barriers, creating a stronger policy environment for women’s and children’s health, and strengthening and improving the delivery of health services. The table at the end of the chapter summarizes the types of commitment, lists the countries making pledges and provides illustrative examples for each commitment.

1. Reducing financial barriers

The Global Strategy highlighted the financial gap that must be addressed to meet the health MDGs and called all stakeholders to reconsider their financial contributions. One of the most positive developments from the country commitments is the significant financial support pledged by both donor countries and high-burden countries. Together, these commitments equaled US\$26 billion, or 64% of the total pledges to the Global Strategy. From a donor perspective, 15 donor countries pledged financial support for high-burden countries, which totaled more than US\$16 billion over the next five years. Thirteen high-burden countries have committed to increase domestic health funding, with a focus on women’s and children’s health. In Africa, countries have reiterated the pledge made in Abuja to spend 15% of the budget on health. These pledges equaled approximately US\$8.6 billion of new money for women’s and children’s health. Twelve governments are increasing health contributions to support the removal of user fees for services designated for women and children. A final category of commitments focuses on increasing equitable access to affordable health services, especially among the poor and otherwise marginalized. In this category, five countries have made commitments to fund the decentralization of financial authority to rural areas.

Overview of total financial commitments (US\$40 billion) pledged by stakeholders during MDG Summit, New York, September 2010



Note: Additional commitments have been made but could not be translated into dollar value. These estimates are made in current dollars.

Source: "Summary of Commitments for Women’s and Children’s Health" made at Every Woman, Every Child side event hosted by United Nations Secretary-General Ban Ki-moon on September 22, 2010

2. Creating a stronger policy environment friendly to the health of women and children

The Global Strategy also urged countries to cultivate progress by addressing the root policy issues that impact women’s and children’s health. In response, 14 countries have made legislative commitments to strengthen policies for reproductive, maternal, newborn and child health (RMNCH). The pledges range from embedding gender in national development agendas to enforcing laws on the minimum age of marriage and the endorsement of mortality audits. Eight countries committed to policy measures to improve their health systems, such as strengthening registration of vital statistics and developing community-based health care. Finally, six countries made commitments on cross-cutting policy approaches, which include enforcement of laws on HIV/AIDS and the adoption of best-practice policies for fighting malaria.

3. Improving delivery of health services

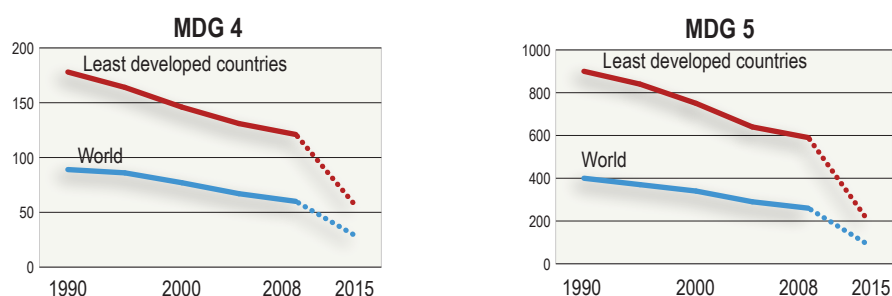
These commitments aim to improve delivery so that women and children have universal access to an integrated package of essential health services. Many have been earmarked for strengthening health systems infrastructure – with 18 countries pledging to increase investment – or for strengthening human resources for health, with 11 countries pledging increased support. This includes providing basic and comprehensive emergency obstetric care, expanding the numbers of trained midwives, and ensuring that a higher proportion of women have access to skilled birth attendants during labor. In addition, 12 countries have pledged to strengthen services for family planning in the context of reproductive health, for example by increasing availability of contraceptives and family planning and providing educational services to families and adolescents. An additional 17 countries have pledged to strengthen services for maternal and child health, including increasing the number of children immunized and diseases covered, and the number of women receiving antenatal care.

To strengthen cross-cutting interventions benefiting women’s and children’s health, 15 governments pledged to work with local and international stakeholders in areas such as nutrition, gender equality, women’s empowerment and human rights. Other commitments include provision of insecticide-treated bednets to pregnant women and children under five, and access to care and treatment for HIV/AIDS (including antiretroviral therapy). Seven countries have committed to place emphasis on equity, to ensure access to services for those most in need.

Next steps for commitments

Moving forward, countries need to take ownership to fulfill their ambitious commitments, and donor countries to meet their commitments in a timely and transparent manner. Donor countries share the burden of responsibility for keeping women’s and children’s health high on the international agenda and for motivating other wealthy nations to participate. In the same way, the high-burden countries will strive to make good their commitments in a way that is transparent to the international community and free from corruption at the national and local levels. All countries can encourage other countries to join them in committing to improve the health of women and children.

Trends in maternal mortality ratio and under-five child mortality rates (1990-2008) and targets (2015) by least developed countries and the world¹



Note: Maternal Mortality Ratio is number of maternal deaths per 100,000 live births. Under five child mortality rate is number of child deaths per 1,000 live births

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Type of Commitments Pledged to the Global Strategy for Women's and Children's Health²

TYPE OF COMMITMENT	COUNTRIES MAKING COMMITMENTS	EXAMPLE
Reduce financial barriers		
Financial support for high burden countries	Australia, Canada, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Republic of Korea, Russia, Spain, Switzerland, United States, United Kingdom	Australia will invest approximately AUD1.5 billion over the next five years on interventions shown to improve maternal and child health outcomes
Increased domestic health spending	Afghanistan, Benin, Burkina Faso, Democratic Republic of the Congo (DRC), Ghana, Liberia, Niger, Nigeria, Rwanda, Tanzania, Zambia, Zimbabwe, Yemen	Afghanistan has pledged to increase health spending from \$10.92 to \$15-\$30 per capita
Removal of user fees	Afghanistan, Benin, Congo, Haiti, Liberia, Mali, Niger, Nigeria, Sierra Leone, Tanzania, Zimbabwe	Zimbabwe has committed to abolish user fees for pregnant women and children under 5 and starting an MNC survival fund
Decentralize financial authority	Afghanistan, Bangladesh, Ghana, Kenya, Yemen	Ghana has committed to decentralize health spending by allocating 40% to the districts
Cultivate policy environment		
RMNCH policy	Afghanistan, Bangladesh, Benin, Burkina Faso, Congo, Haiti, Liberia, Mali, Niger, Rwanda, Tanzania, Zambia, Zimbabwe, Yemen	Niger has pledged to improve legislative framework including passing a law for minimum age of marriage (18), a law against domestic violence, and a law focused on education of girls
Health system policy	Bangladesh, Burkina Faso, DRC, Congo, Liberia, Mali, Nigeria, Zimbabwe	Mali has pledged to develop a community-based national health care policy
Cross cutting policy	Afghanistan, Benin, Burkina Faso, Liberia, Nigeria, Rwanda	Nigeria has pledged to adopt policy for providing HIV, TB, and Malaria care at primary health care facilities
Improve delivery of health services		
Health systems: infrastructure	Afghanistan, Bangladesh, Benin, Burkina Faso, Cambodia, DRC, Congo, Ethiopia, Haiti, Kenya, Liberia, Mali, Nepal, Niger, Nigeria, Rwanda, Tanzania, Yemen	Ethiopia has pledged to increase midwives from 2050 to 8635
Health systems: human resources	Afghanistan, Bangladesh, Burkina Faso, Cambodia, Liberia, Mali, Niger, Nigeria, Rwanda, Tanzania, Yemen	Yemen has committed to train 250 community midwives per year
Family planning, and reproductive health	Afghanistan, Bangladesh, Benin, Cambodia, DRC, Haiti, Mali, Nepal, Niger, Tanzania, Zambia, Yemen	Nepal has pledged to offer at least five family planning methods and voluntary surgical contraception at all district hospitals and mobile clinics
Maternal and child health	Afghanistan, Bangladesh, Benin, Burkina Faso, Cambodia, DRC, Congo, Ethiopia, Haiti, Liberia, Nepal, Niger, Nigeria, Rwanda, Sierra Leone, Tanzania, Yemen	Benin has pledged to provide MNCH care at all levels by 2018 and that 90% of pregnant women and children will be vaccinated against polio and tetanus
Cross-cutting interventions	Afghanistan, Bangladesh, Benin, Burkina Faso, Cambodia, DRC, Congo, Ethiopia, Nepal, Niger, Nigeria, Rwanda, Sierra Leone, Tanzania, Yemen	Tanzania committed to expand PMTCT and pediatric care to all RMNCH facilities. The country will also increase exclusive breastfeeding from 41% to 80%
Equity	Afghanistan, Bangladesh, Burkina Faso, Cambodia, Liberia, Nepal, Yemen	Cambodia has pledged to ensure that 95% of the poor are covered by health equity funds

See endnotes page 52

Putting the Global Strategy for Women's and Children's Health into action

Network of Global Leaders

Overview

The United Nations MDGs Summit 2010 and the UN Secretary-General's Special Session, which launched the Global Strategy for Women's and Children's Health, marked a turning point for improving maternal and child health. The commitments emerging from such a diverse group of stakeholders were extraordinary in providing means to achieve MDGs 4 and 5 (see UNSG's introduction). The special session built on President Obama's Global Health Initiative, launched last year, Prime Minister Harper's G8 Muskoka Initiative and the AU 2010 Summit. The Network of Global Leaders are pleased that our own efforts over the last few years have contributed to these developments.

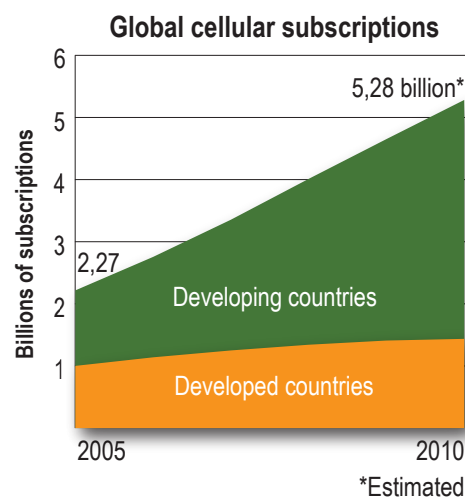
2015 is not far away, and we therefore commend the strong and prompt commitments announced by leaders at the special session. Many other leaders are following suit and currently conveying their commitments to the UN. These commitments, with concrete financial, policy and service delivery targets, represent an essential platform for speeding up progress.

These examples of national leadership were applauded at the UN. New models for international cooperation are emerging in the demand-side and supply-side of global health. On the supply-side, we welcome new actors in development aid and global solidarity, like China and Brazil, who are influencing the international development agenda and using their own development experiences and know-how in advancing women's and children's health. Both traditional donors and new donors need to come together to support the Global Strategy.

Furthermore, it is essential that we move our focus away from inputs to outcomes by linking finance to results, as emphasized by Germany, the United States and other key partners. On the demand-side, India and Nigeria are demanding from partners a tighter fit to national priorities and plans. Nepal is spearheading a new collaborative platform among development partners to support national health plans. In addition, civil society is mobilizing communities and local leaders to increase focus on crucial health issues for women, adolescents and children.

We welcome the renewed stewardship of the UN and the World Bank at this crucial time to capture new developments and commitments. They should build on these efforts to facilitate the most effective use of commitments made. This stewardship requires further cooperation and harmonization among multilateral organizations at a national level, with information, analyses and updates made widely and regularly available.

Economic development is at the core of overall development. The improved health of women and children contributes hugely to economic development, which will in turn contribute to better conditions for women and children. The private sector can make enormous contributions in developing countries – in terms of innovation, risk taking, capital investment, increasing access to products and services, scaling up innovation, and driving improvement in the quality of services, and also provide new tools for improving the health of women and children. Mobile phones and broadband internet access for new health-care services are excellent examples. In Ghana, for instance, nurse midwives use mobile phones to discuss complex



Source: ITU

cases with their colleagues and supervisors. Rwanda uses a system of rapid SMS alerts, through which community health workers inform health centers about emergency obstetric and infant cases, enabling the centers to offer advice or call for an ambulance if needed.

As shown in the attached graph, there are now more than 5 billion mobile phone subscriptions in the world, expanding at a rate of about 10% per year in the developing world. It is gratifying to note that 2 out of every 3 new mobile subscribers are women. Mobile services at scale represent an enormous area

of potential growth, and social and financial inclusion of the most vulnerable populations. We therefore welcome the full incorporation of the private sector in the Global Strategy and welcome the Secretary-General's initiative to harness the private sector's full potential in women's and children's health.

In 2010, for the first time, data showed that significant progress is being made not only in reducing child mortality but also maternal deaths. Most importantly, several low-income countries from different parts of the world are showing good progress and are on track to reach MDGs 4 and 5. This provides great opportunities for countries to learn from each other's successes. We urge the UN, the World Bank, academia, health-care professionals associations and civil society to work together to increase national data-collection capacity, shorten collection intervals and facilitate more rapid analysis of data nationally and internationally to allow timely feedback on results and to accelerate progress at all levels.

The UN Secretary-General's Special Session was a seminal event. We are delighted by his determination to continue the momentum. We all need to do more, and we will do what we can to support him in this noble effort to ensure that the Global Strategy will deliver on its promise to improve women's and children's health around the world.

Economic development is at the core of overall development. The improved health of women and children contributes hugely to economic development, which will in turn contribute to better conditions for women and children.

Armando Guebuza
President of Mozambique

Jens Stoltenberg
Prime Minister of Norway

Jakaya Kikwete
President of Tanzania

Abdoulaye Wade
President of Senegal

Luiz Inácio Lula da Silva
President of Brazil

Susilo Bambang Yudhoyono
President of Indonesia

Ellen Johnson Sirleaf
President of Liberia

Graça Machel
**Founder and President
Foundation for Community
Development, Mozambique**

Country reports

The Republic of Korea

Accelerating Efforts to Improve Maternal and Child Health

Despite the efforts of the international community over the last decade, much more can be done to improve maternal and child health, which is an important priority of the Millennium Development Goals (MDGs). It is imperative that we provide much greater support for regions lagging behind in these areas.

The United Nations Secretary-General's initiative, the Global Strategy for Women's and Children's Health, will play a leading role in focusing the attention of the international community on this issue. This initiative holds particular importance, because it seeks more efficient use of resources and strengthened accountability, in addition to increased resources.

The Republic of Korea considers health as a key priority. As Korea implements its Official Development Assistance (ODA) commitments, its investment in health has rapidly increased in recent years. In 2007, we introduced an air-ticket solidarity levy with the aim of expanding the efforts to eradicate global poverty and disease. The proceeds from this levy are used to save lives in the world's poorest countries by supporting programs designed to help in the fight against HIV/AIDS, tuberculosis, malaria and other diseases.

In addition to continued cooperation with the UN, we have also expanded our support for health-related multilateral organizations, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID and the GAVI Alliance. As a new donor to the GAVI Alliance starting this year, we will further accelerate our efforts to reduce child mortality by tackling the leading causes of child death, such as pneumonia and diarrhea.

As this year's G20 Chair, Korea has made efforts to accord development issues a central place on the G20 agenda

In keeping with our pledge to the Muskoka Initiative on Maternal, Newborn and Child Health, Korea plans to allocate more resources for maternal and child health. Korea also strives to increase the quality of its assistance with a focus on improving access to quality health services and eradicating pandemic diseases.

The G20 Seoul Summit will offer a valuable platform to consolidate international endeavors for sustainable development. As this year's G20 Chair, Korea has made efforts to accord development issues a central place on the G20 agenda. We consider narrowing of the development gap as integral to achieving strong, sustainable and balanced growth. Much work has been done to elaborate a development agenda and to prepare multi-year action plans on development, focusing on the promotion of sustainable and inclusive economic growth and resilience. The multi-year action plans are to be adopted at the G20 Seoul Summit and to be implemented through subsequent G20 Summits. We believe the implementation of the multi-year action plans will also be of great value in enabling the international community to achieve the MDGs, including the most challenging health-related MDGs.

Together, we should work to ensure that every woman and child is in good health, thus paving the way to a more equitable and prosperous global community.

Lee Myung-bak

President of the Republic of Korea

Australia

Investing in health and harnessing the strength of collaboration

In a modern world it is unthinkable that women still die in childbirth. Each year, though, that is the fate of some 350 000 women and girls. The statistics are made worse by the fact that most of these deaths are from preventable or treatable conditions. It is also a sobering reality that each year over 8 million children die, largely in developing countries. The Asia-Pacific region is home to nearly half of these women and children.

On 22 September 2010 at the launch of the UN Secretary-General's Global Strategy for Women's and Children's Health, Australia announced a five-year commitment to improving the health of women and children. The Australian Government will invest AUD 1.6 billion in this initiative as part of our commitment to increase total aid levels to 0.5% of Gross National Income by 2015-2016.

Australia's new funding includes commitments of AUD 140 million for maternal and child health in eastern Africa and an additional AUD 85 million for Papua New Guinea and the Pacific. It will focus on proven interventions that are known to save lives and are simple and cost-effective to implement.

We are also doubling our previous level of support for the critical work of the Global Alliance for Vaccines and Immunisations, investing AUD 60 million. This money will help give children in developing countries life-saving vaccines to protect against diseases which can be debilitating for the child and an added financial burden for families already struggling for survival.

Australia's contribution reflects our strong support for the UN Secretary-General's Global Strategy.

Australia's contribution reflects our strong support for the UN Secretary-General's Global Strategy as the platform for putting the health needs of women and children at the forefront of the development agenda.

We are committed to working closely with other partners to maximize efforts to save the lives of women and children in developing countries. We will partner with regional governments, multilateral agencies and nongovernmental organizations and we have formed a new Alliance for Reproductive, Maternal and Newborn Health with the US, the UK and the Bill and Melinda Gates Foundation.

In addition to our planned spending on women's and children's health, Australia has committed AUD 210 million to support the critical work of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The Australian Government will continue to invest in raising the health standards of our global neighbors and to harness the strength of collaboration with other nations to assist developing countries to reach their full potential.

Julia Gillard
Prime Minister of Australia

Canada

Muskoka Initiative on Maternal, Newborn and Child Health

At the Muskoka 2010 G8 Summit, Canada and our partners launched the Muskoka Initiative on Maternal, Newborn and Child Health (MNCH). The Muskoka Initiative was adopted to address the needs of vulnerable women and children in developing countries, and reflects the collective efforts of a broad coalition of G8 countries, other donors and philanthropic organizations committed to progress on maternal, newborn and child health. Partners have pledged new and additional financing, while making accountability for these commitments a cornerstone of their approach.

Scope: In setting out the Muskoka Initiative, the G8 worked closely with the World Health Organization and the Partnership for Maternal, Newborn and Child Health. The Muskoka Initiative will help developing countries strengthen their health systems and enable the delivery of key interventions along the continuum of care from pre-pregnancy to childhood. The priorities for action include: antenatal care; attended childbirth; post-partum care; sexual and reproductive health care and services, including voluntary family planning; health education; prevention and treatment of HIV/AIDS, malaria and devastating childhood diseases; immunizations; basic nutrition; and access to safe drinking water and sanitation. The Muskoka Initiative will also support improved health information and innovative means of delivering health care and services.

Importantly, partners to the Muskoka Initiative committed to support country-led national health plans and policies. We agreed to support a World Health Organization-led process to harmonize indicators and reporting requirements, to reduce the burden of reporting on countries.

Partners have pledged new and additional financing, while making accountability for these commitments a cornerstone of their approach.

Financing: From the outset, the G8 was firm that only new and additional money would be included in the Muskoka Initiative. Every G8 partner to the Muskoka Initiative, therefore, has committed not only to maintain existing MNCH support, but also to increase this support by a total of US\$5 billion by 2015. The G8 also welcomed The Netherlands, New Zealand, Norway, the Republic of Korea, Spain, Switzerland, the Bill & Melinda Gates Foundation and the United Nations Foundation as partners to the Muskoka Initiative. These key partners confirmed financial commitments of US\$2.3 billion. While US\$7.3 billion was committed at the Muskoka Summit, G8 Leaders expect that significantly greater than US\$10 billion can be mobilized through the Muskoka Initiative.

Canada's contribution: Canada committed C\$1.1 billion to the Muskoka Initiative, and renewed existing spending of C\$1.75 billion over the next five years.

Accountability for commitments: Canada and our partners worked with the OECD, the World Bank, and the Countdown to 2015 to benchmark existing spending relevant to MNCH, and to track future spending. This groundbreaking methodology is available on the G8 website (www.g8.gc.ca). The introduction of this technical accountability mechanism means that donors will be held publicly accountable for the financing committed through the Muskoka Initiative.

Policy endorsement: The G8 was pleased to secure policy endorsement for the Muskoka Initiative from important partners, including: the leaders of key African governments, and the African Union; the governments of Australia, Liechtenstein and Sweden; the Hewlett, McCall McBain, Packard and Rockefeller Foundations; the group of eight international agencies in the health sector (the World Health Organization, the Global Fund to Fight AIDS, TB and Malaria, UNICEF, the GAVI Alliance, the World Bank, the United Nations Population Fund, UNAIDS, and the Bill & Melinda Gates Foundation); the heads of the schools of public health of 22 universities in the United States; and the Micronutrient Initiative based in Canada.

Links to the Global Strategy: Canada worked closely with the United Nations to ensure the Muskoka Initiative was both in alignment with the Global Strategy, and helped to catalyze further commitments at the United Nations General Assembly in September 2010. As part of the Global Strategy development, Canada, along with Rwanda and the World Health Organization, also co-chaired a process to examine how to improve accountability, ensuring that partners and stakeholders meet the commitments they have set out and that these commitments lead to tangible results and outcomes. We are delighted that the Global Strategy attracted such widespread support and commitment, and will continue to support the United Nations Secretary-General and the wider community in its implementation.

We will also meet, track and publicly report on our financial commitments through an accountability report

Looking ahead: In the decade since the Millennium Development Goals were agreed, there has been progress on maternal, newborn and child mortality. Nonetheless, every year hundreds of thousands of women die in pregnancy and childbirth, and many more are injured. Nearly nine million children die before their fifth birthday. This cannot continue. Going forward, we will work closely with developing country and other partners to support delivery of the most effective health interventions along the continuum of care. We will also meet, track and publicly report on our financial commitments through an accountability report. These practical efforts are aimed at achieving what we all desire – a dramatic reduction in these preventable deaths, and assistance for the women and children who need it most.

Stephen Harper
Prime Minister of Canada

Ethiopia

How we are getting more health for the money

It has been a remarkable decade in global health. Countries have made strides towards the health-related Millennium Development Goals (MDGs) by mobilizing substantial international and domestic resources and using effective new technologies. In Ethiopia, this has coincided with the Government's renewed commitment to ending poverty and accelerating the development of our country. Health is central to these objectives. The Government is gaining real traction from its approach to health-system strengthening and service delivery, and its drive towards universal access to primary health care.

As immunization and access to services have expanded, under-fives mortality has decreased from 204 per 1000 live births in 1990 to 101 per 1000 in 2008. A combination of interventions has reduced maternal mortality from 1068 in 1990 to 470 in 2008. HIV prevalence has declined, due to expanded access to key interventions. Malaria cases and resulting deaths have been cut dramatically by the distribution of 36 million bednets, and scale up of other key interventions. As a result, we are beginning to see the positive economic effects of a healthier population. However, much more needs to be done.

Firstly, we are building a “women-centered” health system, which empowers women to look after their own health and that of their families. To this end, we have launched a national mechanism that links leaders at national, regional and district levels with women's groups in every village. These “women's development teams” are being empowered to monitor the health and well-being of every mother and child in their communities. Supported by our health extension workers (HEWs), who are themselves women, local leaders will be key to expanding access to essential services, including family planning.

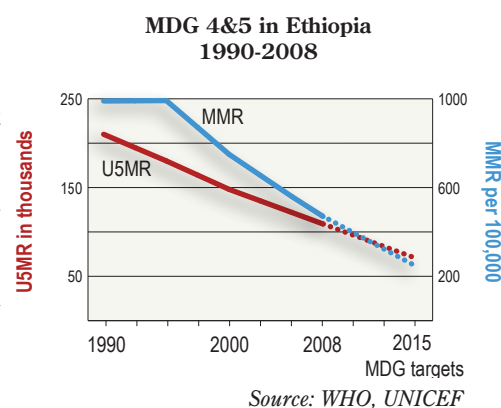
Secondly, we are systematically addressing the so-called “three delays” that endanger expectant mothers. This involves encouraging communities to help women make timely use of services, and expanding ambulance services throughout the country. We are also upgrading health centers to deliver basic and emergency maternal services, and training more midwives.

Thirdly, we are strengthening newborn-care capacities at all levels. This includes training HEWs to manage the most common cause of neonatal death, and strengthening neonatal services in hospitals. While scaling up to universal immunization coverage, we are strengthening our programs and systems, such as cold-chain management, and introducing new vaccines for pneumonia and rotavirus.

The recent MDGs Summit in New York enabled the international community to review countries' progress and to affirm its commitment to the MDGs. Despite the uncertain global economic environment, some developed countries are responding. Many others, we hope, will soon heed the call to increase, sustain and further harmonize their support at this critical juncture. On our part, we remain committed to getting the most out of every dollar invested to improve the health of Ethiopian women and children, and ensure the future development of our country.

Meles Zenawi

Prime Minister of Federal Democratic Republic of Ethiopia



France

Comprehensive and integrated approaches to maximise outcomes

Despite the international economic crisis that has affected all the countries, France's commitment to achieving the Millennium Development Goals, particularly those related to global health, remains even stronger.

Although significant progress has been made in the health sector, much is yet to be accomplished. This is particularly relevant when addressing maternal and child health. Each year, it is estimated that over 350,000 women lose their lives during pregnancy or childbirth. Further, 9 million children die before their fifth birthday.

France welcomes the Secretary General's Global Strategy for Women's and Children's Health.

The health of children and that of mothers are closely inter related, which requires not only targeted responses and complementary approaches, but also access to services and care provided by robust health systems. Furthermore, comprehensive and integrated approaches are essential to maximise outcomes. The complexity of this question involves political, social and economic issues as well as non-health sectors such as those responsible for water, sanitation, nutrition, education, power, communications, transport and infrastructure.

France confirms its focus in achieving health related MDGs with an emphasis on child health including vaccination, reproductive health, support for improving access to medication, reducing the burden of diseases such as HIV/AIDS or communicable diseases. Health system strengthening is another major focal area for France.

The promotion of gender equality and the empowerment of women are an essential part of France's commitment.

Since 2000, France has multiplied by four its Development Aid dedicated to health and is one of the main European donors of official development assistance in terms of volume. There has been a general increase in French contributions to international organisations which work on reproductive health.

Considering all the tools implemented by France the health sector represents, an annual average expenditure of nearly 1 billion Euros in 2009. These sums are broken down into 73 percent for multilateral contributions and 23 percent for bilateral contributions.

Concerned by progress yet to be made to reduce child and maternal mortality, France has strongly supported the G8 Muskoka initiative to strengthen the efforts on MDG4 and MDG5.

France has pledged 500 additional million Euros from 2011 to 2015.

Moreover, French previous and ongoing contributions include financing programs of multilateral organizations, such as UNFPA, WHO and UNICEF, mainly in the African region.

France also provides technical assistance mainly to West African countries in order to assist them in designing and implementing their policies to fight maternal mortality.

The promotion of gender equality and the empowerment of women are an essential part of France's commitment. France plays an important role in terms of advocacy, defending access to reproductive health and rights, including family planning, in all international fora and partnerships. France supports the "Reproductive health Supplies Coalition" whose activities aim at promoting universal access to reproductive health services and commodities.

With regards to MDG 4, France will continue to invest in vaccination programs, one of the main activities that enable preventing child mortality and represents an extraordinary cost effective action in public health.

France is the second international donor for GAVI with 15 M € (from 2003 to 2006) and 1,3 billion Euros from 2007 to 2026, through its contribution to the International financial facility for immunization (IFFIm).

France is also the second largest donor at the Global Fund and has recently announced an increase of its contribution of 20% that will represent over a billion Euros (360 M € per annum from 2011 to 2013).

Innovative financing constitutes a crucial mechanism which provides sustainable, predictable and additional ODA financing

France is also the first contributor to UNITAID (145 M€ in 2009).

While the Global Fund finances programs aiming at preventing HIV/aids transmission from mother to child, UNITAID contributes to decreasing the price of paediatric antiretroviral medicines. Both organisations also play an important role in decreasing child and maternal mortality through their activities against malaria.

Innovative financing constitutes a crucial mechanism which provides sustainable, predictable and additional ODA financing. Innovative financing is a pragmatic response which is based on solid experience since 2006. In barely four years, it has raised almost three billion extra dollars for development. France plays a leading role in this field. During the last summit in New York France has pledged for a large participation for the implementation of an International tax on financial transactions that could rise up to 40 billion per annum.

Finally, we are convinced that it will not be possible to reach the MDGs without having viable and strong health systems. With this aim, France provides active support to international partnerships such as IHP+ and initiatives for health system development, especially the “Providing for Health” (P4H) to promote and support the development of social health protection in developing countries.

Nicolas Sarkozy
President of France

Germany

Focusing on Outcomes: A Promising Approach to Development Cooperation

The United Nations Summit in New York in September confirmed that the international community is firmly resolved to strengthen its efforts to achieve the Millennium Development Goals (MDGs). This I can only welcome. For, despite some remarkable progress, we still have a long way to go in many areas. There are considerable differences, both in the achievement of individual MDGs and from one region to the other.

To my mind there is no doubt that we have to improve the effectiveness of development policy instruments. It is vital that they are oriented towards concrete results –based on the MDG indicators. How much money do people have to live on? How much do they have to eat? Do their children go to school? What is the situation regarding health care?

In my opinion, there are two important starting points for strengthening results orientation in development cooperation. Firstly, development funding should be linked to the results obtained. Results-based financing is a new concept currently being tested in some countries. Indeed, Germany is supporting a pilot project together with the governments of Norway and Malawi. Secondly, national ownership needs to be strengthened by creating more space for national stewardship.

Combining these two elements is a promising way to enhance the effectiveness of development policy in our efforts to achieve the Millennium Development Goals. In my meetings in New York, I found a lot of support for this approach. However, the next step must be to translate this general orientation into practical action.

Germany is working with its international partners – states, international organizations and non-governmental organizations – to develop the concept further. The questions that need to be resolved in this process are by no means exclusively technical; some are also political. One example is the question of linking financial support to results, where we only have experience at the sub-national level so far. What could it look like at the international level? Another example is the concrete definition of the enlarged space for action. Everyone agrees there should be less “micro steering” by donors – but where does the micro level end? What are the fundamental convictions underlying micro steering?

...there are two important starting points for strengthening results orientation in development cooperation - Firstly, development funding should be linked to the results obtained. Secondly, national ownership needs to be strengthened by creating more space for national stewardship.

No matter how the details are fixed, to me one thing is clear: human rights are non-negotiable, because without them sustainable development is impossible. The link between the Millennium Development Goals and human rights underlines the comprehensive approach anchored in the Millennium Declaration. In addition to human rights and economic and social development, equal attention has to be paid to good governance, peace, security and, finally, environmental protection. These programmatic fields of action must not be played off one against the other because, ultimately, progress and setbacks in these fields are mutually dependent.

Angela Merkel
Chancellor of Germany

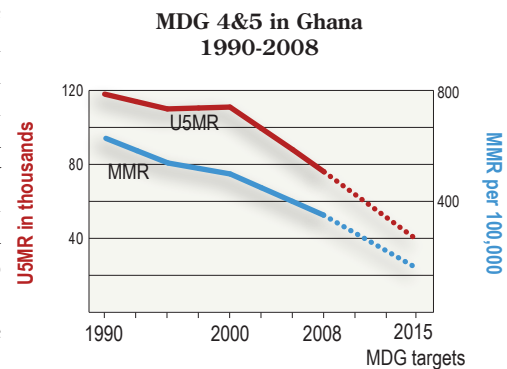
Ghana

Initiatives to achieve the health MDGs

Ghana is currently on track to achieve Millennium Development Goals (MDGs) 1, 2 and 3 by 2015. However, much more needs to be done to achieve MDGs 4, 5 and 6 for improving the health of women and children and combating disease.

The Government of Ghana and its development partners have implemented various measures to save the lives of women and children. One of the most important is the exemption of children under 18 from fees for health care. Another is the provision of free maternal health services to women. By removing these financial barriers, we are enabling women and children to access health care earlier, which can save lives.

The integration of the Expanded Program on Immunization (EPI) into normal district activities has resulted in high coverage of all antigens. Ghana acknowledges the support of its development partners, notably GAVI and UNICEF, in developing our EPI to where it is today. In addition, Ghana has invested in immunization for polio and measles. No child has died from measles in Ghana since 2003, and under-five mortality has decreased significantly since 1990. However, the reduction in neonatal mortality has been marginal. To counter this, a national survey has been conducted to inform decisions on the manpower and equipment needs of facilities to address maternal and neonatal emergencies. We also appeal to our development partners to increase their support to enable us to introduce new vaccines, such as pneumococcal and rotavirus, which will accelerate progress towards MDG 4.



Source: WHO, UN

Innovations

Community-based health planning and services (CHPS): The expansion of CHPS in all districts started in 2004, to give communities and rural populations access to basic primary health care. Community Health Officers (CHOs) work in CHPS zones, and can promptly treat children with diarrhea and acute respiratory infections, which often saves lives. The CHOs are supported by the District Health Directorates, District Assemblies and other partners.

Recruitment and retention schemes for health workers: Access to skilled staff is key to saving the lives of pregnant women and children. Since 2002, Ghana has increased output of the various categories of health professionals, and since 2006 has raised their salaries to reasonable levels. This has greatly enhanced retention.

Improved clinical care:

Various partners in the health sector are helping Ghana to improve clinical care in rural areas by strengthening health infrastructure, providing basic equipment and implementing new ways of managing the health workforce. The decline in maternal and child mortality is evidence that the interventions put in place are yielding results.

The Government of Ghana alone cannot provide the resources to enable us to achieve the health-related MDGs. While we strive to meet the Abuja Target of allocating 15% of government expenditure to the health sector, we appeal to our global development partners to commit more funding to support implementation of our accelerated plans for attaining the MDGs.

John Evans Atta Mills

President of Republic of Ghana

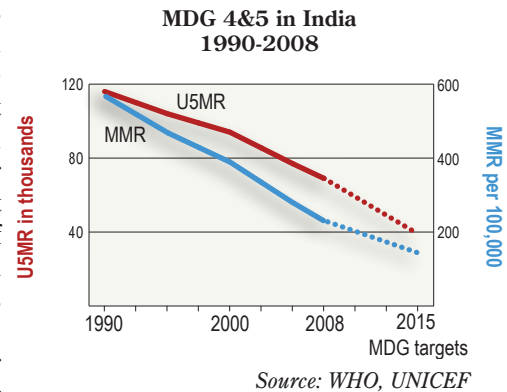
India

Providing universal access to basic health services

More than ever before, it is now necessary for all countries to join together to reaffirm our commitment to achieve the Millennium Development Goals (MDGs), particularly those related to health. Such a global commitment is required to ensure that the economic crisis that has affected almost every country protects the poor and the vulnerable sections from further deprivation. Since a healthy body is the economic asset of the poor, it falls upon us to ensure that resources as required are apportioned to their well-being. Despite competing demands which force countries with low resources to make choices, priority attention needs to be given to measures that will ensure that none die prematurely on account of conditions that are entirely preventable.

It is in the above context that the Secretary-General's Global Strategy for Women's and Children's Health needs to be applauded as it seeks to address the problems of the most vulnerable sections, namely women and children. The aims to reduce maternal and infant mortality and morbidity, and promote the healthy well-being of young mothers and children, are objectives that every society should place as core concerns of development.

Keeping in view the above, India launched a community-based strategy for revitalizing primary health care to provide universal access to basic health services. This process is being implemented under the National Rural Health Mission and is essentially focused on providing quality care under the Reproductive and Child Health program. Almost US\$3.5 billion are being spent on these efforts annually. Based on evidence, 235 out of 600 districts have now been identified for a more focused approach to achieve Millennium Development Goals 4, 5 and 6. Though these districts account for 35% of the population, they also account for nearly 70% of maternal and infant mortality, high levels of fertility and high levels of morbidity and mortality on account of infectious diseases. Under this approach, facilities are being strengthened for providing excellent quality of care alongside strategies for demand generation through a well-structured conditional cash transfer scheme.



It is our belief that the interventions mentioned above would enable us to achieve our goals within the given timeframe. India remains committed to ensuring the effective use of domestic and donor aid in this regard and, as a responsible stakeholder of the global community, continuing to assist in extending technical advice to countries in greater need.

India pledges its commitment to achieve the MDGs health goals within the timeframe of 2015.

Ghulam Nabi Azad
Minister of Health & Family Welfare, Government of India

Indonesia

Roadmap for achieving the MDGs

Like many countries, Indonesia is prone to natural disasters and other major crises, which create formidable obstacles hampering efforts to meet the MDGs. The global economic crisis, for example, significantly eroded the impact of some of Indonesia's achievements.

2010 is therefore a pivotal year. With only five more years to meet the MDGs we must intensify our efforts and find innovative breakthroughs. The health-related MDGs, particularly MDGs 4 and 5, are cornerstones for achieving all others. But we acknowledge the need to view the MDGs holistically and to find a comprehensive solution – while recognizing the challenges that remain.

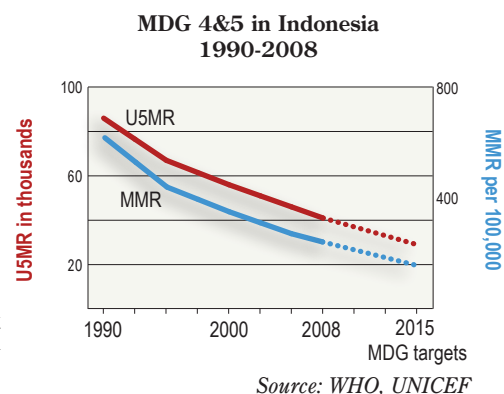
Indonesia's Government has taken every measure to ensure success. Chief among these is its national roadmap, which includes a comprehensive analysis of the country's efforts, as well as policies and strategies for addressing unresolved challenges – particularly those concerning the health of women and children.

This roadmap is translated into action through strategic plans developed by each province and district, ensuring that national policy is tailored to the particular problems that each region faces.

The roadmap contains the following pledges:

- By 2015, all birth deliveries will be performed by skilled birth attendants
- In 2011, the government will fully fund deliveries of babies born to at least 1.5 million poorer women.
- In 2011, health funding will increase by US\$556m to support professional health workers and achieve high-quality services in 552 hospitals, 8,898 health centers and 52,000 village health posts.

To ensure these pledges are realized, the Government has sought synergies among the commitments made by stakeholders, particularly sustainable collaborations between the private sector and civil society, which promote capacity-building initiatives and the use of information and communications technology.



High-quality services

The Government is also expanding community access to high-quality health services by:

- Revitalizing facility-based outreach services tailored to local needs. It has set up community health centers (Puskemas and Posyandu) as the primary health-care providers in rural areas, and improved basic emergency obstetric and neonatal services (PONED) and comprehensive emergency obstetric and neonatal services (PONEK) provided by these health centers and district hospitals.
- Increasing access to family-planning services, particularly for post-natal mothers and groups with unmet needs. It has expanded the network of integrated reproductive health services, including adolescent reproductive health services and high-quality family-planning services, focusing on poor and less developed regions.
- Strengthening the capacity and competence of rural midwives by partnering with private health providers and traditional birth attendants, particularly in regions where maternal health is of greatest concern.
- Strengthening the referral system aimed at dealing with unnecessary delays in obtaining emergency health services that can often result in avoidable deaths.

Susilo Bambang Yudhoyono
President of Indonesia

Japan

Embracing the well-being of women and children in our new global health policy

Maternal, newborn and child health (MNCH) has made the slowest progress among the Millennium Development Goals (MDGs). Despite the remarkable progress in reducing child mortality, performance has varied from country to country, and even within individual developing countries. Many pregnant women lose their lives without receiving quality preventive and clinical services, and many children die within first month of their birth.

It is unacceptable that women and children are excluded from the benefits of progress, just because they are vulnerable. MNCH is the basis for success in reducing poverty and fostering economic growth. Securing a healthy future for mothers and children is, therefore, a diplomatic objective of critical importance, and is also a valuable investment.

It was for this reason that, as part of the “Kan Commitment” announced at the UN MDGs Summit, I launched Japan’s new global health policy, with MNCH as one of its main pillars. Under this policy, Japan will provide assistance to the health sector totaling US\$5 billion from 2011 to 2015. It will also make the utmost effort, in cooperation with other countries, to save the lives of 11.3 million children and 680 000 mothers.

I launched Japan’s new global health policy, with MNCH as one of its main pillars.

As part of our new policy, we proposed a model called EMBRACE (Ensure Mothers and Babies Regular Access to Care) to ensure the continuum of care from pre-pregnancy to after childbirth. To save the lives of mothers and children, it is essential to deliver a sequence of health services, including ante- and post-neonatal care at facilities with adequate equipment and human resources, and necessary immunizations. EMBRACE is based on Japan’s own experience and on discussions among qualified international stakeholders. It contributes to the implementation of the Muskoka Initiative and the Global Strategy for Women’s and Children’s Health.

I strongly hope that the governments of developing countries will adopt the EMBRACE model to reduce maternal and child deaths, and that donors and international organizations will pool their efforts to provide support. For its part, Japan, together with the international community, will take action in accordance with EMBRACE through additional assistance of up to 50 billion yen from 2011 to 2015, which Japan announced at the Muskoka Summit.

We in the international community already have the knowledge and technology that can save lives. In order to achieve this goal, it is essential to pool our resources and maximize the impacts of our assistance. It is, therefore, of great significance that this year a number of countries have reaffirmed their political determination and commitment to take meaningful action.

We must bear in mind that the health of women and children is closely related to other issues, and health goals cannot be achieved by health interventions alone. It is now, therefore, more important than ever to address the MDGs in a comprehensive manner and from the viewpoint of human security, which has as its objective enabling every individual to realize her or his full potential.

Naoto Kan
Prime Minister of Japan

Nepal

Millennium Development Goals Award recognizes years of declining mortality

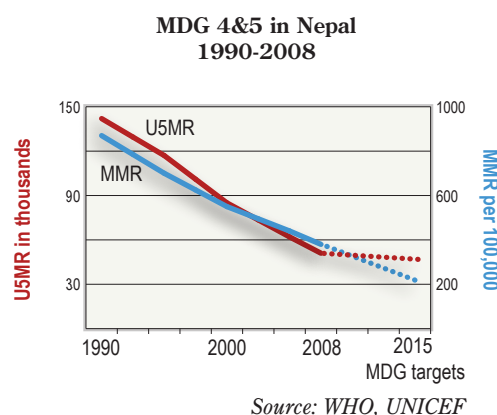
In September 2010, Nepal received the Millennium Development Goals Award from the United Nations for its exceptional progress towards reducing maternal mortality and achieving MDG 5. Between 1990 and 2006 Nepal's maternal mortality ratio declined by an impressive 67%, from 850 to 281 per 100 000 live births.

During the same period, under-five mortality rate declined by 62%, from 162 to 61 deaths per 1000 live births. For this achievement, Nepal received the award for the highest average annual rate of reduction of child mortality since 1990 among all 72 GAVI countries at the fourth GAVI Partners Forum in Hanoi in November 2009.

Thus, Nepal is one of the few developing countries on track to achieve MDGs 4 and 5, and probably some other MDGs.

Some of the keys to Nepal's success against MDGs 4 and 5 have been:

- Over 50 000 highly motivated Female Community Health Volunteers, providing health education and motivating parents to use life-saving health services
- Payment of transport costs for pregnant women to deliver at health facilities, and cash incentives to skilled birth attendants for deliveries at home and in health facilities
- Free delivery care, and incentives for women who take a complete package of antenatal, delivery and postnatal care
- Provision of free medical checks and essential medicines in local health institutions
- Increased availability of family planning, and provision of safe abortion services
- Sustained increases in government budget and donor support for primary health care.



Given the post-conflict challenges, Nepal's difficult terrain and its vulnerability to natural disasters and climate change, further efforts are required to sustain and deepen the gains made. It is particularly difficult to serve remote areas and marginalized groups with adequate human resources and infrastructure, so greater coordination and integration of services are needed, especially at district level.

Above all, Nepal needs to tackle the underlying causes of ill health and mortality, particularly the unacceptably high rates of malnutrition, widespread poverty and harmful and discriminatory cultural practices. Health-systems strengthening is vital, and targets to this end are embedded in Nepal's strategic health plan. This has a rights-based framework and a clear focus on cross-cutting issues such as gender and social inclusion.

In three years, the health budget has increased from 6% to 7% of the national budget. Recently, leading development partners such as DFID, the World Bank, USAID, GAVI, UNFPA and UNICEF signed a joint financing agreement (JFA). This reaffirmed their commitment to follow a single financial management and reporting framework for Nepal's health strategy, with some donors pooling their development funds and others providing complementary support. The Global Fund (GFATM) has expressed an interest in joining the JFA soon, while AusAID continues to support the health sector-wide approach (SWAp).

With such enhanced donor support to Nepal's nationally owned health plan, we expect to accelerate progress towards achieving MDGs 4 and 5, while ensuring better value for money. We also remain committed to all the other MDGs, to fulfill our shared commitment to the United Nations Secretary-General's Global Strategy for Women's and Children's Health.

Madhav Kumar Nepal
Prime Minister of Nepal

Nigeria

Maintaining our focus on driving down maternal, newborn and child mortality

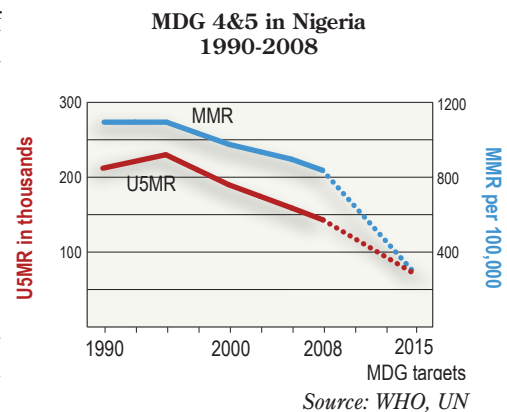
Since the Millennium Development Goals (MDGs) were launched in 2000, Nigeria has integrated them into the heart of its development planning and financing. This is yielding positive results in progress towards the MDGs in our country.

Our progress in reducing infant and child mortality is satisfactory. The infant mortality rate was estimated at 75 deaths per 1000 live births in 2008, compared with 87 per 1000 in 1990 (our target for 2015 is 30 deaths per 1000). The under-fives mortality rate also dropped from 201 per 1000 to 157 per 1000 (the target for 2015 is 75 per 1000).

However, maternal mortality remains a huge burden. There are various estimates based on data from 1990 to 2008, which underscores the challenge of obtaining robust country estimates for national planning and action, and also for international comparisons.

Nigeria and 11 other countries reportedly account for 65% of the estimated 358 000 maternal deaths in 2008. The Nigeria National Demographic & Health Surveys (NDHS) have shown steady progress in the decline of maternal deaths, from an estimate of 800 per 100 000 live births in 2003 to 545 per 100 000 in 2008. However, much more work is needed to improve women's access to reproductive health services and commodities.

Other important initiatives related to the MDGs include the planned distribution of 63 million long-lasting insecticide-treated nets to all families, in collaboration with our international development partners, to reduce the burden of malaria.



We are also improving access to health-care services by applying the debt-relief gains negotiated in 2005 to implement several innovative programs. These are targeted at improving health indices, particularly in rural areas. Innovative schemes include a nationwide midwifery service and targeted provision of free basic health care through community health insurance. We are rapidly making significant investments in immunization infrastructure, using both MDG debt-relief grants and global partnership support.

We are committed to accelerating progress towards achieving the MDGs on schedule. However, this would require a worldwide re-commitment to sustained long-term investments to address the challenges. For us, the platform to deliver this is the National Strategic Health Development Plan and the MDGs Countdown Strategy. These serve as a common framework of mutual accountability for results between the federal, state and local governments and all other stakeholders in the national health system

We intend to adhere to the commitments and understandings enshrined in the 2001 Abuja Declaration, such as allocating 15% of annual budget to the health sector. We plan to mobilize additional financial resources through innovative approaches to realize the US\$32 per capita investment required to fully fund the National Health Plan (2010-2015). Furthermore, we intend to uphold the Nigeria IHP+ country compact with our development partners, to make huge resources available to deliver on the health MDGs and other national health objectives and targets.

Goodluck EA Jonathan
President of Federal Republic of Nigeria

Rwanda

Leadership through Successive Innovations

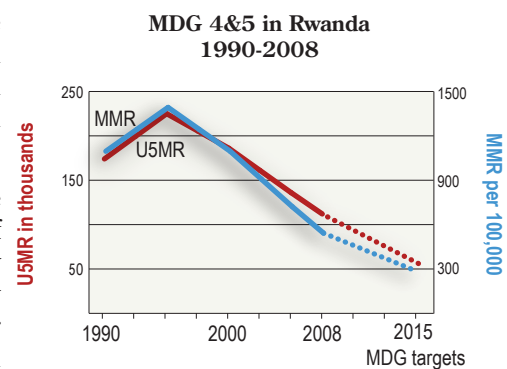
The Government of Rwanda is committed to improving child and maternal health as an integral part of its health-care system and poverty-eradication program. It will continue to initiate innovative approaches in the management of health services to realize this important goal.

Between 2000 and 2008 child mortality in Rwanda declined by 48% – from 196 to 103 deaths per 1,000 live births. By 2015 we aim to further reduce under-five mortality by 75% – to 50 deaths per 1,000 live births – through interventions such as universal immunization coverage, Integrated Management of Childhood Illnesses (IMCI), and increased use of insecticide-treated nets to reduce the prevalence of malaria.

The maternal mortality in Rwanda has steadily gone down by 63%, from 1,071 deaths per 100,000 live births in 2000 to 383 in 2008 – and we still consider it unacceptably high. Major causes of death include bleeding, infections, hypertension, obstructed labor, malaria and shortage of health personnel.

These improvements in maternal and child health have coincided with a series of reforms in the Rwandan health system including performance based contracting between the national and local governments, and in facilities, health insurance, maternal audits and the use of mobile technology.

Our major strategy to improve maternal health is to increase access to necessary services. This will raise the percentage of mothers who give birth in a health facility, which has already increased progressively and currently stands at 65%. Equally important is the increased provision of voluntary counseling and testing (VCT), and prevention of mother-to-child transmission (PMCT) services in all our health facilities.



Source: WHO, UNICEF

As a practical measure, we have implemented a real-time alert system for improving maternal and child health in Rwanda using the Rapid SMS model. The alert system tracks the maternal and neonatal life cycle, ensuring that critical points are documented and sent electronically to a central database, with an auto-response alert of each critical event sent to the nearest health centre. This system also includes an alert for each maternal or neonatal death, which then initiates a maternal and newborn death audit by the supervising health facility.

Our government recognizes that family planning is critical for maternal health and socio-economic development, and plans to increase contraceptive use from the current rate of 45% to 70% by 2012.

Rwanda is also committed to continue finding innovative solutions to achieve universal health insurance, which currently covers 97% of our population.

We plan to roll out and deepen a national health education program to reach all adolescent girls and to promote effective nutrition practices, especially among under-fives, school children, pregnant women and breastfeeding mothers.

By 2012, every district will have at least seven ambulances for emergency referral services and 100% of our district hospitals will have basic equipment for obstetric and neonatal care. By then, we also plan that 80% of the population will be within an hour of a functional health facility.

These innovative community health-care systems ensure that an ever-increasing number of people will have access to accessible and affordable health services, translating into greater delivery of services and better health for all.

Paul Kagame

President of the Republic of Rwanda

United Kingdom

Women's and children's health at the center of the international development agenda

2010 has been a significant year for women's and children's health. Sustained political leadership and a series of high-level events have rightly placed these issues at the center of the international development agenda. These events include the African Union Summit, the Women Deliver conference, the G8 and the Asia-Pacific Conference. The year has culminated with the launch at the United Nations Millennium Development Goals Summit of the Global Strategy for Women's and Children's Health, which aims to save the lives of 16 million women and children.

The Global Strategy for Women's and Children's Health is significant in several respects:

- The unprecedented range of policy, financing and service-delivery commitments it has already generated, so far totaling over US\$40 billion
- The new partnerships that it has forged, with significant commitments from developing countries and new partners, including the private and philanthropic sectors
- The importance it places on the role of innovation and technology to connect the poorest billion people on the planet to the global economy
- The agreement it reflects on the need for clearer results and greater accountability in tracking progress against commitments made.

The UK was proud to announce that we are re-orienting our aid program to put women at the heart of UK development efforts. Building from our contribution to the G8 Muskoka Initiative, our commitment is to save the lives of at least 50 000 women in pregnancy and childbirth and a quarter of a million newborn babies and to enable 10 million couples to access modern methods of family planning over the next five years. We also announced a new alliance, with the United States and Australian Governments and the Bill and Melinda Gates Foundation, to support a number of high-need countries in reducing unintended pregnancies and maternal and newborn mortality. The alliance will work to help 100 million more women access modern family planning by 2015. Our forthcoming Reproductive, Maternal and Newborn Health Business Plan will lay out how we will deliver this.

Our commitment to development imposes on us a double duty to ensure maximum results on the ground and to ensure full accountability, both to our own taxpayers and to the world's poor.

Our commitment to development is clear. The UK is on track to deliver against our aid commitments, and we are fully committed to achieving, from 2013, the UN target of spending 0.7% of gross national income on overseas aid. Our commitment to development imposes on us a double duty to ensure maximum results on the ground and to ensure full accountability, both to our own taxpayers and to the world's poor. It is both morally right and in our national interest. We are creating a new Independent Commission for Aid Impact to monitor the use of our precious aid resources. We will publish the details of our aid spending online, so that the performance and impact of development policies are transparent to all.

I am determined that we use the launch of the Global Strategy on 22 September 2010 as a springboard for an even stronger joined-up international approach. Together, we will need to ensure that women's and children's health remains high on the international agenda, that further commitments are made, including from new partners, and that we support the accelerated delivery of results at country level. This will require the development of an independent and robust accountability framework that brings together existing processes. We must ensure that countries and partners cannot make promises without being held accountable for them – including for failing to meet them.

David Cameron

Prime Minister of the United Kingdom of Great Britain and Northern Ireland

United States of America

Women and children's health: A new era of development cooperation

Health is at the heart of human progress. It affects whether women can survive childbirth, whether infants can grow and thrive, whether children can attend school, and whether parents can work to support their families. Improving maternal and child health, and promoting access to family planning, HIV/AIDS prevention, treatment and care, and immunization are essential to sustainable development. Every country, every multilateral partnership and alliance, and every community—from big cities to small villages on every continent—has a role to play.

The United States welcomes the Secretary General's Global Strategy for Women's and Children's Health and its vision of a coordinated global effort that focuses on the women and girls whose health has the biggest impact on families and communities.

Under President Obama's leadership, we share this focus. The United States has elevated development—and with it global health—alongside diplomacy and defense as pillars of U.S. foreign policy and recognized development as a strategic, moral and economic imperative. Our new approach charts a course for investments in transformative and sustainable development outcomes through relationships with partner countries built on mutual accountability.

The United States has elevated development—and with it global health—alongside diplomacy and defense as pillars of U.S. foreign policy and recognized development as a strategic, moral and economic imperative.

The President's Global Health Initiative reflects this new policy. It is a multiyear, \$63 billion commitment that builds on the global health successes of the last decade and draws on America's long tradition of development through innovation. We will continue and expand our work with partners in and outside of government—with members of civil society, private sector partners, faith leaders, and multilaterals—to develop and support scalable and sustainable solutions.

And like the Secretary General, we are emphasizing the health of women and girls. Through the Global Health Initiative, we will provide integrated and essential health services for women and their children, including not only skilled care during pregnancy, childbirth, and the post-partum period, but also family planning, prevention and treatment of HIV/AIDS, TB, and malaria, and essential child health interventions. And we will link our health programs to broader development efforts to address the social, economic, and cultural factors that too often limit access to health services for women and girls.

Phase two of our work in global health will require new staff, skills, tools and knowledge to enable country-led health programs to be smarter, more efficient and more effective, and offer quality services as close as possible to the people who need them.

The United States is increasing funding for applied research, expanding access to effective technologies and practices, building learning partnerships, stimulating innovation in partner countries, and expanding global access to knowledge. We are also embracing a new model for doing business to improve the way our development institutions work and ensure greater impact on the ground.

As an example of cooperative effort, we have entered into a partnership with the United Kingdom, Australia and the Bill and Melinda Gates Foundation to help more mothers give birth in hospitals or with the aid of skilled health workers, and to help them gain access to quality postnatal care and family planning. These efforts are specifically targeted to address aspects of Millennium Development Goals 4 and 5, reduction of child mortality and improvement of maternal health, where progress has been especially slow.

This partnership, like the broader Global Health Initiative, demonstrates U.S. commitment to improving the health of women and girls.

That will only be possible with a sustained global effort to improve the health of hundreds of millions of women and children around the world. By learning, using, and sharing the best approaches, and by focusing on what each of us does best, we can deliver historic leaps in development and accelerate progress towards the Millennium Development Goals.

Hillary Rodham Clinton

Secretary of State of the United States of America

African Union

Putting the Global Strategy for Women's and Children's Health into practice

Recent data on maternal and child mortality at the global level is encouraging, but in Africa MDGs 4, 5 and 6 remain formidable challenges. Some African countries still have the world's highest rates of maternal, newborn and child morbidity and mortality, and Africa as a whole still has the world's highest incidence of HIV and AIDS, malaria, tuberculosis and other communicable and non-communicable diseases.

African Union (AU) leaders have focused on maternal and child health through a range of instruments. For example, the Africa Health Strategy (2007-2015) enables coordination between countries, civil society and the international community, and develops and strengthens health systems. Its vision is "an integrated and prosperous Africa free of its heavy burden of disease, disability and premature death".

In 2006 and 2007 the AU adopted the Continental Policy Framework on Sexual Reproductive Health and Rights and the Maputo Plan of Action for its implementation. These were developed to tackle maternal and infant morbidity and mortality and to accelerate implementation of the MDGs, particularly those related to health.

In addition, the AU Commission has begun to revitalize the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) – a treaty body that monitors the implementation of the African Charter on the Rights and Welfare of the Child. The Charter's provisions, if implemented, will protect children and promote their health and welfare.

... it is imperative that African countries continue to invest in the health of women and children, recognizing that they are the engine for national development.

Campaign on Accelerated Reduction of Maternal Mortality in Africa

In May 2009, the AU launched its Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), with the theme "Africa Cares: No Woman should Die while Giving Life". This has led to notable achievements in Member States and further action to prevent deaths among mothers and newborns. To help promote CARMMA, the AU launched the African Women's Decade during October 2010.

CARMMA recognizes that without a comprehensive sexual and reproductive health strategy that gives women control over their bodies, maternal mortality will continue to hamper African development. It also takes into account such issues as the African reality-women's sexual rights and choices, gender equality, economic dependence, informed health choices, armed conflicts, the situation of refugees, unsafe sex, and harmful practices such as early marriage and female genital mutilation.

So far 23 AU Member States have launched CARMMA, showing how continent-wide policies can provide an impetus for action at national level. They are: Angola, Cameroun, Central Africa Republic, Chad, Eritrea, Ethiopia, Gambia, Ghana, Guinea Bissau, Lesotho, Malawi, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Togo, Uganda, Zambia and Zimbabwe.

However, the implementation of CARMMA is not an end in itself, and it is imperative that African countries continue to invest in the health of women and children, recognizing that they are the engine for national development.

The latest actions agreed by the African Union

In July 2010 at the 15th Ordinary AU Session of the Assembly Session in Kampala, Uganda, AU leaders agreed to:

- Launch CARMMA in all AU countries and broaden it as an advocacy strategy for promoting maternal, newborn and child health; involve key stakeholders such as women, children, young people, disabled people, parliamentarians, community and religious leaders, civil society organizations, the media, and the private sector; institutionalize an annual CARMMA week for the next four years.
- Strengthen health system to provide comprehensive, integrated, maternal, newborn and child health care services – particularly through primary health care, family planning, infrastructure development and skilled human resources.
- Provide stewardship and achieve policy coherence by developing integrated health plans with cross-disease and cross-sector health goals; coordinate multi-sectoral actions and multi-agency partnerships.
- Provide support for sharing and scaling up cost-effective practices; request the AU Commission to map and disseminate such practices.
- Provide sustainable financing by mobilizing domestic resources more effectively, mobilizing resources through public-private partnerships and reducing out-of-pocket payments through initiatives such as national health insurance and waiving user fees for pregnant women and children under five.
- Request the AU Commission, in collaboration with partners such as the G-8, to develop a mechanism for AU Member States to access such funds.
- Institute a strong and functional monitoring and evaluation framework at country level to provide accurate, reliable and timely data on maternal, newborn and child health.
- Advocate the establishment of a task force to prepare an annual review of progress on maternal, newborn and child health.
- Extend the Abuja call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa (the Abuja Call) to 2015 to coincide with the MDGs.
- Provide sustainable financing by enhancing domestic resources mobilization including meeting the 15% Abuja target, as well as, mobilizing resources through public-private partnerships and by reducing out-of-pocket payments through initiatives such as waiving of user fees for pregnant women and children under five and by instituting national health insurance.

AU leaders agreed to... Provide sustainable financing by enhancing domestic resources mobilization including meeting the 15% Abuja target...

Bingu wa Mutharika

President of Malawi

Chairperson of African Union

European Commission

Strengthening national health systems to deliver high-quality health care for all

The successful completion of the United Nations Summit on the Millennium Development Goals (MDGs) has created a new momentum to deliver on our commitments to women's and children's health.

The European Commission's recently adopted communication "The EU role in Global Health" emphasizes solidarity towards equitable and universal coverage of quality health care, and we have made a firm policy commitment to support reductions in maternal and child mortality. Our focus is on strengthening national health systems to deliver basic, equitable and high-quality health care for all. The EU is part of the G8 Muskoka Initiative on Maternal and Child Health and, at the MDGs Summit, reiterated its commitment to intensify its efforts to achieve the health-related MDGs.

We are encouraged by the results of our action. Global figures on maternal and child mortality have revealed some progress. But whereas this progress is notable, it is less than half of what is needed to achieve MDGs 4 and 5.

The EU fully supports the UN Secretary-General's Global Strategy for Women's and Children's Health. It provides us with a common direction to meet the challenge of reducing maternal and child mortality through support for country-led health plans, integrated delivery of quality health services, stronger health systems, sustainable financing and improved monitoring. The Global Strategy is also contributing to progress on related MDGs, including poverty reduction, gender equality, education, water, sanitation and nutrition. The MDGs are interconnected: we cannot achieve one without another.

The EU is part of the G8 Muskoka Initiative on Maternal and Child Health and, at the MDGs Summit, reiterated its commitment to intensify its efforts to achieve the health-related MDGs.

The EU has been and will remain substantially engaged in achieving MDGs 4 and 5. The European Commission will contribute US\$1.42 billion over the next three years. The collective contribution of the Commission and the 27 EU Member States amounts to around US\$4 billion over the same period. In addition, at the MDGs Summit the EU announced an MDGs initiative amounting to €1 billion to make progress on those goals we are furthest from achieving. This includes support for national plans that aim to accelerate progress towards MDGs 4 and 5. The Commission has also increased its contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria by 10% – to €330 million over the next three years.

Funds alone will not make the difference. We need political commitment, and we need to translate that commitment into sustainable action. We need equity, not only between countries but also within countries, ensuring universal access to basic quality health care. We need to implement the aid effectiveness agenda and we need to increase policy coherence. The EU has therefore increased its commitment to channel health Official Development Assistance (ODA) through partner countries' own development programs and using partner countries' procurement and public financing management systems. The EU has also increased its funding predictability and is improving policy coherence, for example with regard to access to medicines, availability and migration of health professionals, food security, food assistance and nutrition.

José Manuel Barroso

President of the European Commission

The Regional Task Force for the Reduction of Maternal Mortality

A joint response in the Latin American and Caribbean region

The reduction of maternal mortality remains a priority in Latin America and the Caribbean, because 10,000 mothers still die there each year – despite a 41% reduction in the region’s maternal mortality ratio since 2000. The hardest hit belong to the poorest and most neglected sectors of the population, including rural and indigenous women and adolescent girls. This reflects the entrenched inequalities in Latin American and Caribbean countries, and highlights the need to implement proven strategies to eliminate avoidable maternal mortality.

The Regional Task Force for the Reduction of Maternal Mortality (Grupo de Trabajo Regional, or RTF) consists of 23 partners and is currently chaired by UNFPA. It aims to achieve its goal by attracting political commitment from decision makers and leaders, through enhanced coordination, collaboration and evidence-based advocacy.

Active since 1998, the RTF has steadily increased commitment to maternal health within its member agencies, and has fostered intra-agency support for “good practices” and lessons learned. It has also helped national health providers, and other national partners, to mobilize resources and develop their capacities.

Regional priorities for 2011-2012

The RTF is helping countries to accelerate progress towards the targets of a 75% reduction in maternal deaths by 2015 and universal access to reproductive health services. It has provisionally identified the following priorities for 2011-2012:

- **Implementing the Safe Motherhood Initiative.** To protect and promote the rights of women, mothers and newborns of all ethnicities and backgrounds. This includes developing national and regional capacities, and identifying and disseminating best practices and lessons learned.
- **Promoting universal access to sexual and reproductive health (SRH), with special emphasis on reducing unsafe abortions and empowering women, adolescents and youths.** For example, Guatemala, Panama, Peru, Bolivia and Ecuador are promoting intercultural SRH models that encourage education and involve community and local-authority participation.
- **Strengthening national health capacities through in-service training and improved emergency obstetric care.** For example, Nicaragua and Venezuela are strengthening emergency obstetric care clinics and family planning. Haiti is establishing 10 emergency obstetric and neonatal care units in the wake of the January 2010 earthquake.
- **Improving the generation and use of SRH data to support better decision making and monitoring in maternal health.** For example, Brazil, El Salvador and Honduras are improving their data registries and capacity to estimate maternal mortality.
- **Strengthening the participation of communities and civil society, and enhancing social auditing at national and/or subnational levels.** For example, Bolivia and Nicaragua have established social auditing mechanisms and are improving in-service training at national and subnational levels.

The RTF provides a successful model for effective collaboration between health agencies and other partners to accelerate the reduction of maternal mortality in Latin America and the Caribbean. Above all, it proves that a joint response is often the most effective.

Marcela Suazo

Director, Latin American and Caribbean Regional Office
UNFPA

Civil society organizations

Introduction

Civil society includes a vast array of organizations – including the business community, faith-based organizations, philanthropists, NGOs, health-care professionals associations and academic and research institutions – all of whom have a critical role to play in making the Global Strategy a reality. New organizations that have never before played a part in women’s and children’s health are clamoring to contribute.

There is already incredible momentum from civil society. At the MDGs Summit in September, civil society organizations (CSOs) committed over US\$9 billion to improve women’s and children’s health and made significant non-monetary commitments.

The role of civil society

Financial commitments are just the starting point. Civil society can and does contribute through service delivery, infrastructure development, human resource capacity building, advocacy and accountability. This assistance is especially valuable because many organizations use their strong local ties to tailor their support to the needs of local communities.

A lot of the problems impacting women and children in developing countries could be addressed today by applying innovative approaches. Already, many organizations are sharing innovative and creative ideas from their core areas of expertise. For example, mobile and broadband access (when available) can be used to educate, collect data and deliver health services to women and children.

Increasingly, CSOs are collaborating with each other and with governments and multilateral agencies to deliver goods and services more efficiently and effectively. They are cooperating with new players, such as Intel and the Ty Danjuma Foundation, by using the unique organizational advantage of each player. They are sharing best practices and capabilities across organizations, so as many women and children as possible can benefit.

CSOs bridge the divide from the highest levels of governments to the furthest corners of the world, thus elevating the concerns on the ground to the decision-makers who can address them. As a result, civil society plays a critical role in holding governments and multilateral organizations accountable for delivering on their pledges. They track donations down to the grass roots and clinic level, and encourage leaders to deliver on their promises when they do not see tangible results on the ground.

A challenge to civil society

The MDGs focused on women’s and children’s health cannot be reached by governments and the UN alone. NGOs, philanthropic foundations, businesses and health-care professionals associations are ready and willing to devote their time, talents, resources and energies to these complex problems. In the following pages, selected organizations explain what they will do to make the Global Strategy for Women’s and Children’s health a reality. Given the immense potential and scope of CSOs, it is right that civil society leaders should strengthen their efforts for women and children by increasing their fundraising, expanding the services they offer, developing innovative solutions to the most pressing issues and holding themselves and others accountable for results.

Intel

Combining Public/Private Partnerships with a Comprehensive Design Approach is Improving Women's and Children's Health

As a leader in ICT innovation, Intel's activities increase technology access to enrich lives and stimulate opportunity. Intel's experience shows the power of collaboration between governments, private-sector companies and NGOs in initiatives that employ the latest technology to improve women's and children's health. In the coming decade, we expect to make great strides as we develop solutions to major global problems in healthcare, education and the environment.

Digital Health technologies are essential to improve the quality of and access to healthcare for women and children. Intel focuses on four major elements.

Public/Private Partnerships — the Key to Success and Sustainability

Healthcare programs and initiatives driven by public/private partnerships have more support from stakeholders, more innovative designs, faster deployments, faster time-to-healthcare services and greater sustainability. Intel focuses on developing partnerships that include national and regional government officials, local community leaders, private-sector companies and NGOs. It has found that this not only yields better initial results but also removes obstacles to scaling up initiatives from pilots to full programs.

The Mailafiya ("Giver of Health") project in Nigeria has been developed by the provincial government, the Ministry of Health, local healthcare providers, tribal leaders, Intel, and open-source software providers. It deploys mobile healthcare teams to 800 underserved villages with little or no access to basic healthcare, and includes comprehensive worker training, off-road trucks, basic healthcare tools, essential medications and ruggedized netbooks. The program has increased the number of patients with clinical interaction by 270% and increased diagnoses of chronic diseases impacting maternal and child health by 900%.

This decade we will create and extend computing technology to connect and enrich the lives of every person on earth

Infrastructure Development That Enables Better Health

Increased broadband access drives better health directly (through health programs using broadband) and indirectly (through increased socio-economic growth). The effects of Intel's broadband programs are considerable and pervasive, as broadband increases national competitiveness and enables faster communication. Studies indicate that a 10% increase in penetration accelerates economic growth by about 1.4 percentage points in developing economies, leading to better health for women and children.

To increase broadband access, Intel collaborates with governments, telecommunications operators and local organizations to reduce costs and complexity and enable low-cost access for citizens, students, seniors, healthcare professionals and small businesses. Intel serves as a catalyst between governments, industry and NGOs to accelerate solutions and programs and to remove complex policy and technical obstacles. Intel also participates in the development of Universal Service Fund policies and programs that use tax and subsidy structures to provide a baseline level of telecommunications services to more citizens.

Building Greater Community Health

Intel leads many programs that improve the quality, cost, and accessibility of healthcare services for women and children. Intel's expertise in digital technology helps governments and healthcare leaders improve health education, enhance health worker productivity, increase clinic efficiency and expand access in underserved areas.

In Bangladesh, Grameen-Intel — a joint venture to promote social entrepreneurship through ICT solutions that target major social problems — created a maternal health solution. Currently deployed in rural clinics, this improves pre-natal care for mothers using a solution based on mobile phones and computers. Local healthcare providers use a phone-based pre-natal survey to identify high-risk pregnancies, enabling faster treatment by clinics and follow up by mobile health workers. It delivers better healthcare and creates entrepreneurship opportunities for women.

Empowerment and Expanded Opportunities for Women and Children

Through education and entrepreneurship programs, Intel and its partners are expanding the opportunities available to women and children, improving incomes, quality of life and health.

Our education programs help children across the globe, improving their health and opportunities. Intel's efforts focus on blends of technology, programs and resources to maximize effectiveness and scalability. The skool™ Interactive Learning and Teaching Technology program provides online access to relevant, localized resources (including education on diet, pregnancy and chronic disease). Skool is available in 23 countries and seven languages, and serves 3 million students. Overall, Intel has invested \$1 billion in education, trained 8 million teachers in 60 countries and established 200 educational programs in 70 countries.

In Bangladesh, an innovative program developed in partnership with NGO D.Net* trains and equips women entrepreneurs to bring advanced technology and communications to villages that have no internet access. Using bicycles in rural communities, these women carry a low-cost PC, a mobile phone with Internet connectivity, a digital camera and a headset, and give access to information, services and technology to 130,000 people in 15 villages. They earn a good living while providing important services.

Intel will continue to work with governments, the private sector and NGOs to develop sustainable solutions, transforming women's and children's health worldwide.

Paul S. Otellini

President and Chief Executive Officer
Intel

Bharti Enterprises

Mobile information and communication technology can transform millions of lives

Wireless telephony reaches far more people than any other technology. There are now more than 5 billion people across the world connected by mobile, more than 70% of whom live in low- and middle-income countries. More than 85% of people live in areas covered by mobile networks. It's now time to leverage the growing strength of wireless telephony to transform global health.

Information and communications technology (ICT) in general, and wireless telephony in particular, could enable us to get the right healthcare information to the right person at the right time, wherever they are. It can support diagnosis and treatment efforts, power the collection and sharing of health data, and advance education and research in the most remote environments. It can extend the delivery of health services by promoting healthier lifestyles, offer continuing education and disease outbreak alerts, and send instructions to rural health workers, connecting them with urban experts. It can support the continuum of care by giving patients and health providers instant access to secure electronic health records and decision-support systems.

Mobile solutions are already used all over the world in scores of pilot projects, illustrating the potential of "mHealth". Now we must integrate solutions across the continuum of care by combining the strength of modern technology with the expertise of dedicated health professionals. This requires a high degree of public and private cooperation, understanding and leadership. Indeed, the greatest barrier to the rapid and effective deployment of mHealth is that we have not yet made these connections – at the level of national governments, districts, and villages.

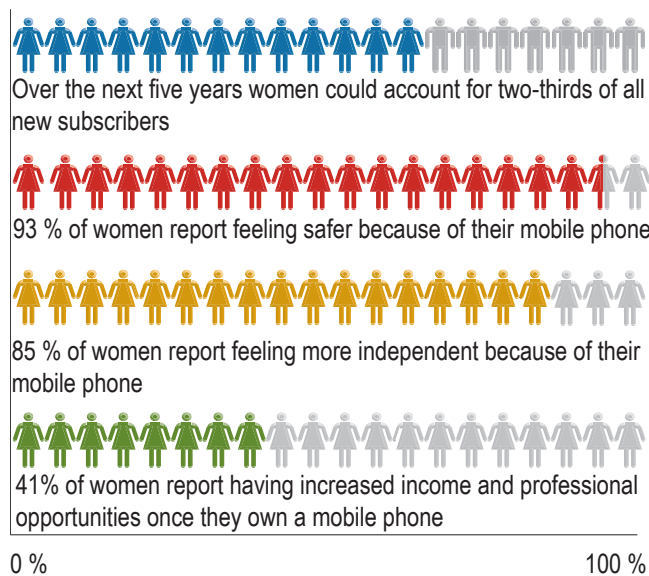
The Global Strategy for Women and Children's Health makes a powerful call for more innovation, particularly for the use of wireless technology. We take up that challenge, and are committed to:

- Extending our networks and services to everyone we can possibly reach
- Partnering with the UN and other organizations to develop mHealth best practices
- Supporting mobile health initiatives such as the mHealth Alliance and the Maternal mHealth Initiative of The Partnership for Maternal, Newborn and Child Health to achieve the Health Millennium Development Goals (MDGs)
- Bringing together leaders of the wireless and ICT industries with leaders of health, public and non-profit organizations to achieve sustainable solutions.

Mobile ICT can transform millions of lives. We look forward to working with friends across the world to implement the Global Strategy and achieve the MDGs.

Sunil Bharti Mittal
Chairman and CEO
Bharti Enterprises

Mobile phones and women



Source: ICT

The Bill & Melinda Gates Foundation

Investing in the health of women and children ensures that nations thrive

Investing in the health of women and children ensures that families, communities and nations thrive. This is something that UN Secretary-General Ban Ki-moon understands well, and I commend his leadership on the Global Strategy for Women's and Children's Health. This new global strategy will help global health stakeholders join together and save the lives of more than 16 million women and children. Another tireless champion is Norway's Prime Minister Jens Stoltenberg who has mobilized worldwide support for putting Millennium Development Goals (MDGs) 4 and 5 at the top of the global development agenda.

Commitment to Women and Children

Improving women's and children's health is my personal priority as co-chair of the Bill & Melinda Gates Foundation. We recently committed US\$1.5 billion in new grants over the next five years to support family planning, maternal, newborn and child health and nutrition programs in developing countries. This pledge complements our spending in other areas that affect women's and children's health, such as developing and delivering childhood vaccines and preventing and treating pneumonia, diarrhea, malaria and HIV/AIDS.

During this year's United Nations General Assembly, I joined U.S. Secretary of State Hillary Clinton, U.K. Deputy Prime Minister Nick Clegg, and Australia Foreign Minister Kevin Rudd in announcing the launch of a five-year global alliance to accelerate progress in averting unintended pregnancy and reducing maternal and neonatal mortality. Through this partnership, we hope to achieve more value for our investments by coordinating our implementation at the country level. The alliance will help reach 100 million women with an unmet need for family planning and will result in millions of mothers' and newborns' lives saved by increased access to needed maternal and postnatal care services

We have inexpensive and effective interventions that can save the lives of millions of women and children.

Progress and Challenges

The global health community should be proud of the important progress that has been made on MDGs 4 and 5 in recent years. Child mortality has declined from 12 million deaths to fewer than nine million deaths per year from 1990 to 2008. For the first time in decades, the number of women dying in pregnancy and childbirth has dropped significantly. Yet millions of newborns, children and women still die every year from preventable causes. Inexpensive and proven tools exist, from childhood immunizations and nutrition to safe childbirth practices and family planning. We must ensure that women and children have access to these life-saving solutions.

Time for Action

The global community is increasingly recognizing the moral imperative as well as the economic prudence of investing in women and children. We have inexpensive and effective interventions that can save the lives of millions of women and children, resulting in healthier families, communities, and nations.

Safeguarding the health of mothers and children is one of the most urgent global health priorities. By working together, we can create a future where all women and children have the opportunity to live healthy, productive lives.

Melinda French Gates

Co-Chair

Bill & Melinda Gates Foundation

The TY Danjuma Foundation

Improving Maternal and Child Health in Nigeria

General TY Danjuma established the TY Danjuma Foundation in 2009 as an independent grant-making organization. Based in Abuja, Nigeria, it makes targeted grants to help build a Nigeria where all citizens have access to affordable, quality health care and education, and equal opportunities to realize their potential.

As a not-for-profit philanthropic organization, the Foundation works through Non-Governmental Organizations (NGOs) and Community-Based Groups (CBOs) in Nigeria within its four focus areas: Community Health Initiatives; Education; Income Generation; and Policy Advocacy. In addition, the Foundation is also dedicated to promoting locally driven philanthropy in Nigeria.

Women and children are a focus of the Foundation's strategy. To this end, it helps NGOs to enhance community health care by providing free medical and surgical care (e.g. gynecological surgery and cesarean sections) and donating medical equipments. The free health care reached about 47, 000 people in 2009, 1590 of these were surgical cases. The Foundation also supports training for hospital personnel and technical assistance for rural health facilities.

Other direct benefits to women include free family planning, nutrition counseling and reduction in pregnancy complications from Neglected Tropical Diseases (NTDs) such as onchocerciasis (river blindness). Furthermore, children in targeted communities benefited from free vitamin A. In poor rural communities, the Foundation supported the renovation of bore holes and hand pumps, so women and children no longer have to walk long distances to fetch water from infected sources. This has reduced diarrhea in children and improved the socioeconomic status of women.

In 2010, the Foundation awarded grants to 16 NGOs to provide interventions in nine states of the country. These interventions include:

More indigenous private-sector and philanthropic contributions are needed in Nigeria to counter the

- Free obstetric and gynecological surgery,
- Rehabilitation of bore holes and village hand pumps,
- Treatment and support for people with leprosy,
- Provision of youth-friendly health facilities,
- HIV education,
- Control of NTDs,
- Free eye care and eye surgeries,
- Education on basic sanitation and hygiene,
- Improved school hygiene facilities to encourage adolescent girls to attend school.

strong reliance on the government and foreign donors to provide finance. As convener of the first Nigerian Philanthropy Forum, the Foundation aims to promote philanthropy in Nigeria and to broaden the scope of actors and institutions' involved in philanthropy. The Executive Director of the Foundation serves on the African Women's Leaders Network (AWLN) on Reproductive Health, which is another avenue to increase awareness of the need to invest in maternal and child health.

Since its establishment in 2009, the Foundation has given more than US\$10 million in grants. It has also committed over the next five years to earmark a minimum of US\$5 million specifically for maternal and child health in rural communities, as its contribution to ensuring that Nigeria attains the Millennium Development Goals (MDG) goals by 2015.

Thelma Ekiyor

Executive Director

TY Danjuma Foundation

Non-Governmental Organizations

Joint statement: How we will deliver

The health and well-being of women and children are at the heart the Millennium Development Goals (MDGs). And non-governmental organizations (NGOs) are at the heart of efforts to achieve the MDGs, fighting to ensure that policies and programs reflect the priorities of women and children, especially those living in the poorest and most marginalized areas.

The NGO world is as diverse as the communities it represents and serves, and the roles NGOs play are equally diverse. NGOs educate, empower, advocate, mobilize, train, treat, innovate and monitor. Above all, we act – with and for the people we serve – to fight for the rights and needs of the vulnerable in communities around the world.

NGOs helped shape the Global Strategy as it was being written, and pledged more than \$6 billion (15% of the total announced on 22 September). Moving forward, we will play an equally central role in implementing the Global Strategy, working individually, collectively, and with partners, to:

- Develop, test and evaluate innovative approaches to delivering essential health and social services, especially for the most vulnerable
- Strengthen community and local capabilities to adopt and scale up implementation of proven interventions
- Educate, engage and mobilize communities
- Track progress and hold all stakeholders (including our own community) accountable
- Advocate for increased attention to and investment in women’s and children’s health

Advocacy

Advocacy is a role for which NGOs are widely recognized, and it will continue to be central to what we do – globally, regionally, nationally and locally. We must continue to push governments, donors, and others with resources and power to invest and support progressive action. We will leverage our relationships with local communities to articulate their needs and work with grassroots partners to advocate for the services that respond to their demands. For example, Family Care

International (FCI) has committed to work with civil society partners in the countries that have made commitments to the Global Strategy to ensure that those commitments are realized; Women Deliver has pledged to mobilize its 15,000 advocates around the world to push political leaders to take action now and to engage youth and corporations in working to implement the Global Strategy.

Above all, we act – with and for the people we serve – to fight for the rights and needs of the vulnerable in communities around the world.

Service Delivery

NGOs will act urgently to address key gaps in the delivery of services, building community awareness and strengthening skills so that families understand the critical issues and take ownership and responsibility for their own health. NGOs will also continue to invest in innovative approaches to reach the most vulnerable populations. Save the Children will help train and educate 400,000 health workers to address the need for life-saving services. The International Planned Parenthood Federation (IPPF) will help increase coverage of family planning services by increasing new users of its services by at least 50% by 2015. World Vision is working with households by scaling up support groups for mothers; with communities to train volunteer health workers and breastfeeding counselors; and with districts to implement new clinical protocols for key childhood diseases. BRAC is working in partnership with governments and UNICEF to provide

comprehensive health interventions to over 25 million people living in Bangladesh’s rural areas and slums, and will take bold steps to reach an additional 80 million people in the next five years, 2011-15. CARE will work to improve poor women’s access to services by educating, empowering and mobilizing communities around their health rights and bringing them together with healthcare providers and local governments so that each is held accountable for their responsibilities to improve health.

Accountability

Through our work on the ground, particularly with marginalized communities, NGOs serve as watchdogs, monitoring government and donor compliance – or failure – in meeting financial, service and policy commitments. The White Ribbon Alliance mobilizes and empowers women and communities to directly challenge health managers and elected officials when the quality of services is not what they expect – and have a right to receive. World Vision’s five-year global campaign Child Health Now will engage governments in over 100 countries to fulfill their commitments and empower communities to advocate for more effective local, provincial and national responses.

NGOs, in partnership with a range of stakeholders, are making incredible strides in improving the lives and health of women and children worldwide. Many have stepped forward to reaffirm and increase their commitments over the next five years through the Global Strategy. NGO leadership and commitment is critical to this global effort. The international community and national governments must work with NGOs as equal and essential partners for health care and development, in planning, monitoring and implementing the important commitments made through the Global Strategy. Together, we can improve the health of women and children around the world, and make achieving MDGs 4 and 5 by 2015 a reality.

Fazle Hasan Abed
BRAC

Theresa Shaver
White Ribbon Alliance

Robert Glasser
Care International

Jill Sheffield
Women Deliver

Gill Greer
International Planned Parenthood Federation

Ann Starrs
Family Care International

Kevin Jenkins
World Vision International

Jasmine Whitbread
Save the Children

Foundation for Community Development

Closing the gap to meet the MDGs

With just five years to meet the MDGs, there is still much to do. Unless we make radical adjustments, we will fail to meet the health MDGs – an avoidable and unacceptable tragedy when the lives of millions of women and children are at stake.

It is not enough to hope, promise and envision. We need to translate the Global Strategy for Women's and Children's Health into action plans. We need targets against which we can measure progress and hold leaders and ourselves accountable.

Three actions can be taken now:

1. **Articulate costs.** To understand where the greatest needs exist, countries should reassess their progress. This means determining which initiatives are working, which should be adjusted or discontinued, and what additional actions are needed. For example, countries must ensure that health systems with qualified personnel are within reach of local communities so services are delivered in a timely and efficient manner. The investment required to build clinics where health services are not available must be realistically costed. Once gaps have been quantified, governments should commit to the areas that national health budgets will cover. Remaining gaps should be shared with the international community. NGOs can also collaborate with governments, take ownership of specific initiatives, and avoid duplication.

2. **Build social pacts.** Governments alone cannot deliver on the promise of health for all. Sustainable changes require social mobilization of leaders, civil society, the private sector, religious organizations, and every woman. This collaboration must translate into a social pact that includes all stakeholders and citizens, and defines the health services that partners will deliver. This must then be clearly communicated to every town, village, family and individual. This empowers local communities to take ownership of the health of their women and children and to demand accountability on the basis of this social contract.

Sustainable changes require social mobilization of leaders, civil society, the private sector, religious organizations, and every woman.

3. **Develop awareness.** Having sufficient financial and personnel resources is insufficient. People must understand when and how to access health services. Education is critical and often a missing link between women and the delivery of needed services. Women intuitively understand threats to health, but they need to be educated on how these can be prevented and given the means to take action. Women also need to be informed of their right to have health services available and accessible to them. Unless women know where clinics are, can reach them, have the means to go to the clinic and have the support of their families to seek care, they will continue to risk giving birth at home. Women need to understand that there are HIV treatments and ways to avoid transferring it to their babies. Without education, strengthening of delivery services will prove ineffective. Countries need to understand this reality and allocate resources appropriately.

We have five years to deliver on the MDGs commitments to the poorest women and children. We have the capabilities, the resources and the determination to meet these goals. By understanding the investment that each country needs, developing social pacts and educating individuals on health seeking behaviors, we can accelerate progress and improve the lives of millions.

Graça Machel

Founder and President

Foundation for Community Development

World Council of Churches

Faith and compassion can help us implement the Global Strategy

Every year, 8 million children die from preventable causes, and 350 000 women die from preventable complications in pregnancy and childbirth. The World Council of Churches (WCC) believes that these losses contradict basic principles of human dignity, equity and justice. No woman should die giving life, and no child should die from easily preventable causes. The situation requires immediate, sustained and collective action of the type envisioned by the Global Strategy for Women's and Children's Health.

The Global Strategy is a rallying cry for civil society organizations (CSOs) of all kind to press for stronger action on women's and children's health. Faith-based organizations (FBOs) have a high level of social capital – through their long history of people-centered work and civic partnerships with governments and other decision-makers – and are trusted sources of support and services for many, especially the most vulnerable. Moreover, the moral authority of religious leaders gives them enormous potential to inspire and unite people across national borders, and to confront and change harmful practices in society. FBOs are therefore key partners in the development process.

The WCC is committed to the Global Strategy through a specific project. This aims to mobilize FBOs and CSOs to work together across belief and value systems, to be accountable and to hold governments accountable. To encourage FBOs and other organizations to consult freely on the Global Strategy, the WCC has forged alliances with Religions for Peace, the African Council of Religious Leaders, Islamic Relief, the African Christian Health Association Platform and many national religious and interreligious organizations. These alliances are in 13 countries: Afghanistan, Armenia, Bolivia, Ethiopia, India, Indonesia, Kenya, Malawi, Moldova, Mozambique, Niger, South Africa and Zimbabwe. This initiative also enjoys the support of a broad base of national governments, UN agencies and other international organizations.

Preliminary results from the WCC initiative confirm that the Global Strategy could have a far-reaching impact if governments and other stakeholders meet their commitments. Our engagement work is bringing together members of governments, health-care workers, technical experts and representatives of both civil society and the private sector. This is a concerted effort to form national and regional plans based on advocacy, information sharing and capacity building to translate the Global Strategy into tangible gains for women and children. We can already see this campaign taking root in several other countries.

FBOs are committed to ensuring that: pregnant women, mothers and children get the care they need; children are safe from preventable illness; and sexual and reproductive health services are available to all. We believe that love and compassion can positively affect public health if faith communities work in partnership with governments and civil society. Working together under the umbrella of the Global Strategy is the best current option for meeting the health-related development goals by 2015.

Olav Fykse Tveit

General Secretary

World Council of Churches

Health Care Professional Associations

Commitments for the Global Strategy

Health Care Professional Associations (HCPAs) are an official constituency groups within The Partnership for Maternal Newborn & Child Health (PMNCH) and are essential to the success of the UN Secretary-General's Global Strategy. HCPAs are typically linked closely to academic institutions and provide technical expertise in research, innovation, education, training, policy development, standards, guideline development and advocacy along the continuum of care at the international and national levels. Typically, the expertise of HCPs is provided gratis, a significant voluntary contribution that is largely unrecognized.

The commitments by HCPA's from April 2010 until the launch of the Global Strategy totalled US\$31.2m, of which the in-kind contribution is the most significant and represents a major leverage factor for funding agencies. Since that time, the International Paediatric Association has committed an additional \$24.5m, for a revised total of \$55.7m, with more from other HCPAs pending.

HCPAs are committed to working collaboratively with other partners (Ministries of Health, NGOs, UN agencies and Bilaterals) in 25 countries across Africa, Asia and Latin America over the next five years to help integrate RMNCH policies and develop common frameworks for action across medical, midwifery and nursing institutions and district-level health systems. The HCPAs will also work to strengthen health systems through better human health resource management. One important activity is task shifting / sharing, where tasks normally performed by a physician are carried out in a limited fashion by a health care professional with less education. The HCPAs can help countries assess where task shifting could be useful and help develop training and evaluation programs. The HCPAs will focus on working with policy and implementing agencies to improve coverage and quality (effective coverage) of the key 22 Countdown supported interventions in these 25 target countries by at least 20% between 2011 and 2015. Collectively these commitments are estimated at \$15m of in-kind contribution. Often, the rate-limiting step for commitments is the required funding to deliver a program to improve coverage and quality of key interventions, rather than the in-kind contribution.

In addition, specific commitments included to date have been made by:

- The International Federation of Gynecology and Obstetrics (FIGO) – \$7.2m (2010-2014).
FIGO and Gynuity will focus on working collaboratively to improve coverage and quality in reducing maternal mortality and morbidity from post-partum haemorrhage, beginning with Nepal, India, Burkina Faso, Cameroon, Ethiopia, Mozambique, Nigeria and Uganda.
- The International Confederation of Midwives (ICM) – \$2.5m (2011-2015).
ICM will work collaboratively to further strengthen midwifery associations in order that they contribute to RMNCH policies at government levels and provide in-service training in Basic Emergency Obstetric Newborn Care. ICM will also help countries implement standardized competencies, education and regulation frameworks for midwives. ICM will work with HCPAs and stakeholders to develop policy to improve coverage and quality of midwifery services.
- The International Paediatric Association (IPA) – \$27.4m (2010-2015)
IPA aims to develop a cadre of 50 champions for promoting childhood immunizations and achieving Millennium Development Goals (MDGs) 4 & 5, by working closely with GAVI, in-country EPI programs and UN agencies to increase vaccination coverage by 30% and improve access to core interventions in 80% of target areas. In addition, the IPA member organizations in Africa, Asia and Latin America are joining with the Global Development Alliance (AAP, USAID, Save the Children, MCHIP and Laerdal Corporation) to help train more than 1 million providers in neonatal resuscitation and essential newborn care. The IPA with WHO will engage more than 150 paediatric organizations in education programs regarding tobacco use, environmental health and adolescent health over the next five years.

- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) – \$252,000 (2010-2011)
RANZCOG will develop partnerships with governments and NGOs enabling funding to be directed to activities for improving outcomes in Pacific Island Country and Territory (PICT), especially PNG and Fiji, to assist local healthcare workers to advocate for increased resources at a local level for maternal and child healthcare through associated financial and policy commitments and activity.
- Royal College of Obstetricians and Gynaecologists (RCOG) – \$1.96m
RCOG/LSTM will focus on skills training in Life Saving Skills & Essential Obstetric and Newborn Care for health care workers and trainers. RCOG/LSTM will work with policy and implementing agencies to build capacity and quality (effective coverage) of obstetric and newborn services in at least four new target countries between 2010 and 2015, including Libya, Pakistan and Nigeria.
- Society of Obstetricians and Gynaecologists of Canada (SOGC) – \$850,000
SOGC will work with policy and implementing agencies to improve coverage and quality of EmONC in at least one country per year between 2010 and 2015. SOGC will focus on skills training in Emergency Obstetric/Newborn Care for at least 40 health care workers and 6-7 trainers to deliver the AIP course in each target country each year – Haiti, Morocco and Mali. This course includes monitoring and evaluation, maternal death audits and a Train the Trainer module.
- The World Federation of Societies of Anaesthesiologists (WFSA) – \$556,000
WFSA will work with policy and implementing agencies to build capacity and quality of obstetric anaesthesia services in Bangladesh, Nepal, Kenya and Uganda between 2010 and 2015. WFSA will focus on skills training in obstetric anaesthesia for 60 health care workers and trainers to deliver the Train the Trainer course in each target country. The Global Pulse Oximetry Project, developed in conjunction with the WHO to improve patient safety, will be implemented in target countries as funding is obtained.

Gamal Serour

President
International Federation of Gynecology and Obstetrics (FIGO)

Edward W. Weaver

President
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Bridget Lynch

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William Keenan

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Executive Vice-President
The Society of Obstetricians and Gynaecologists of Canada

Angela Enright

President
World Federation of Societies of Anaesthesiologists

Academia, research and training institutions

Laying the groundwork for progress in women's and children's health

Academic, Research and Training (ART) institutions represent partners whose primary function within reproductive, maternal, newborn and child health (RMNCH) is to: generate, synthesize and disseminate knowledge and evidence, and ensure this is understood by decision-makers, and/or conduct teaching and training programs.

ART partners include universities, health-professional schools, research institutes, science establishments and training organizations working in the field of RMNCH. We believe that the Global Strategy for Women's and Children's Health will be an effective mechanism to increase momentum towards the Millennium Development Goals, and to mobilize resources for women's and children's health worldwide. We are honored to support this unique global effort.

Coordinated research agenda for women's and children's health

The Global Strategy calls for a coordinated global research agenda for women's and children's health. As the lead stakeholders in this agenda, we shall endeavor to expand research in this area to develop new interventions and more-effective models of delivering care.

We commit to a range of activities to achieve a coordinated research agenda. These include developing and synthesizing context-specific evidence to inform policies and programs, and conducting studies into the implementation and evaluation of health programs under real-world conditions. It is also important to innovate affordable solutions by harnessing novel approaches and technologies, and to create a more efficient pipeline of research – from discovery to development and from development to delivery.

High-quality evidence and analysis are essential, so the ART partners will provide evidence and analytic inputs to systems for program monitoring and evaluation. We will ensure that these and our other results are given to countries and understood by them. And, last but not least, we will help to educate and train the health workforce

To create a coordinated research agenda, we will require strong partners at institutions around the globe. To achieve our aims, we further commit to build the research and innovation capacity of at least 100 research institutions (75% belonging to low- and middle-income countries) and establish a global network of academics, researchers and trainers from developed and developing countries.

Next steps

We are far from achieving a coordinated global research and innovation enterprise, as envisaged by the Global Strategy, which would require new resources and efficient systems to coordinate its activity. We therefore call for the allocation of a fixed proportion of country budgets and donor assistance to research and innovation, and the creation of an agile Research and Innovation Fund for Women's and Children's Health.

With additional resources and a dedicated fund for research, we can answer critically important questions about women's and children's health, and help people in dire need.

Representing the ART constituency of The Partnership for Maternal, Newborn & Child Health:

José M Belizán

Chairman, Department of Maternal & Child Health Research
Institute for Clinical Effectiveness and Health Policy, Argentina

Vinod Paul

Chairman, Professor, Department of Pediatrics
All India Institute of Medical Sciences, India

Jane Schaller

Professor of Pediatrics Emerita
Tufts University

Women's and children's health: keeping the promise

World leaders at the MDGs Summit in New York reaffirmed their support for improving women's and children's health – with commitments to policy changes, financing and service delivery. The challenge is to ensure that pledges made at international conferences are delivered on the ground – on time and in full.

Changing the lives of the poorest women and children goes well beyond money. It is about the way health services are financed and provided. It is about the way policies influence the status of women – their position in the family and their power in the community. It is about removing the social and economic obstacles that limit access to care. If these are the changes we are committed to, these are the changes we now have to measure.

The World Health Organization (WHO) has been asked by the G8 and by the UN Secretary-General to lead new work to strengthen accountability for women's and children's health¹.

The importance of accountability

Accountability ensures that promises made become promises kept. It requires accurate and timely information about commitments that have been made. Governments that have and use accurate and timely information about the ongoing status and outcomes of their plans are much more likely to be successful. At the local level, accountability requires that impact is measured, allowing leaders to identify which initiatives are effective and which should be discontinued. It empowers the public so that individuals know the benefits and the services they should receive and can call leaders to account when those benefits are not provided. For health-care providers, a system of accountability provides baseline expectations that must be met in order to secure future investment and to meet international standards. For donors, a system of accountability reminds and encourages organizations to follow through and deliver on promises made towards women's and children's health. Pledges that are announced publicly, and which are tracked by the international community, are more likely to be fulfilled. To engage and promote increased participation from the private sector, aid organizations must be able to articulate the connection between their work and its impact on maternal and child health. A holistic approach to accountability will result in goal-oriented implementers, a more informed and active public, more informed donors and a more supportive international community.

Key ingredients for accountability

Several ingredients are essential for an effective accountability strategy. First, stakeholders must be involved and their voices heard from the onset of the planning process. To strengthen women's and children's health we must leverage the ideas of governments, donors, multilateral agencies, philanthropic institutions, NGOs, the private sector and health care professionals to implement a realistic and relevant approach. Early consensus-building will encourage stakeholders to take ownership of the accountability effort and promote mutual accountability. The Accountability Working Group for the Global Strategy for Women's and Children's Health identified three core principles²:

- **Accountability must be tied to measuring results, especially outcomes and impacts.** This includes defining what success and progress are and assessing how collective actions contribute to improved outcomes
- **National leadership and ownership** are the foundation of accountability, so partners should align their accountability efforts in women's and children's health to national health strategies and national monitoring and evaluation platforms
- **Existing country- and global-level mechanisms and processes** should be built on, enhanced, standardized and strengthened. This could be achieved by harmonizing investments to strengthen national capacity, by enhancing and better integrating global mechanisms, and by reducing the number of reporting requirements on national governments.

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A strong country-led monitoring and evaluation platform as part of the national health strategy is the foundation for accountability. The platform includes an institutional and policy environment that aims for evidence-based decision making and transparency. The platform's technical framework provides the basis for rationalization of indicators and data collection, and for ensuring data sharing, data quality and analysis to inform country progress and performance reviews. By using international standards, country statistics can then be compared and analyzed against peers since the collection method and tracking approach will be aligned.

Globally, agreement on what information is to be collected and is most relevant to gather and analyze should be reached. Too often, global aid organizations require similar data but in a different structure, forcing governments to invest additional time and resources in reporting activities that add no extra value. Here again, a cooperative approach between the many international stakeholders to standardize reporting requirements is critical to reducing the countries' reporting burden. Joint investments in strengthening the country-led monitoring and evaluation platform – which should be the basis for all global reporting – are essential.

Accountability for results: counting every woman and every child

In order to be accountable for results on women's and children's lives, countries need to be able to count them. Many countries today are only able to report low-quality or partial data because of poor infrastructure and systems, insufficient record keeping, and a lack of qualified personnel. In particular, many countries do not keep track of basic information like births and deaths, which is essential for measuring progress in women's and children's health. Registration of births and deaths provides one of the few direct, continuous, cross-cutting sources of comparable data across the health MDGs. Although the strengthening of registration systems requires investment and integrated partner efforts, the payoff would be tremendous.

The absence of birth and death registration systems in low- and middle-income countries, and the resulting weakness of vital statistics on births, deaths and causes of death, has hampered efforts to build a reliable evidence base for health improvement and to directly measure the health MDGs.

Strengthening civil registration systems is a medium- to long-term effort, requiring high-level and sustained political commitment and resources, community involvement, and a solid legal foundation. However, actions can be taken right away to improve the quality and make better use of the systems that do exist, and implement strategies for generating vital statistics in the interim, while civil registration is strengthened. These include birth and death registration systems with partial coverage, and careful planning and harmonization of household surveys to collect information on vital events, as a near to medium-term strategy to provide more frequent information. Each country faces a different set of challenges, so strategies must be tailored accordingly.

The IT revolution provides new opportunities for civil registration systems, but it has not yet been harnessed in support of the development and improvement of birth and death registration systems in countries. The Broadband Commission's report emphasized the major opportunities to accelerate progress towards the MDGs that are provided by broadband networks, such as on-line health records and public-health information. Several projects, initiatives and partnerships have emerged that aim to link health action with information technologies, such as mobile phones, PDAs and web-based data systems. The challenge is to ensure that such efforts are driven by need rather than technology.

Cause-of-death data are a particular cause for concern. The quality of cause-of-death data is highly variable, even in health facilities where the International Classification of Diseases is used to certify and code causes of death. In many countries, the majority of deaths occur outside health facilities and there is no medical certification. Initial experiences of work to strengthen the analysis of causes of maternal death through maternal death audits have been very promising in India and other countries. Circumstances of maternal deaths are examined in order to find out why the death occurred. A maternal death audit should be a non-judicial review, one that goes beyond medical reasons to identify the social, economic and cultural reasons that led or contributed to the death.

Accountability for commitments: tracking investments and policies and getting the right instruments

Commitments made towards the Global Strategy can be divided into three categories: financial, policy and service delivery. Below we describe the known approaches to tracking each type of commitment as well as the gaps.

At the MDGs Summit in September 2010, two types of financial commitments were made. The first refers to resource flows within countries – for example Niger committed to increase health spending from 8% to 15%, with free care for maternal and child health, including obstetric complications management and family planning, over the next five years. Commitments of this type make up roughly 23% of the financial commitments to the Global Strategy. Tracking can be carried out by estimating beneficiary flows in National Health Accounts (NHA) or special sub-accounts on women’s and children’s health. So far, these have been done only as one-time studies by a few countries. More work needs to be done to convert these into annual monitoring instruments.

The second type of financial commitments is that made by donors to provide resources over a defined time period. However, the existing systems have limited or no reporting of disbursements from new and emerging donors, civil society organizations (CSOs), the private sector and philanthropic institutions. Tracking international financial commitments as they are converted to disbursements that are made available for use by countries is key. However, the direct linkage to health outputs and outcomes can only be done if the actual spending in the country is tracked.

For all financial commitments – both national and international – there is a need to agree on what constitutes a new commitment and the degree to which new funds are genuinely additional. In addition, for financial commitments expressed as additional contributions for general health, there is a need to agree on what is to be counted and tracked as contributions to women’s and children’s health.

Policy commitments include amendments to country laws or statutes. Bangladesh, for example, committed to implementing a minimum legal age for marriage, in an effort to curb adolescent pregnancy. Service delivery commitments focus on providing or targeting services for women and children. For example, the Liberian government announced it would increase the number of facilities providing emergency obstetric care and increase coverage of childhood immunization to 80%. Policy and service delivery mechanisms are currently tracked by the International Health Partnerships Plus (IHP+), which uses a scorecard to monitor partners’ performance in meeting their commitments. In addition, there are a variety of similar tracking bodies in place that focus on specific countries or initiatives. Many of the same challenges mentioned above apply to tracking these types of commitments: lack of tracking of non-traditional actors, limited capacity at country level to track progress against commitments and lack of a common approach to tracking data across countries.

There are already instruments and reporting mechanisms that track progress towards women’s and children’s health and empowerment. Monitoring of the MDGs provides a means for benchmarking and assessing progress towards human development. MDGs monitoring takes place at the global, regional and country levels. The human rights monitoring process also systematically brings together multiple stakeholders, linked to international and national policies and programs, and provides a forum to promote mutual accountability towards achieving progress. In relation to human rights, accountability is centered on two levels. At the inter-state level, states have to report their compliance with their treaty obligations. States are also accountable to individual citizens as rights-holders at both the domestic and international level, through the Universal Periodic Review process and human rights treaty bodies, such as the Committee on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. Mechanisms for state accountability also include parliamentary oversight and investigations, national human rights institutions and external monitoring by media and NGO investigations. States’ responsibilities in relation to human rights issues include and extend beyond the MDGs.

There remain significant challenges to implementing a culture of accountability for all stakeholders in the effort to improve the health of the neediest women and children:

- There is no single process or body in place that consolidates the information tracked by these mechanisms and provides an overview of the progress made against women's and children's health
- There is no commonly accepted approach or framework to ensure that comparable and reliable data are collected through the different processes and approaches.

What should be done?

With 2015 quickly approaching, we need answers quickly. Many of the building blocks for improving accountability exist – what is needed is an effort to bring them together. We are therefore committed to work with countries and their partners to build consensus on the way forward and to develop political and technical solutions that will make greater accountability possible. To this end, we are establishing a high-level process to address all aspects of accountability for the health of women and children. The process will be inclusive involving countries, UN agencies, academia, civil society, health-care professionals and the private sector. It will also be multi-disciplinary, engaging experts from the fields of health, statistics, financing, politics, justice/internal affairs, gender and human rights.

This process will lead to recommended actions in three main areas:

1. Enhancing countries' accountability by better counting of critical events, especially number of births, number of deaths and causes of death
2. Harmonizing existing accountability efforts to agree on an accountability framework to monitor pledges, results and resources, at the national and global levels, including who will be responsible
3. Identifying and harnessing opportunities for innovation in accountability using information technology to bring maximum benefit to countries.

We commit to beginning work in early 2011 and to bringing the recommendations arising from this process to the attention of ministers of health during the World Health Assembly in May 2011. Final recommendations and action points will be provided to the G8 Summit and to the UN General Assembly later in the year.

We look forward to working with you on this critically important area in the year ahead.

Margaret Chan

Director General
World Health Organization

Delivering as One UN

Given the need for vastly better health for poor women and families worldwide, the UN's Population Fund (UNFPA), UNICEF, the World Bank, and the World Health Organization mobilized their efforts in 2008 to better harmonize their maternal and child country programs.

Referred to as the H-4, the Heads of agencies issued a 'Joint Statement on Maternal and Newborn Health – Accelerating Efforts to Save the Lives of Women and Newborns', which described how the agencies would champion more coordinated, complementary approaches, which would reduce the administrative burden on developing country governments, while promoting better aid effectiveness. In mid-2010, UNAIDS joined the four UN agencies, subsequently referred to as H4+.

To date, the group has jointly programmed its maternal and newborn health work in countries such as Bangladesh, Ethiopia, Nigeria and Pakistan; mapped the respective roles and responsibilities of each of the H-4 + partners; coordinated support in the 25 countries with the highest burden of maternal mortality; and carried out joint technical support missions.

'Delivering as One' mirrors the call by the UN Secretary-General for system-wide coherence and coordinated support to countries in their efforts to achieve the MDGs and other internationally agreed development goals, and extends to H4+. This approach has been formally pursued in pilot countries, such as Pakistan and Vietnam, where the UN has a single-country program, as well as in other countries in the spirit of The Paris Declaration¹ and The Accra Agenda for Action². Wider partnership mechanisms operating at country level, such as the International Health Partnership and Related Initiatives (IHP+), engage an increasing number of national governments, multilateral agencies and civil society organizations.

Building on the work to date, the H4+ agencies have been tasked by the UN Secretary-General with building support and mobilizing commitments at country level for implementing the Global Strategy for Women's and Children's Health, which was formally launched on 22 September 2010. In support of the Global Strategy, WHO, UNFPA, UNICEF, UNAIDS and the World Bank have collectively committed to mobilizing political support for the Global Strategy in the 49 lowest-income countries; increasing the speed of the downward trend in maternal and child mortality by strengthening country and regional technical capacity to implement commitments; advocating for equity-based approaches that include universal access to an integrated essential package of health services for women and children; and addressing the root causes of ill-health, such as gender inequality.

The H-4 + agencies have further committed to engage with other key sectors such as education, gender, nutrition, water and sanitation, culture and human rights; strengthening ongoing inter-agency collaboration in order to deliver increased and sustained financial resources for maternal and child health, as well as linking additional global resources to evidence-based country-driven interventions; and sustaining the momentum of the Global Strategy beyond 2015.

Over the next five years the H4+ agencies will support the implementation of the Global Strategy in three principal ways:

Encourage country commitments based on national plans. The H4+ agencies will work with 25 low-income countries to accelerate progress towards MDGs 4 and 5 in line with the Global Strategy and linking these efforts with achieving MDG 6. They will support these countries to identify new commitments in action areas with little progress in implementation, or in ambitious action areas where additional attention and resources could yield important results. The H4+ agencies will support countries update national health plans, estimate the cost of implementing these plans and link with donors who are willing and able to provide support.

Support country-level implementation. The H4+ agencies will work closely with governments,

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development partners, civil society and other stakeholders to support the implementation of the policy and service delivery commitments. In each country, the H4+ agencies will use their comparative advantage to support countries according to their needs, collaborate with other stakeholders to maximize impact, and use existing infrastructure to make best use of available resources and avoid unnecessary duplication.

In accordance with an agreed division of labor, the H4+ agencies will provide support in areas including: improving policy and legislative environment; encouraging better use of data to identify disparities and appropriate program strategies; addressing human resources constraints; ensuring a more efficient use of financial resources; monitoring and evaluation of program implementation; and strengthening procurement and supply management. Further, the H4+ agencies will ensure that implementation is based on the principles of equity, addresses the root causes of the ill-health of women and children, and is informed by a strong understanding of bottlenecks to service provision.

Contribute to strengthened accountability. The H4+ agencies will work with other partners to ensure monitoring and accountability for the commitments made in the framework of the Global Strategy. As accountability and implementation are two sides of one coin, the H4+ agencies' support for country implementation and the WHO-led accountability process will form part of a continuum.

The H4+ agencies will also play a critical role in collecting data and reporting on progress. UNICEF, UNFPA and WHO will work with countries to estimate the outcomes and impact of interventions to improve maternal and child health through the analysis of routine data, population-based surveys and statistical modeling. In addition, the H4+ agencies are committed to helping countries strengthen their own monitoring and evaluation systems to more systematically track progress. This work will ensure that programs yield impact and promises made for women and children are kept.

Anthony Lake

Executive Director
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Thoraya Ahmed Obaid

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Key opportunities in making a difference for the Global Strategy for Women's and Children's Health in 2011

History will see 2010 as a turning point for the health MDGs. Never before in one year have so many new partners joined together in new initiatives for women's and children's health – from government leaders and parliamentarians to development partners in education, nutrition and gender. It is now essential to consolidate the gains of 2010, and to seize the many new opportunities to advocate for women and children that 2011 and beyond will present.

Broadening our partnerships for results: The advocacy roadmap for 2011

Looking forward, 2011 offers key opportunities to broaden our partnerships, mobilize further commitments across sectors, and honor the pledges made (see Annex: Roadmap – Key opportunities to advance our efforts for Every Woman and Every Child). The World Economic Forum in Davos in January, the World Mobile Congress in Barcelona and the UN Commission on the Status of Women in February will be excellent places to introduce the Global Strategy for Women's and Children's Health to prospective private-sector partners. We can explore new alliances that could yield greater investment, better value for money and increased impact through innovative technology and processes.

In March, the African Union (AU) conferences for finance and health ministers in Addis Ababa offer an important opportunity to follow up on the AU's Kampala Declaration by sharing key financial and policy evidence and advocating for increased investment. The African Investment Case, led by the H4 + agencies (UNAIDS, UNICEF, UNFPA, WHO and the World Bank), will be an important source of new data on the regional financial gap that must be filled to meet the MDGs.

At a global level, the Inter-Parliamentary Union annual assembly in Panama City in April will feature presentations on the Global Strategy, and recent evidence on progress from the Countdown to 2015 report of 2010. Parliamentarians have a critical role in overseeing national budgets, drafting legislation to protect the rights of women and children, and giving voice to public concerns. That is why UN agencies and civil society will work with the Inter-Parliamentary Union, the Pan-African Parliament and national parliaments to ensure policy and budget support for maternal, newborn and child health (MNCH). They will also help to create a legislative environment conducive to the full development of state accountability in implementing commitments.

The Global Strategy presents new arguments and costing calculations for why women's and children's health is a good investment for consideration by regional and global finance decision-makers. The meetings of the International Monetary Fund's International Monetary and Financial Committee and the joint World Bank/International Monetary Fund Development Committee in Washington DC in April – and the Asian Development Bank's annual meeting in Hanoi where the World's finance ministers will gather in May – offer key platforms to advocate for increased investment in programs for women's and children's health and health system strengthening (including human resource capacity building). We can also highlight the critical linkages between health, infrastructure, trade and economic development.

At the World Health Assembly in Geneva in May, the World Health Organization and its partners will present key accountability strategies and concepts for the Global Strategy. The world's health ministers will be invited to review them and comment. Their feedback will significantly shape the inaugural accountability report of the Global Strategy to the UN General Assembly in September 2011.

Midwives and other health professionals can promote the Global Strategy at the congress of the International Confederation of Midwives in Durban in June, highlighting the need to invest more in health workers and systems.

After the introduction of the Muskoka Initiative at the last G8 summit, the G8/G20 in France in June 2011 will be an important occasion to take stock of progress and commitments against the Muskoka pledges. It will also be an opportunity to advocate for the inclusion of health issues as a core part of any G20 discussions

on development. Similarly, the first annual report of the AU Task Force in July, as mandated by the Kampala Declaration of 2010, will highlight progress achieved in the region against pledges made. The UNGASS +10 review of HIV/AIDS progress in New York in June will look at progress towards integrating our work across the health MDGs, with important implications for the accountability process.

These gatherings will be the drum beat leading to the high point of the year – the UN General Assembly in September – where the first accountability report of the Global Strategy will be presented. The 2011 focus on non-communicable diseases at the UN General Assembly will also help us to keep global health high on the agenda, and to promote an integrated approach.

These global and regional activities will be enhanced by concerted country-level support for the implementation of commitments that target improved health outcomes for women and children. Throughout 2011, national MNCH communities will rally behind African governments in week-long celebrations of the Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA).

The coming year, 2011, will pose several questions: have the many commitments of 2010 been budgeted and implemented? How are we progressing towards the goals set out in the Global Strategy? What have we achieved? Where do we need to accelerate progress? How do we plan to do this?

The road ahead will put us all to the test. The stakes have never been higher, but the promise never greater. At our Partnership Forum in New Delhi in November we will begin translating the pledges in concrete actions to bring health and well being to the lives of women and children. In 2011, we will all play our part in delivering concrete action and measurable results.

Julio Frenk

Chair of the Board
**The Partnership for Maternal,
Newborn & Child Health**

Flavia Bustreo

Director of the Secretariat
**The Partnership for Maternal,
Newborn & Child Health**

References and resources

References to chapter 2 – Analysis of Country Commitments

1. The group of least developed countries, as defined by the United Nations General Assembly in its resolutions (59/209, 59/210 and 60/33) in 2007, comprises 49 countries, of which 33 are in Africa, 10 in Asia, 1 in Latin America and the Caribbean, and 5 in Oceania. The group includes 49 countries

<http://esa.un.org/unpp/index.asp?panel=5>

Source: 1) Trends in Maternal Mortality: 1990 to 2008 Estimates developed by WHO, UNICEF, UNFPA and The World Bank, Geneva, 2010, page 43, 2) UNICEF, Child info – Monitoring the Situation of Children and Women, 2010

http://www.childinfo.org/mortality_ufmrcountrydata.php

2. Note: Commitments are being made ongoingly and are available on UN Secretary-General's website:

www.un.org/sg/globalstrategy.shtml

Source: Analysis developed based on commitments as of 1 October 2010 drawing on Commitments Summary

www.un.org/sg/hf/global_strategy_commitments.pdf

References to chapter 6 - Women's and children's health: keeping the promise

1. In July 2010, the G8 requested that the WHO "work with relevant partners to provide guidance on monitoring and evaluation of the MNCH initiative, including the identification of a set of core indicators to measure progress in developing countries." Additionally, in the Global Strategy for Women's and Children's Health, the UN Secretary-General requested that the WHO "chair a process to determine the most effective international institutional arrangements for global reporting, oversight and accountability on women and children's health, including through the UN system"

2. The Background Paper for the Global Strategy for Women's and Children's Health: Accounting for Results and Progress in Maternal, Newborn and Child Health

References to chapter 7 - 'Delivering as One' UN

1. The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organizations to continue to increase efforts in harmonization, alignment and managing aid for results with a set of monitorable actions and indicators.

http://www.oecd.org/document/18/0,3343,en_2649_3236398_35401554_1_1_1_1,00.html

2. The Accra Agenda for Action (AAA) was drawn up in 2008 and builds on the commitments agreed in the Paris Declaration.

http://www.oecd.org/document/18/0,3343,en_2649_3236398_35401554_1_1_1_1,00.html

Resources

United Nations Secretary General Global Strategy for Women's and Children's Health

www.un.org/sg/globalstrategy.shtml

Partnership for maternal Newborn and Child Health

www.pmnch.org

United Nations Foundation

www.unfoundation.org/

The Global Campaign for the Health MDGs

www.norad.no/globalcampaign

— Also includes electronic version of this report and annexes

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Global Strategy for Women's and Children's Health - pmnch@who.int

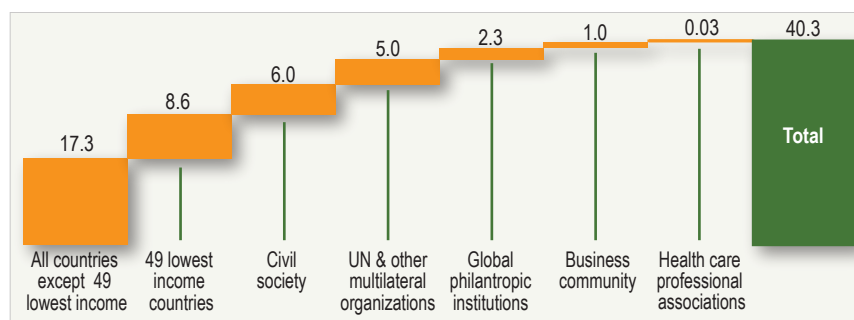
Annex

How the financial commitments to the Global Strategy were calculated

At the MDGs Summit in New York on 22 September 2010, the UN Secretary-General announced an unprecedented US\$40 billion in commitments from a wide variety of stakeholders. These commitments are summarized by stakeholder group in the exhibit below.

Exhibit: Financial commitments (by stakeholder group) to the Global Strategy

This annex provides a brief overview of the methodology used to arrive at the US\$40 billion total, and



proposes next steps in the accountability process to ensure that calculations are as consistent and reliable as possible.

Description of calculations

The table below summarizes how financial commitments were calculated for each stakeholder group. Given the short period between when commitments were received and the launch of the Global Strategy at the MDGs Summit, a simple methodology was used. No attempt was made to monetize service-delivery commitments or policy commitments. All commitments were reported in 2010 US\$, using exchange rates obtained during 20-22 September 2010.

TYPES OF COMMITMENTS	METHODOLOGY USED
Official Development Assistance by donor countries	Donor countries usually reported the amount pledged over a specific timeframe (e.g. 2011-2015). Most pledges were dedicated specifically to women's and children's health, so 100% of these pledges were counted. Of the contributions of Norway and France to the Global Fund, 46% was counted towards MNCH, based on the Muskoka methodology. Commitments included in the Muskoka Initiative were only counted once. Commitments announced at the June 2010 G8 Muskoka Initiative were counted in this total. Commitments announced after April 2010 were included in the estimate of additional financial support.
Countries funding their own health systems (49 lowest-income + Indonesia)	Most commitments were to increase the amount of government spending on health (usually reported as per capita spending or percentages). Using World Bank data on the baseline health expenditures for each country, estimates were produced for the additional government expenditures on health. Then, 25% of the value of this pledge was taken as a contribution to women's and children's health. This is the same assumption used by the Countdown to 2015 report.
Institutional commitments by civil society, the business community, health care professional associations, philanthropy, UN agencies and multilaterals	Most commitments in this category were pledged for women's and children's health, so in these cases 100% of each commitment was counted. Since it was difficult to determine where commitments were double-counted (e.g. in cases where commitments by civil society organizations represented a blend of donor money already counted towards the Global Strategy, as well as new money not otherwise counted), the entire amount donors reported was included.

Proposed next steps

Any efforts around accountability must begin with a clear understanding of what was pledged. The immediate next steps will be to agree on inclusion criteria for commitments and to review existing commitments rigorously – to arrive at a final financial estimate of total commitments. In particular, the following next steps will be considered:

- **Compare commitments to gap:** The financial gap estimated in the Global Strategy is in 2005 US\$. The commitments are calculated in 2010 US\$. To make these comparable, the financial gap should be restated in 2010 US\$, which will increase the amount of the gap.
- **Agree start date:** Currently, there is no agreed start date from which commitments should be tracked. Since the financial gap was calculated taking into account commitments through the end of 2008, counting new commitments from the beginning of 2009 may be considered.
- **Eliminate double-counting:** A revised analysis must aim to eliminate double-counting between NGOs and donors, as well as commitments that restate previous pledges. Where it is difficult to identify duplicated commitments, commitments should be counted but flagged as “potential double-counting”.

The revision of financial commitments will be included in the high-level Commission on Accountability and Information convened by WHO.

This report was produced under the overall directions of Dr. Tore Godal, Special Advisor to the Prime Minister of Norway in close collaboration with Sherpas and special advisors of the Network of Global Leaders, the Executive Office of the Secretary General of the UN, key representatives of UN agencies, the UN Foundation and The Partnership for Maternal, Newborn & Child Health.

A core group has coordinated the contributions in close collaboration with the Ministry of Foreign Affairs. Lars Grønseth (Norad), Helga Føgstad (Norad), Magnus Aasbrenn (MFA), Heidi Rommetvedt (Norad), Abigail Moreland (BCG), Matthew Rall (BCG) and Siri Wendelborg (Consultant).


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FOR MORE INFORMATION AND ANNEXES:

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*As we seek to usher in a new era
for the health of women and children,
let us be flexible in our approaches;
let us learn from what works
and what doesn't; and let us challenge
ourselves and others to deliver.*

*This publication showcases
what our partners will do to move
from commitments to action.*

Ban Ki-moon
Secretary-General of the United Nations