



The PMNCH 2014 Accountability Report

Tracking Financial
Commitments
to the
Global Strategy
for Women's and
Children's Health



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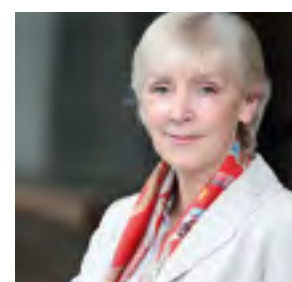
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Tracking Financial Commitments
to the Global Strategy
for Women's and Children's Health





Mrs. Graça Machel
Chair, PMNCH



Dr. Carole Presern
Executive Director, PMNCH

Dear Readers,

On behalf of the Partnership for Maternal, Newborn & Child Health (PMNCH), we are pleased to introduce the 2014 Accountability Report: Tracking Financial Commitments to the Global Strategy for Women's and Children's Health. This report builds on the extensive global, regional and national efforts to date on ensuring accountability for commitments made to advance the UN Secretary General's Global Strategy.

Our fourth annual accountability report finds that our coordinated efforts to ensure that resources are being directed towards improving the health of women, adolescents and children are paying off. Commitment-makers are delivering on their financial commitments and are well on their way to disbursing the almost US\$60 billion pledged to the Global Strategy for the period 2011–2015.

Multiple players are implementing very significant policy and service delivery commitments, which are harder to quantify. However, the report also highlights that combined funding from development partners and national expenditures still falls short of the reproductive, maternal, newborn and child health (RMNCH) needs worldwide. Based on these findings, the following recommendations emerge:

- All actors need to ramp up their respective efforts to mobilise additional resources from international and national sources for RMNCH.
- Country leadership, through all national stakeholders, is vital for the success of our collective commitment to women and children's health.
- Country-led health plans are the foundation of the Global Strategy and our commitments need to reflect country-specific priorities better. We know what works in RMNCH – it is evidence based and cost-effective. Every stakeholder has to do all it takes to achieve the maximum impact on reducing deaths and suffering.
- Sexual and reproductive health and rights needs much more focus at all levels, but especially from political leaders.

- Evidence shows the significant impact of investments on vulnerable and marginalized populations requiring special attention. Community-led efforts should be supported to address these challenges and advance inclusion.
- Increased investments in high-impact and health-enhancing interventions, such as education, skills and employment; clean water, sanitation and hygiene; nutrition; infrastructure; and girls' and women's empowerment, are critical to achieving our shared goals.
- Funding is not adequately matching the need – reaching the unreached and focusing on equity, and healthy lives for all is essential.
- At the UN General Assembly in September 2015 all stakeholders should account for the commitments they made, to ensure we know whether we have reached our collective goals. And, if we have not, identify why we failed to do so and what we need to do in order to improve our results. We also need to develop accountability platforms for the Post 2015 Development Framework.

The findings from this report stress the importance of holding all stakeholders accountable. The accountability model showcased in this report can also serve as an example for other sectors, as well as for the Post 2015 Development Framework.

With the target date of the MDGs less than 500 days away, all of us in the RMNCH community and beyond, must work much harder to ensure that promises are being kept. Financial and non-financial resources need to be deployed wisely so that the wellbeing of the world's women and adolescents, newborns and children are at the centre of every effort and action.

Mrs Graça Machel
Chair, PMNCH

Dr. Carole Presern
Executive Director, PMNCH

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Executive Summary

Background

This is the fourth annual report that the Partnership for Maternal, Newborn & Child Health (PMNCH) has undertaken since 2011 on analyzing commitments to the Global Strategy for Women's and Children's Health (Global Strategy) and their implementation.¹

This year's report focuses exclusively on the commitments made to the Global Strategy that were specifically expressed in financial terms. It provides (i) an update on the estimated value of financial commitments, (ii) the progress made in their disbursement and implementation, (iii) an analysis of how these commitments have affected financing for reproductive, maternal, newborn, and child

health (RMNCH) more broadly, and (iv) an assessment of the degree to which financial commitments and overall RMNCH funding are aligned with the priorities spelled out in the Global Investment Framework for Women's and Children's Health (GIF), and the Global Health 2035 roadmap, published by The Lancet Commission on Investing in Health (CIH).

The analysis in this report is focused on commitments that were listed on the EveryWoman Every Child (EWEC) website, and covers commitments for the timeframe of the Global Strategy (2011–2015).²

Core findings

This year’s analysis of financial commitments shows a number of encouraging trends in the implementation of Global Strategy commitments and RMNCH financing more broadly, although it also points to important areas requiring additional focus.

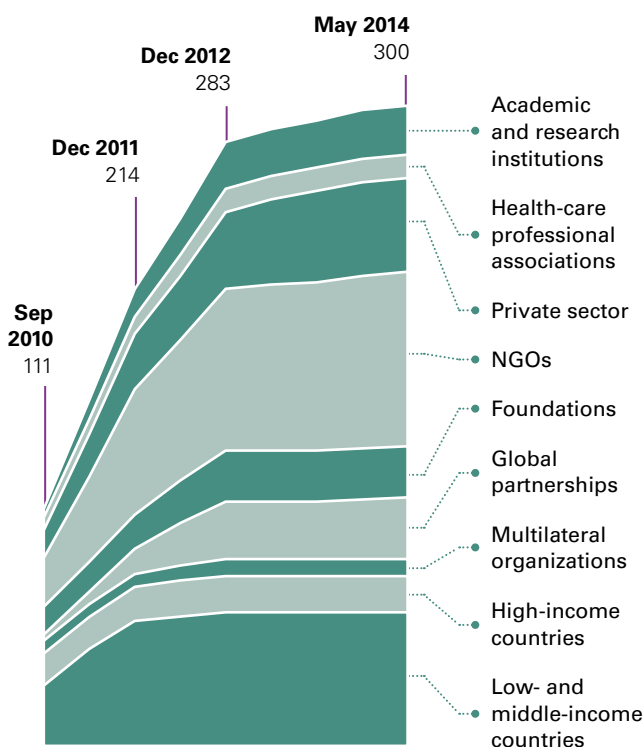
FINDING 1 → The number of commitment-makers has tripled, from about 100 in 2010 to 300 in 2014 (Figure i).³ The capacity of the EWEC movement to attract and maintain partners over time indicates a high degree of sustained political commitment to women’s and children’s health. For example, many of the 40 partners making commitments to the Every Newborn Action Plan (ENAP) in 2014 were those who had made previous commitments to the Global Strategy, demonstrating a continued perception of the added value of the EWEC platform.⁴

FINDING 2 → Financial commitments to the Global Strategy have now reached almost US\$60 billion (i.e. US\$45 billion once doubled-counted* figures are removed). An important feature of the financial commitments is that up to US\$22 billion is new and additional funding for women’s and children’s health. Of this additional amount, US\$13–17 billion is targeted at the 49 Global Strategy focus countries, which represents 15–19% of the US\$88 billion funding gap for RMNCH between 2011 and 2015.⁵ If non-financial commitments were monetized, the value of all commitments would be substantially higher. However, additional financing is still needed to achieve the goals of the Global Strategy and to reach the targets outlined by the GIF and the Global Health 2035 report.

*“Double-counting” relates to funding committed twice by different stakeholders: For example, there could be a bilateral donor commitment to a global health partnership that is reported as a Global Strategy commitment by both the donor and the partnership.

Figure i

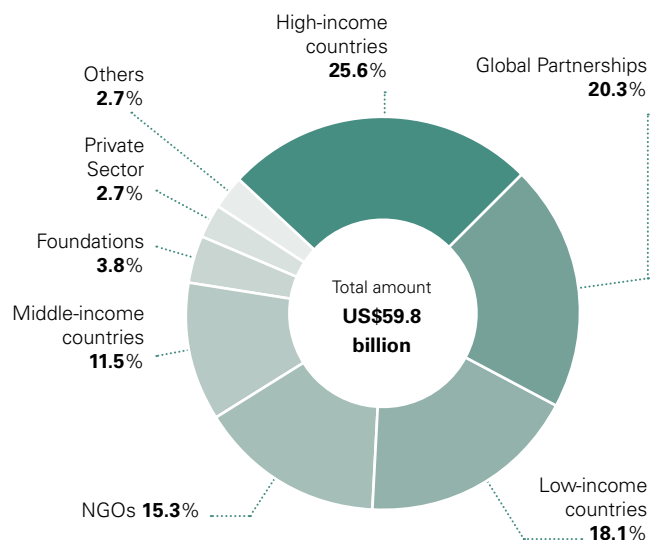
Global Strategy commitment-makers tripled to 300 in 2014 – up from 111 commitment-makers in 2010



Source: Every Woman Every Child website.

Figure ii

Financial commitments to the Global Strategy have reached almost US\$60 billion

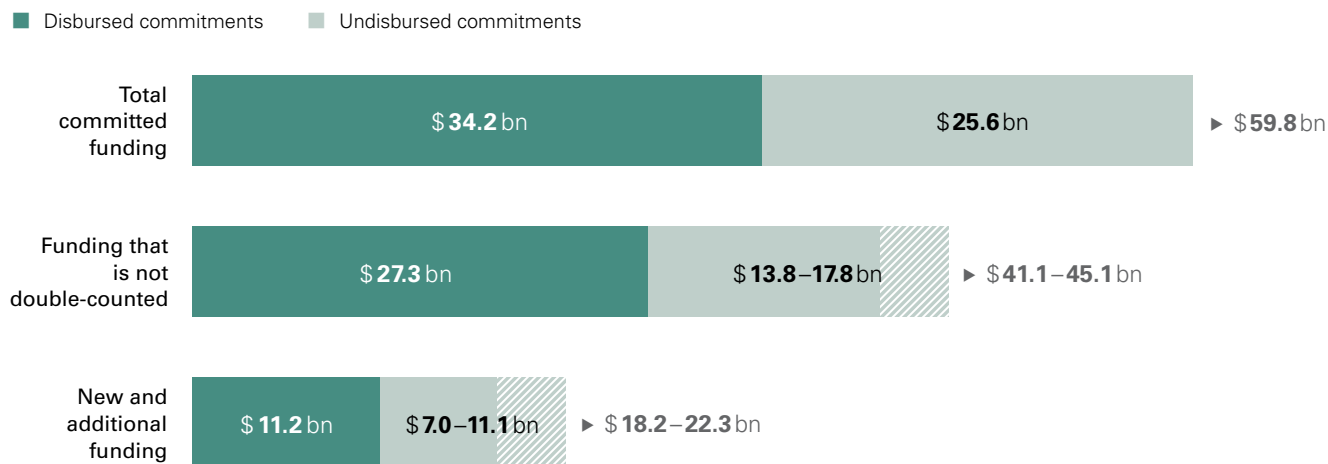


Other includes multilaterals, health care professional associations, and academic, research and training institutions.

Figure iii

Disbursements against Global Strategy commitments

(actual disbursements are likely to exceed those shown; commitment-makers provided data through either Dec. 2012 or Dec. 2013)



Note: Striped green color visualizes range of commitments. "Double-counting" relates to funding committed twice by different stakeholders. New and additional funding relates to investments that stakeholders committed in addition to their RMNCH spending levels prior to the Global Strategy.

FINDING 3 → Commitment-makers are making strong progress with their disbursements. Almost 60% (US\$34 billion) of the US\$60 billion committed has now been disbursed (Figure iii), and once double-counted funds have been removed; a total of US\$27.3 billion has been disbursed to date. However, the true rate of disbursement is likely to be even faster due to delays in the reporting of disbursements. Figure iv shows the steady upward climb in disbursement of committed funds over time – from 20.1% of committed funds in 2012 to 57.2% in 2014 (Figure iv).

FINDING 4 → The Global Strategy has positively influenced international donors. The overall analysis of trends in donor funding for RMNCH indicates that the Global Strategy has made an impact on RMNCH donor financing.⁶ Donors disbursed a total of US\$6.8 billion to improve RMNCH in the 49 Global Strategy countries in 2012, an increase of 11.1% since the launch of the Global Strategy in 2010. Disbursements to the 75 Countdown to 2015 (Countdown) priority countries rose from US\$8.0 billion in 2010 to US\$8.7 billion in 2012, a growth of 8.4% (Figure v).⁷ Donors who are also major commitment-makers to the Global Strategy drove this increase. Data provided for this report signal further growth in RMNCH donor funding in 2013.

Figure iv

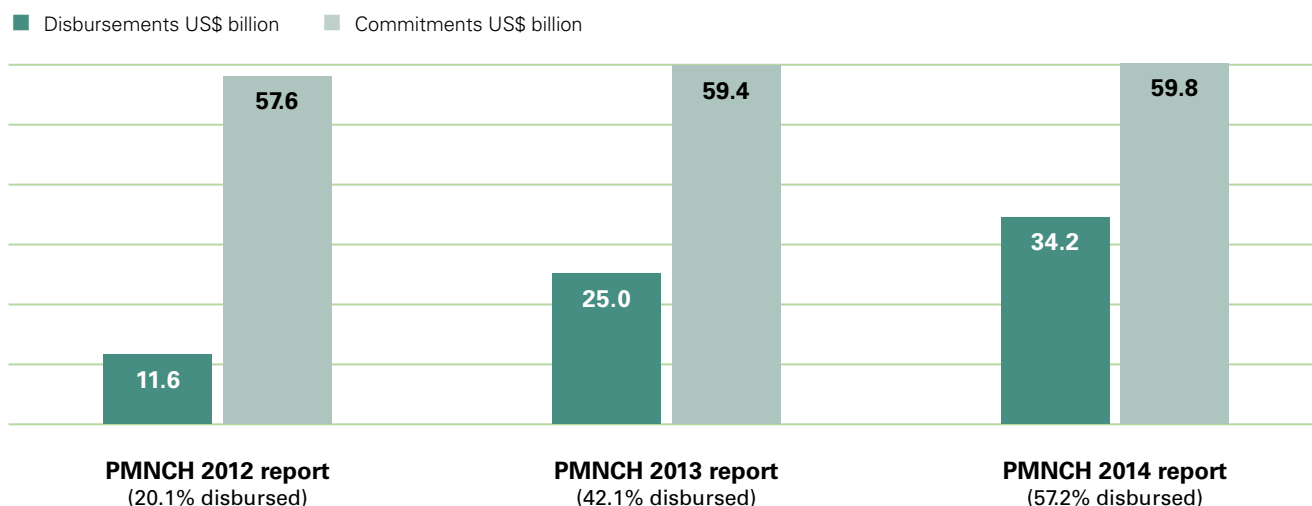
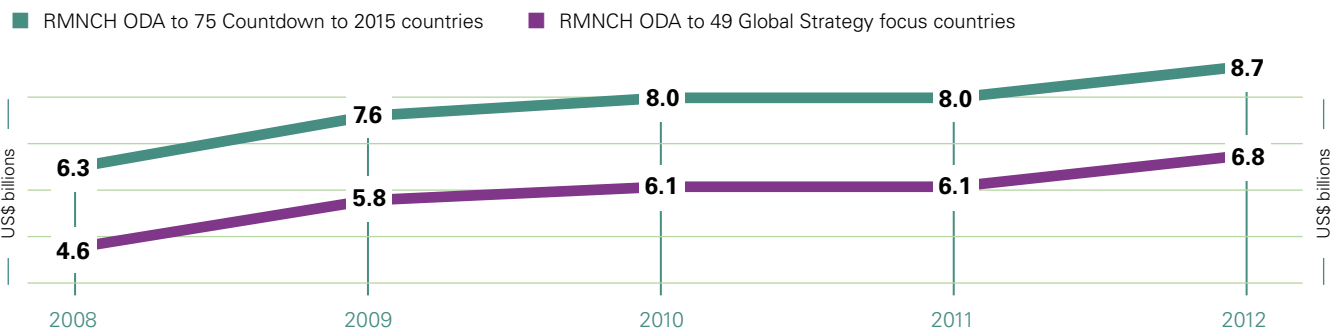
Trends in Global Strategy disbursements

Figure v

Overall ODA for RMNCH continues to show an upward trend – but is still short of need



Source: OECD CRS.

FINDING 5 → There are still inequities in the geographical targeting of donor funding (Figure vi).⁸ A number of low-income countries (LICs) with very high absolute numbers of maternal and child deaths and/or very high mortality rates, and poor access to reproductive health services, including several francophone countries such as Cameroon, Chad, and Niger, receive comparatively little donor support (Figure vi). In some of these countries, such as Sierra Leone and Chad, RMNCH donor support has even fallen since 2010. This is despite the stated focus on equity in the Global Strategy and repeated references in the annual independent Expert Review Group (iERG) reports to the importance of equitable investments.

FINDING 6 → Donor funding for family planning and other key interventions has increased since the launch of the Global Strategy, but is far from sufficient to achieve agreed targets. From 2010–2012, donor disbursements for family planning increased by 47% (to US\$561 million in 2012) for the Countdown coun-

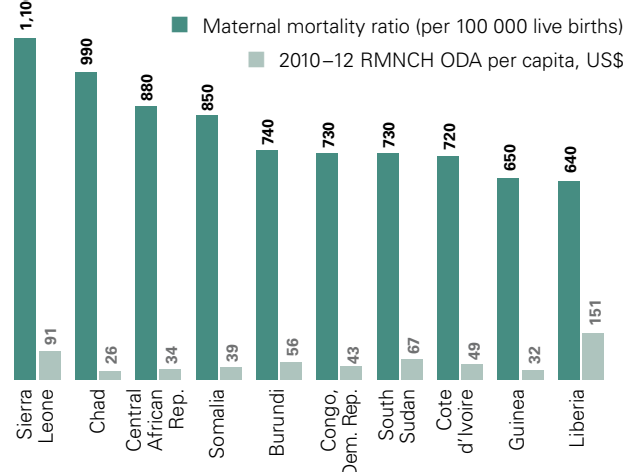
tries, and by 52% (to US\$451 million) for the 49 Global Strategy countries. In the same period, increases were also substantial for maternal and newborn health (MNH), which increased by 22% (to US\$1.2 billion in 2012) for the Countdown countries, and by 24% (to US\$904 million) for the Global Strategy countries. However, the additional MNH funding is insufficient to close the US\$7.9 billion funding gap estimated by the Global Strategy.⁹ HIV-related RMNCH funding continues to be the largest funding area, followed by immunization. Child health investments fell short of expectations and malaria funding declined in 2011, but was followed by an increase in 2012.

FINDING 7 → Domestic expenditures for RMNCH (including family planning) increased but fall short of need. RMNCH expenditures by the governments of the 49 Global Strategy countries increased to a total of US\$2.7 billion in 2012, a 15% increase from 2010. Domestic funding for RMNCH from the 75 Countdown countries grew by 21% between 2010 and 2012.

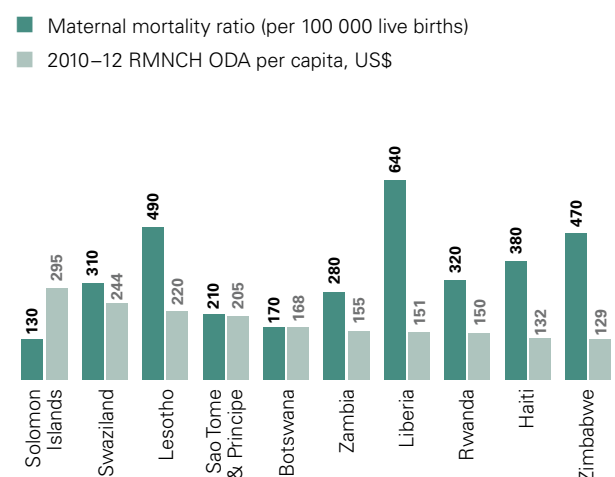
Figure vi

There are inequities in the geographical targeting of donor funding and countries' needs

Countries with the highest maternal mortality rates compared with their RMNCH ODA per capita (2010–2012)



Countries with the highest RMNCH ODA per capita (2010–2012) compared with their maternal mortality rates



Note: There are similar geographical inequities when analysing RMNCH ODA and countries' under-five mortality burden. Source: OECD CRS & WHO, UNICEF, UNFPA, World Bank: Trends in maternal mortality, 1990–2013

Recommendations

RECOMMENDATION 1 → Efforts to mobilize additional resources from international and domestic sources for RMNCH need to be continued and must be kept high on the political agenda. RMNCH must remain central in the post-2015 development framework. The framework should include clear realistic targets to end preventable maternal, newborn and child mortality and to improve access to sexual and reproductive information and services and ensure the realization of sexual and reproductive health and rights. Given the unprecedented support catalyzed by the Global Strategy, a new mobilization and advocacy effort similar to the Global Strategy should be considered for the post-2015 era to finance the unfinished agenda of Millennium Development Goals MDGs 4–6 and achieve a “grand convergence” in global health.

RECOMMENDATION 2 → Funding should be focused on the most cost-effective, evidence-based intervention packages that have the largest impact on reducing mortality and that are currently receiving too little attention. Donors and countries should refer to the Global Investment Framework for Women’s and Children’s Health to guide their investments, which should be particularly targeted at the most underfunded of its six packages and those with the highest impact. The child health, MNH, and immunization packages require the largest additional investments alongside the other packages. The family planning package has the potential to have the largest impact on reducing mortality.

RECOMMENDATIONS 3 → Funding needs to be better matched with mortality burden to achieve equitable progress among countries and healthy lives for all.¹⁰ Funding should become more closely aligned with mortality burden so that countries in greatest need receive sufficient donor support. Stakeholders should use existing global platforms, and consider new platforms, such as the potential RMNCH Global Financing Facility, to better coordinate their RMNCH investments to increase efficiencies in their allocations to countries.

RECOMMENDATION 4 → Countries need to further prioritize and strengthen efforts to self-finance their RMNCH needs. More domestic resources from middle-income countries (MICs) are required for RMNCH to free up donor funding for the poorest countries, but LICs also need to strengthen their efforts to self-finance their RMNCH needs. Global Health 2035 also projected that LICs and lower middle-income countries (LMICs) are on course to experience very significant economic growth, which will create greater domestic fiscal space for health financing.

RECOMMENDATION 5 → Strengthen political leadership for family planning at country level to create support for contraception and sexual and reproductive health and rights. The Global Investment Framework for Women’s and Children’s Health and Global Health 2035 report argue that family planning deserves particularly high, early prioritization. While there is substantial global attention focused on supporting family planning, more political leadership is needed at country level. Domestic leadership should be directed at supporting interventions to increase both the supply of contraceptive information and service programs, and to address social, cultural and behavioral factors that inhibit women, girls and couples from accessing available services.

RECOMMENDATION 6 → Initiate a major final Global Strategy accountability reporting session at the UN General Assembly (UNGA) in September 2015 to ensure accountability right up to the finish line. Without such a process, there is a risk of “slippages” in accountability. The UNGA in September 2015 would be a timely high-level event for this final reporting session, although data for the entire period of the Global Strategy will only be available in 2016 at the earliest.

RECOMMENDATION 7 → To strengthen accountability for RMNCH beyond 2015, a harmonized method should be agreed on to track progress against the post-2015 targets for RMNCH. While efforts are ongoing to include RMNCH targets in the post-2015 development framework, the RMNCH community should also agree on an approach for ensuring accountability towards these goals. This approach would involve agreeing on one method for assessing progress towards closing the RMNCH funding gap estimated by the Global Investment Framework for Women’s and Children’s Health.





Introduction

Unprecedented collective action for women's and children's health

This report reviews the progress made in implementing the financial commitments to the **Global Strategy for Women's and Children's Health** (Global Strategy).¹¹ The strategy was launched by the United Nations Secretary-General (UNSG) Ban Ki-moon in September 2010 with the aim of saving 16 million lives in the world's 49 poorest countries by 2015 (Appendix 1 provides an overview of the specific goals of the Global Strategy).

With the target date of the Millennium Development Goals (MDGs) in sight, the Global Strategy represents the most significant global effort to accelerate progress towards the health-related MDGs: MDG 4 (child survival), MDG 5 (maternal and reproductive health), MDG 6 (HIV, TB, and malaria), and MDG 1c (hunger).¹² The Global Strategy identified six key areas in need of urgent action to improve women's and children's health (Box 1.1). The Every Woman Every Child (EWEC) effort was established at the same time to advance the Global Strategy and to mobilize and intensify global action to improve reproductive, maternal, newborn, and child health (RMNCH).

Four years later, the Global Strategy has succeeded in mobilizing significant support and in uniting a broad range of stakeholders around a joint framework for action. To date, **300 stakeholders have made commitments** toward achieving the goals articulated by the strategy.¹³

In addition, many new initiatives, such as the UN Commission on Life-Saving Commodities for Women and Children¹⁴ and Family Planning 2020¹⁵ have been launched in support of the strategy. Other key events in 2012 were the release of the *Committing to Child Survival: A Promise Renewed* report, the launch of *Born Too Soon: The Global Action Report on Preterm Birth*, and *Saving Lives at Birth: A Grand Challenge for Development*. Following an extensive consultative process, the Every Newborn Action Plan (ENAP) was officially launched in June 2014 to take forward the Global Strategy by focusing specific attention on newborn health.

Box 1.1

Six key areas identified by the Global Strategy that need urgent action to improve RMNCH

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

Strengthened accountability for women's and children's health

Ensuring accountability for Global Strategy commitments and women's and children's health has been a priority since the launch of the strategy in 2010. Based on the accountability framework of the **Commission on Information and Accountability for Women's and Children's Health** (COIA), the independent Expert Review Group (iERG) was formed in 2011.¹⁶ The iERG reports directly to the UNSG and has published two reports (2012; 2013) to comment on progress for women's and children's health.¹⁷

The **Partnership for Maternal, Newborn and Child Health** (PMNCH) has also played a major role in advancing accountability for women's and children's health. To date, PMNCH has produced three reports on commitments to the Global Strategy.¹⁸ The PMNCH 2011 Report provided an initial content analysis of commitments. Building on the 2011 report, the PMNCH 2012 and 2013 Reports informed the annual iERG reports through their analysis of progress in implementing Global Strategy commitments. This cur-

rent 2014 report again assesses progress in implementing commitments to the Global Strategy in response to a request from the iERG to inform its reporting to the UNSG.

This year's report focuses exclusively on the commitments made to the Global Strategy that were specifically expressed in financial terms ("**financial commitments**"). It reviews progress made in implementing these financial commitments and how these commitments have affected financing for RMNCH more broadly. While many significant non-financial commitments were also made to the Global Strategy (e.g. service delivery, policy, and advocacy commitments), these are difficult to monetize and are not analyzed in this report. However, efforts by the Executive Office of the Secretary General and the World Health Organization (WHO), in collaboration with PMNCH, are underway to develop a streamlined reporting platform that would bring the tracking and reporting of all commitments made to the Global Strategy and EWEC, both financial and non-financial, under one umbrella.

A Global Investment Framework for Women's and Children's Health to guide future investments

In 2012, the iERG recommended the creation of a global investment framework for women's and children's health to guide a more strategic approach to investing in RMNCH. Such a framework was developed in 2013. WHO, PMNCH and the University of Washington co-chaired a collaboration with many parties to develop a **Global Investment Framework for Women's and Children's Health** (GIF), published in *The Lancet* in 2013.¹⁹

With the 2015 deadline for the Global Strategy and the MDGs fast approaching, the GIF takes a forward-looking perspective. The framework outlines the key areas across the continuum of care where additional investments are needed to close, by the year 2035, the health equality gap still faced by women and children today. The GIF confirms the impressive health, social and economic benefits of investing in RMNCH in 74 out of 75 Countdown to 2015 countries that account for more than 95% of all maternal

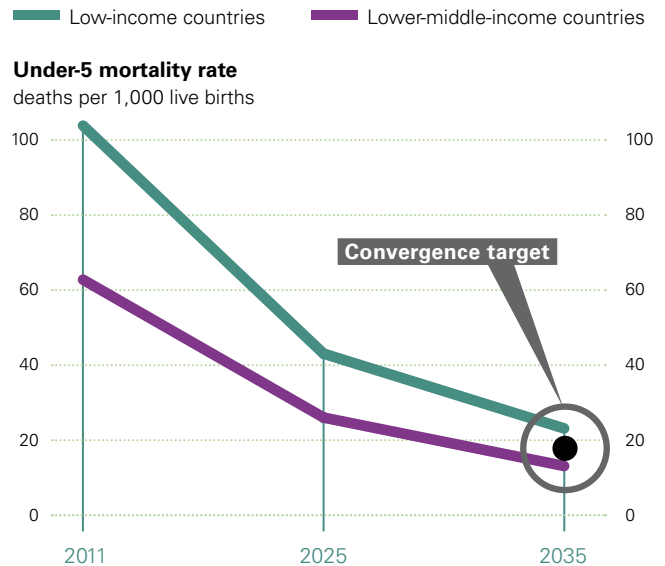
and child deaths (South Sudan was excluded because of poor data availability). Increasing health expenditure by US\$5 per person per year up to 2035 could yield up to nine times that value in economic and social benefits. The returns from investing in family planning would be particularly impressive: across 27 countries with very high unmet need for family planning (e.g. Afghanistan; Chad), the economic rate of return from scaling up access to modern contraception from now to 2035 would exceed 8% of their GDP.

The GIF was also one of the key inputs for a highly influential, high-impact report, *Global Health 2035*²⁰, by the **Lancet Commission on Investing in Health (CIH)**, consisting of 25 global health and economics experts. *Global Health 2035* showed that through an enhanced investment scenario to scale up current and new health tools, a “grand convergence” in global health—that is, a reduction in infectious, reproductive, maternal, newborn, and child deaths to universally low levels—would be possible by 2035 (Figure 1.1). Investments in RMNCH are at the core of the *Global Health 2035* strategy—convergence is only possible through aggressive scale-up of key RMNCH interventions such as family planning, childhood vaccinations, safe pregnancy and childbirth, and management of childhood diarrhea and pneumonia. CIH modeling shows an extremely impressive economic return on this investment—a benefit: cost ratio of about 9 in low-income countries (LICs) and 20 in lower middle-income countries (LMICs).

The GIF is of particular relevance to this PMNCH 2014 report, as it serves as a guide to countries and donors alike in optimizing their commitments to women’s and children’s health. It calls out fifty **evidence-based RMNCH interventions** grouped into **six broad packages**, with nutrition included in two of them. Investments in RMNCH should focus on these packages (Box 1.2), with varying emphasis based on country contexts.²¹

Figure 1.1

Impact of enhanced health investments on under-five mortality rates in low- and lower-middle-income countries, Enhanced investment scenario



Source: The Lancet Commission on Investing in Health (CIH)

Three different investment scenarios in these six packages were modeled by the GIF: low, medium, and high.²² The high investment scenario would result in 147 million fewer child deaths, 32 million fewer stillbirths, and 5 million fewer maternal deaths between 2013 and 2035 in the 74 high-burden countries. Achieving these outcomes would require additional investments of US\$5 per person per year in these 74 countries (a total of US\$30 billion per year in additional investments over and above current spending).

In Chapter 4 of this report, we examine to what extent disbursements target key intervention packages highlighted by the investment framework, what trends can be observed, and where the gaps appear most pronounced.

Box 1.2

Six packages of interventions recommended by the GIF	
1	Family planning (with modern contraceptive methods)
2	Maternal and newborn health (e.g. pregnancy care, neonatal resuscitation, maternal nutrition, immediate newborn care, kangaroo care, safe abortion)
3	Malaria (insecticide-treated materials and nets, treatment of pregnant women and children, intermittent presumptive treatment in pregnancy)
4	HIV (antiretroviral therapy for children and pregnant women, prevention of vertical transmission, cotrimoxazole prophylaxis for children)
5	Immunization (tetanus toxoid in pregnancy; rotavirus, measles, DTP, Hib, polio, BCG, pneumococcal and meningitis)
6	Child health (e.g. childhood nutrition, treatment of diarrhea and pneumonia)

About this report

The main objective of the PMNCH 2014 Report is to provide an update of the financial commitments to the Global Strategy and the progress achieved in implementing these commitments.

As in previous PMNCH reports, this analysis is focused on commitments that are explicitly listed on the EWEC website. All financial commitments listed on the EWEC webpage as of May 20, 2014 are covered by this report. Furthermore, the report covers commitments for the timeframe of the Global Strategy (2011–2015).²³

Some initiatives that were brought under the umbrella of the Global Strategy and EWEC have a timeframe beyond 2015. For example, most commitments made at the London Summit on Family Planning cover the period until 2020. For the purposes of this report, these commitments were prorated for the period until 2015.

Other financial commitments made to advance the health of women and children that are not listed on the EWEC website were not counted as Global Strategy commitments. Recent financial commitments made to advance the health of women and children (for example, commitments made at the Nutrition for Growth summit in London) are not listed as Global Strategy commitments on the EWEC website, and therefore were not counted in this analysis.

Due to the timeframe for this report's analysis, it was also not possible to analyze commitments made in conjunction with the launch of the ENAP at the PMNCH Partners' Forum in Johannesburg on June 30, 2014.²⁴

The report thus contributes to the global accountability agenda for women's and children's health, helping to track if (i) commitment-makers are living up to their commitments, (ii) disbursements for women's and children's health are being made on time, (iii) resources are being spent wisely and transparently, and (iv) the desired results are being achieved. The report will also help to inform the iERG's reporting to the UNSG.

Overall, the report includes:

- (1) A short **overview of commitments** made to the Global Strategy (financial and non-financial commitments);
- (2) an analysis of the **value of financial commitments**, including the amounts that are double-counted and that are new and additional²⁵;
- (3) an assessment of **progress in disbursing funding** specifically committed to the Global Strategy, and how these disbursements contributed to closing the US\$88 billion funding gap estimated by the Global Strategy for the years 2011–2015 (Appendix 2)²⁶;
- (4) an analysis of the **broader RMNCH financing trends** of international donors, LICs, and middle-income countries (MICs) to analyze how the Global Strategy may have impacted these trends; and
- (5) an assessment of the degree to which financial commitments and overall RMNCH funding are **aligned with the priorities spelled out in the GIF**, and whether the right investments are being made to accelerate progress for women's and children's health.

Building on the analysis conducted for previous PMNCH reports, the 2014 report also provides an updated overview of all stakeholder commitments to the Global Strategy based on an analysis of the commitment text. However, compared to previous years, and as highlighted above, the report does not include an assessment of implementation of non-financial commitments. The focus is on financial commitments, defined as those that specify an amount to be committed. Commitments that are not expressed in explicit financial terms are excluded from this analysis. For example, if a commitment to train and deploy skilled birth attendants, an essential element of the Global Strategy, was not monetized (expressed in financial terms) when it was made, it is omitted from this report. However, WHO and EOSG, in collaboration with PMNCH, are in the process of forming a working group in order to develop a more centralized approach that would bring all tracking initiatives and activities under one umbrella and track all Global Strategy commitments, both financial and non-financial.

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

- **Key informant interviews:** Thirty-two interviews based on semi-structured questionnaires were conducted with commitment-makers with sizable financial commitments, including bilateral donors, low- and middle-income countries, multilateral organizations, global

health partnerships, foundations, non-governmental organizations (NGOs) and the private sector. These 32 commitment-makers account for over 90% of the financial amount of Global Strategy commitments (Appendix 3).²⁷ For the first time since 2011, all 10 bilateral donors that were contacted provided information on their commitments.

- **A review of key databases** including the Organisation for Economic Co-operation and Development's (OECD) Creditor Reporting System (CRS) database²⁸, which tracks official development assistance (ODA) commitments and disbursements, and the WHO's "Global Health Expenditure Database" (GHED), which provides internationally comparable numbers on health expenditures based on National Health Accounts (NHA).²⁹
- **A content analysis** of the commitment statements from the EWEC website.³⁰
- **A desk review** of relevant literature.³¹

This analysis has **three limitations**. First, the diversity of commitments and lack of baseline data and indicators continue to present challenges in assessing and comparing progress. There was no commonly agreed format for making commitments to the Global Strategy in September 2010 so as not to limit potential commitments. Many commitments are therefore linked to activities that were being planned, or were already in operation, prior to the launch of the Global Strategy. Second, part of the data is based on self-reporting which can be subject to bias (e.g. over-reporting).

Third, data availability presented a challenge, in particular in relation to more recent disbursements. Determining the extent of double-counting and whether commit-

ments were truly new and additional specifically for the Global Strategy was also challenging. Furthermore, the GHED only includes expenditure data up until 2012 and the CRS database also only provides data on donor funding (disbursements; commitments) up until 2012; not all commitment-makers were able to provide data for 2013. Due to data limitations, a number of assumptions on domestic RMNCH expenditures needed to be made; given that the CRS database does not allow tracking of RMNCH disbursements directly, the Muskoka methodology was used to estimate the share of ODA benefitting RMNCH (see Chapter 3 for more details). The OECD Working Party on Development Finance Statistics decided to introduce a RMNCH marker to its reporting system to better track funding for RMNCH. The marker will be used for the first time in late 2014 for reporting on 2013 flows (it will be evaluated after a two-year trial period).³²

Despite these limitations, this year's analysis of financial commitments shows a number of encouraging trends in the implementation of Global Strategy commitments and RMNCH financing more broadly, although it also points to important areas requiring more focus.

The report is organized as follows: Chapter 2 provides a broad overview of stakeholder commitments to the Global Strategy. Chapter 3 analyzes the financial commitments to the Global Strategy, including an estimate of disbursements made to date against Global Strategy commitments. Chapter 4 assesses broader RMNCH financing trends to estimate how the Global Strategy impacted overall RMNCH financing. This analysis in Chapter 4 also estimates the alignment of overall RMNCH funding with the GIF. Chapter 5 provides conclusions and recommendations on the way forward.





2

Overview of commitments to advance the Global Strategy

FINDING

The Global Strategy has mobilized unprecedented high-level political support for women's and children's health. The number of commitment-makers has tripled, from about 100 in 2010 to 300 in 2014, with some of them making multiple commitments.

With 2015 fast approaching, the focus of efforts towards saving 16 million lives in 49 countries by 2015 has undergone a strategic shift from motivating new commitments to ensuring the implementation of existing commitments. While the total number of commitment-makers increased from 111 in September 2010 to 283 in December 2012, 17 new stakeholders made commitments to the Global Strategy in 2013 and 2014 (as of May 2014). Later in 2014, additional commitments were made to advance the goals of the Global Strategy, mainly in connection with the launch of ENAP.

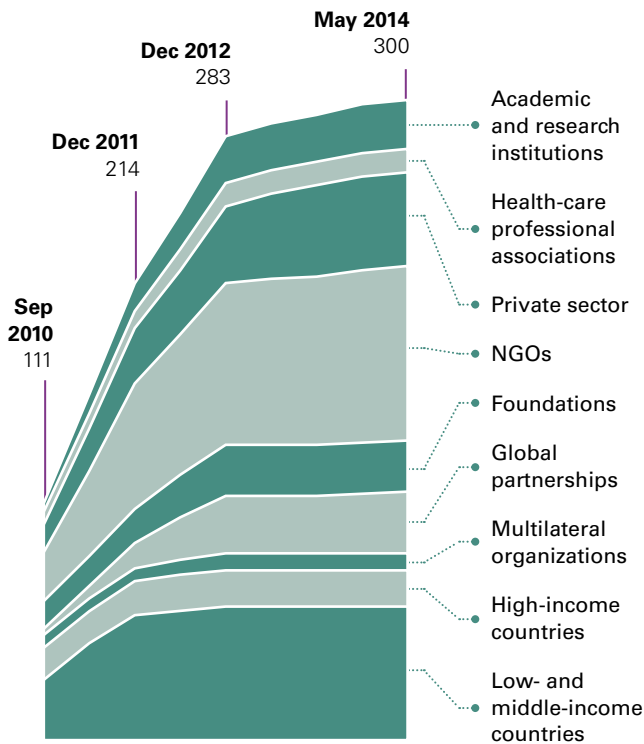
Commitments to advance the Global Strategy were made by all PMNCH constituencies: LICs, MICs, high-income countries (HICs), foundations, multilateral organizations, NGOs, members of the business community, health workers and their professional associations, and academic and research institutions.

The total number of commitment-makers rose from 111 in September 2010 to 300 in May 2014 (Figure 2.1). Some of these commitment-makers made multiple commitments to the Global Strategy. While the number of stakeholders with commitments to the Global Strategy continues to increase, growth was fastest in 2011 and 2012. A total of 172 stakeholders joined the efforts to take forward the Global Strategy during this period, particularly from the private sector and civil society. A number of events in 2011 and 2012 catalyzed additional commitments to the Global Strategy. At the World Health Assembly in 2011, 16 LICs joined the EWEC movement and made commitments to advance the Global Strategy. Two key events in 2012 were the London Summit on Family Planning (FP2020), hosted jointly by the Bill and Melinda Gates Foundation (BMGF) and the UK Government, and Born Too Soon: The Global Action Report on Preterm Birth (Born Too Soon), an initiative to tackle prematurity launched by a broad group of 45 international multi-disciplinary experts from 11 countries.³³ In 2012, 49% (34 in total) of all 69 new

Figure 2.1

Commitment-makers to the Global Strategy

by constituency, Sept. 2010-May 2014



Source: Every Woman Every Child website.

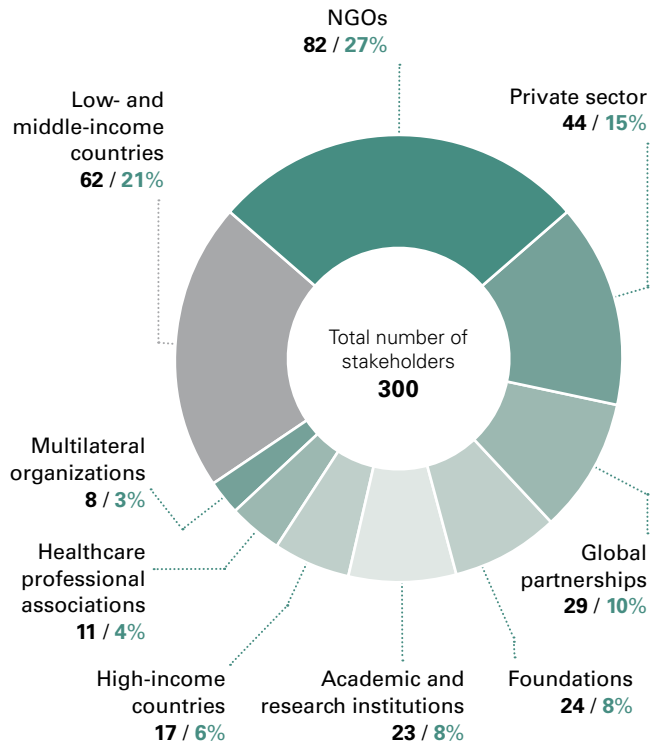
commitment-makers made their commitments in conjunction with the London Summit on Family Planning, where 20 new commitment-makers pledged, and Born Too Soon (14 new commitment-makers). Thus, high-level events have proven to be an effective strategy to mobilize new commitments in support of the Global Strategy.

With 2015 fast approaching, the focus of efforts towards saving 16 million lives in 49 countries by 2015 has undergone a strategic shift from motivating new commitments to ensuring the implementation of existing commitments. Since the beginning of 2013, 17 stakeholders from the private sector (8), NGOs (6), global partnerships (2), and academic and research institutions have made new commitments (1).

Figure 2.2

Commitment-makers

by constituency group



Source: Every Woman Every Child website. Due to rounding, total does not add up to 100%.

Due to the timeframe for this report's analysis, it was not possible to assess commitments made to the ENAP at the 2014 PMNCH Partners' Forum in Johannesburg, where more than 40 new and expanded financial, policy, and service delivery commitments were made to advance the goals of the Global Strategy.³⁴ Many of these commitments have a longer timeframe than the timeframe of the Global Strategy (through 2015), but some commitments align. Canada also made a new commitment to EWEC for the period to 2020 that focuses on newborn health as well as other areas, such as immunization and civil registration and vital statistics systems.³⁵

Figure 2.2 shows the distribution of commitments by constituency groups. Among all constituency groups, NGOs continue to constitute the largest group of commitment-makers, accounting for 27% of all commitments. LICs and MICs, which are the focus of the Global Strategy and account for the highest burden of maternal and child deaths, make up the second-largest group of commitment-makers (21%), followed by the private sector (15%).³⁶

Financial commitments to the Global Strategy

Overview of financial commitments to advance the Global Strategy

FINDING



As of May 2014, the value of financial commitments to the Global Strategy amounted to US\$59.8 billion. An estimated US\$14.6–18.7 billion of the US\$59.8 billion is double-counted funding, so the actual value of financial commitments is in the range of US\$41.1–45.1 billion. The total value of financial commitments to the Global Strategy increased by US\$0.4 billion over the past year, from US\$59.4 billion in May 2013 to US\$59.8 billion in May 2014.

As of May 2014, US\$59.8 billion had been committed by 118 stakeholders who made a financial commitment to support the Global Strategy. Of these 118 stakeholders, 27 were LICs and four MICs.³⁷ These findings are based on an analysis of the financial commitment statements from the EWEC website.³⁸

The PMNCH 2013 Report estimated the value of financial Global Strategy commitments at US\$59.4 million as of

May 2013. Two new financial commitments have been made to the Global Strategy since then. The World Bank announced at the UNGA in September 2013 that it would invest at least US\$700 million for women's and children's health by the end of 2015. This commitment by the World Bank was made on top of an earlier financial commitment of US\$600 million for results-based financing. The other new financial commitment was made by AIDS LIFE/Life Ball, which committed US\$1.9 million towards projects supporting women and children affected by HIV and AIDS.

While the two new financial commitments increased the overall commitment amount, a few downward adjustments had to be made, bringing the total commitment amount to US\$59.8 billion. This overall amount includes both existing and new funding from stakeholders brought under the umbrella of the Global Strategy. However, a significant share of this funding is subject to double-counting and needs to be subtracted to arrive at the actual value of financial commitments (as discussed below).

This funding of US\$59.8 billion is not just committed to the 49 Global Strategy focus countries. It also targets other high-burden countries that are among the list

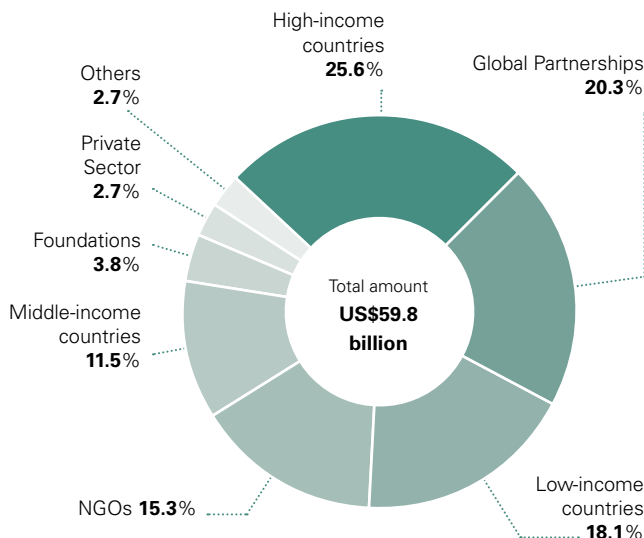
of the 75 Countdown countries, which include the 49 Global Strategy’s countries. Commitment-makers also target other countries beyond the list of Countdown countries.

Figure 3.1 shows that HICs made the largest financial commitments, accounting for more than a quarter of the total committed amount. Large financial commitments – US\$12.2 billion in total – were also made by two global health partnerships, the GAVI Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund).³⁹ LICs also committed to providing significant funding (US\$10.8 billion; see Appendix 4 for the approach used to calculate LIC commitments). However, some of the US\$10.8 billion came from external sources (donors), and is thus likely to be subject to double-counting. Overall, LICs pledged a larger amount of funding than MICs, which relates to the fact that more LICs made financial commitments to the Global Strategy than MICs (27 LICs vs. 4 MICs).

As highlighted above, controlling for double-counting in Global Strategy commitments is essential to avoid artificially increasing the commitment figure. “Double-counting” relates to funding committed twice by different stakeholders: For example, there could be a bilateral donor commitment to a global health partnership that is reported as a Global Strategy commitment by both the donor and the partnership. Double-counted funding was identified based on a content analysis of the commitment text, a desk review of relevant reports and databases, results from the interviews, and a number of assumptions used to overcome incomplete data. Based on that assessment, financial commitments were allocated to the “original source” of funding rather than to the “funding channel” (Appendix 5 explains the methodology in detail).

Figure 3.1

Financial commitments to the Global Strategy
by constituency group (up to May 2014)



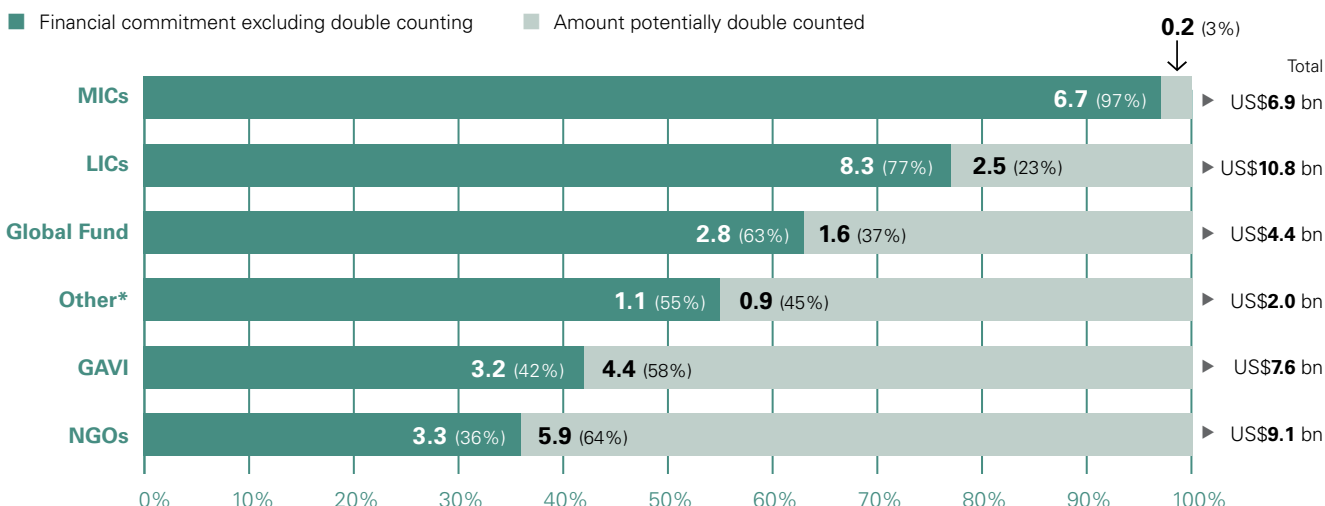
Other includes multilaterals, health care professional associations, and academic, research and training institutions.

The amount of double-counted funding was estimated at US\$14.6–18.7 billion. This funding needs to be subtracted from the overall commitment amount of US\$59.8 billion. Thus the true value of financial Global Strategy commitments is in the range of US\$41.1–45.1 billion (see Figure 3.2). Of this amount, an estimated US\$22.7–26.6 billion is committed to the 49 Global Strategy countries.⁴⁰

Figure 3.2 shows the degree to which commitments by different stakeholder groups are subject to double counting. Stakeholder groups are ordered by the proportion that is subject to double-counting (from lowest to highest), ranging from 3% (MICs) to 64% (NGOs).⁴¹

Figure 3.2

Estimates of double-counted commitments



* Other includes the World Bank, the UN Foundation, UNFPA and Countdown to Zero.

FINDING  **Of the US\$41.1–45.1 billion in financial commitments, US\$18.2–22.3 billion is confirmed new and additional funding. Of this amount, an estimated US\$12.9–16.8 billion is targeted at the 49 Global Strategy countries. This represents 14.6–19.1% of the US\$88 billion funding gap for services for women’s and children’s health in the 49 focus countries.**

Global Strategy commitments include previously existing RMNCH financing and additional investments that stakeholders committed to provide in addition to their RMNCH spending levels prior to the Global Strategy.⁴² To determine the amount of additional investments, funding was only counted as additional if some convincing evidence (e.g. from the commitment text, data reported by commitment-makers during interviews or reported in publications) was available to support this assumption. It is therefore likely that the estimate of additional funding is underestimated.

Our analysis indicates that at least US\$18.2–22.3 billion can be considered as confirmed new and additional funding for 2011–2015. International donors account for US\$13.1 billion of the additional funding and LICs for an estimated US\$5.1–9.2 billion. While the financial commitments of MICs are also significant, their commitments reflect prior RMNCH spending (as discussed in Chapter 4, three of the four MICs with commitments to the Global Strategy have still significantly increased their funding).

Of the additional funding of US\$18.2–22.3 billion, an estimated US\$12.9–16.8 billion is targeted at the 49 Global Strategy countries, representing 14.6–19.1% of the US\$88 billion funding gap for services for women’s and children’s health.⁴³ Financial commitments to the Global Strategy will therefore make a substantial contribution to closing the RMNCH funding gap. If it were possible to monetize other commitments that also contribute to meeting the goals of the Global Strategy, the total financial value of all commitments to the Global Strategy would be significantly higher.

However, greater investment in the health of woman and children will be needed in the coming years to reach the targets laid out in the GIF and the Global Health 2035 report.

Table 3.1

Confirmed new and additional financial commitments
(up to May 2014)

Amount considered new and additional, in US\$ billion	
Muskoka commitments (incl. BMGF)	7.3
Bilateral commitments in addition to Muskoka	3.5
LICs	5.1–9.2
GAVI Alliance	1.6
Global Fund to Fight AIDS, Tuberculosis, and Malaria	0.6
Private sector, foundations (excl. BMGF), NGOs	0.1
Total	18.2–22.3

Tracking disbursements against Global Strategy commitments

This section tracks disbursements of financial commitments to the Global Strategy. The analysis is based on data provided by the commitment-makers in key informant interviews, as well as data from the CRS database of the OECD-DAC and WHO’s GHED to complement the self-reported data. Both databases include data up to 2012, but 17 commitment-makers (out of 31) were able to provide data on 2013 disbursements. However, the estimates below are likely to be underestimates of the amounts that were actually disbursed, as only about half of the interviewed commitment makers were able to share 2013 data.

Because the CRS database and the GHED do not allow for direct tracking of RMNCH funding, and because donors’ accounting systems are usually aligned with the CRS database, the disbursement analysis and the analysis on overall RMNCH financing trends in Chapter 4 rely on the following approaches:

- The Muskoka methodology was used to calculate ODA for RMNCH.⁴⁴ This method is based on imputed percentages to funding reported to the OECD by donors under certain purpose codes or to selected multilateral organizations. Many donors calculate their RMNCH spending in this way, which has the advantage that the RMNCH disbursement analysis is in line with donors’ own tracking of implementation progress and overall RMNCH funding estimates.
- In accordance with the assumption laid out in the financial estimates in the Global Strategy, government RMNCH expenditures in LICs and MICs were calculated assuming that they would constitute 25% of total government health expenditures. This proxy, which is based on data from NHA sub-accounts, is only a rough estimate.⁴⁵

FINDING



Commitment-makers are on track with their disbursements of committed funding. Since the launch of the Global Strategy in 2010, at least US\$27.3 billion of the US\$41.1–45.1 billion in financial commitments (free of double-counting) made to the Global Strategy has been disbursed by commitment-makers (60–66%). As a number of commitment-makers were unable to provide disbursement data beyond 2012, the disbursement figures of this report underestimate actual disbursements.

Disbursements against the US\$18.2–22.3 billion in additional commitments amount to at least US\$11.2 billion (50–62%). Of this amount, an estimated US\$7.2 billion are targeted at the 49 Global Strategy countries. These disbursement figures are underestimates as a number of commitment-makers only provided data until the end of 2012.

Disbursements by commitment-makers against committed funding appear to be on track, although a number of commitment-makers were not able to provide disbursement data beyond 2012. This means that the disbursement figures of this report underestimate actual disbursements.


At least **US\$34.2 billion** was disbursed by all stakeholders towards their respective Global Strategy commitments (57% of the US\$59.8 billion in overall financial commitments), **compared to US\$25 billion reported by the PMNCH 2013 Report**. However, the US\$34.2 billion figure includes disbursements that are subject to double-counting. Therefore, for the first time we undertook an analysis to estimate what proportion of this US\$34.2 billion is double-counted.

At least US\$27.3 billion (60–66% of commitments) has been disbursed against the committed amount of US\$41.1–45.1 billion. Eleven HICs with large financial commitments and the BMGF accounted for 37% (US\$16.5 billion) of the US\$41.1–45.1 billion in committed funding.⁴⁶ Two-thirds of these donors were able to provide disbursement figures up to the end of 2013, another third provided data up until the end of 2012. According to these figures, 75% or US\$12.4 billion of the amount from these donors had been disbursed by the end of 2013, but the actual amount is certain to be higher given delays in reporting. Thus, donors are on track in disbursing their commitments, with most of them having disbursed 60% or more by the end of 2013 or 51%

by the end of 2012. Other groups also reported significant disbursements. Three large MICs (India, Indonesia and the Philippines) have disbursed the entire amount committed (US\$6.7 billion). While LICs made significant financial commitments to the Global Strategy – which is commendable – only limited funding has so far been disbursed by LICs. In the interviews, LIC representatives stated that it is difficult for governments to increase funding for health as other development areas are also in need of funding. Additionally, two countries reported that worsening security situations led to an unpredicted increase in funding for security. NGOs reported that 61% of their commitments have been disbursed to date.

Disbursements against the proportion of committed funding that is new and additional (US\$18.2–22.3 billion) amount to at least US\$11.2 billion (or 50–62% of total additional commitments). Of this US\$11.2 billion, an estimated US\$7.2 billion is targeted at the 49 Global Strategy countries. Again, only about half of commitment-makers were able to report on disbursements up until the end of 2013; actual disbursements are thus larger than the figures presented here.⁴⁷

Figure 3.3 (see page 24) depicts the progress that each stakeholder group has made in disbursing their additional financial commitments. It shows that HICs and the BMGF disbursed a total of US\$8.7 billion (81%) of the additional funding they had committed, and health partnerships a total of US\$1.4 billion (65%). The progress is more accelerated for HICs' disbursements against additional funding commitments than against total commitments because two large donors with additional commitments of US\$5 billion reported that these have been disbursed almost entirely as of May 2014. On the other hand, a range of donors whose commitments refer – at least partially – to ongoing funding reported less progress in disbursing these. The figures further shows that LICs struggle to provide the additional funding they had committed. To date, LICs have spent an estimated additional US\$1.1 billion for RMNCH. Evidence on disbursements against additional funding committed by the private sector, foundations (except BMGF), and NGOs (US\$100 million) is unavailable.

FINDING  **Almost a fifth (19% or US\$2.1 billion) of the additional funding was spent on immunization. A total of US\$1.7 billion (or 16% of total additional disbursements) was disbursed for maternal and newborn health. About a quarter of the additional funding is for two major infectious diseases: HIV (13%) and malaria (11%). The amount of additional funding for family planning totaled US\$1.1 billion (or 10% of the total additional funding). About 32% of the additional funding could not be allocated. Additionally, it was not possible to estimate funding for the child health package. However, given that major donors place a strong focus on child health, part of this unallocated funding likely contributes to the child health package.**

One of the key questions that this report tried to answer is which of the six GIF packages benefitted most from the additional disbursements of US\$11.2 billion. However, most commitment-makers were not able to provide data on their additional disbursements broken down by the six GIF packages. The following estimates are therefore

based on a comparison of previous spending trends and most recent data reported. Given the limitations of the CRS database and the accounting systems of donors, it was impossible to provide an estimate of funding for child health. For the same reason, almost a third (32%) of the additional funding could not be allocated by package. As major donors (e.g. Canada) place a strong focus on child health, part of this unallocated funding likely contributes to the child health package.

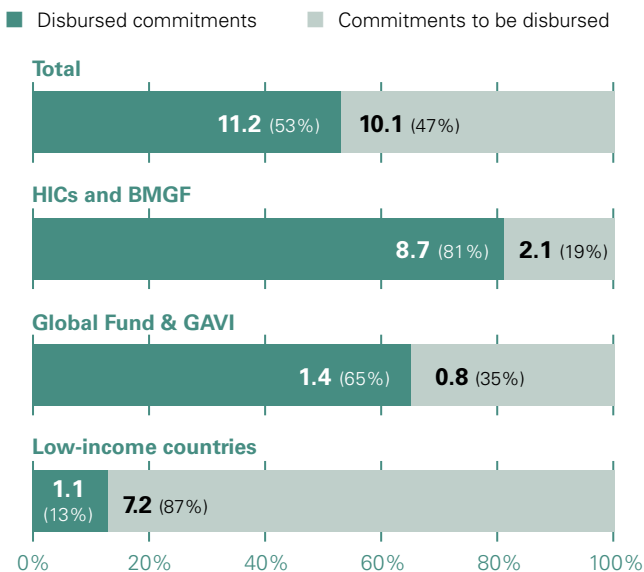
Figure 3.4 shows that all GIF packages for which data were available benefitted from the additional disbursements against Global Strategy commitments. Immunization was the package that received most of the additional investments. Almost a fifth (19% or US\$2.1 billion) of the additional funding was spent on immunization.

A total of US\$1.7 billion in additional funding has been disbursed for maternal and newborn health (16% of the total additional disbursements). About a quarter of the additional funding is for two major infectious diseases: HIV and malaria, which account for 13% and 11% of total funding respectively. The amount of additional funding for family planning totaled US\$1.1 billion (10% of the total additional funding is for family planning services). "Other" includes funding that was reported under activities that could not be classified according to the six packages.⁴⁸ However, a portion of this funding is for child health, as well as for health systems strengthening.

Figure 3.3

Disbursements of additional commitments

in US\$ billions; actual disbursements are likely to exceed those shown: commitment-makers either provided data through Dec. 2012 or Dec. 2013

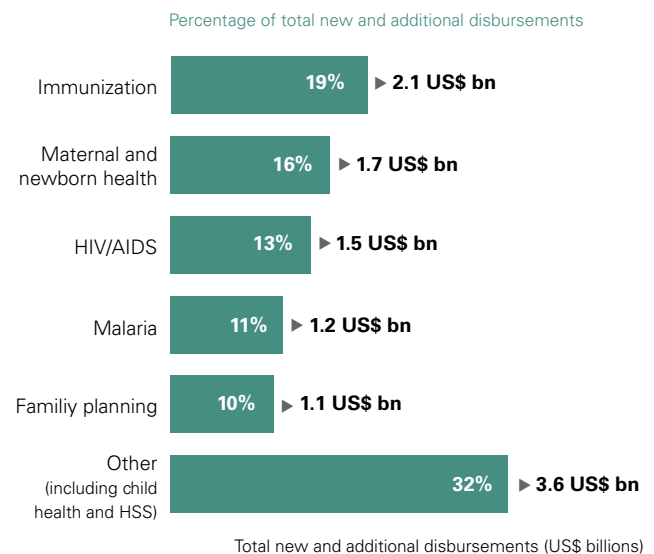


Sources: Self-reported data from commitment-makers, GHED, and CRS database. Figures in current prices. Disbursements from private sector, NGOs, and foundations (except BMGF) are excluded from figure due to missing data.

Figure 3.4

Targeting of additional disbursements against commitments

in US\$ billions; actual disbursements are likely to exceed those shown: commitment-makers either provided data through Dec. 2012 or Dec. 2013



Sources: Self-reported data from commitment-makers, GHED, and CRS database. Figures in current prices. Actual disbursements are likely to exceed those shown: commitment-makers either provided data through Dec. 2012 or Dec. 2013. "Other" funding could not be allocated by package due to data constraints. HSS stands for health systems strengthening.



4

Impact of the
Global Strategy
on overall
RMNCH
financing trends

Overall RMNCH financing trends

FINDING



Donors disbursed a total of US\$6.8 billion to improve RMNCH in the 49 Global Strategy countries in 2012, an increase of 11.1% since the launch of the Global Strategy in 2010. Disbursements to the 75 Countdown countries grew from US\$8.0 billion in 2010 to US\$8.7 billion in 2012, an increase of 8.4%. Donor data provided for this report signal further growth in RMNCH financing in 2013, reflecting the donors' continued support for the unfinished agenda of MDGs 4 and 5.

This section analyzes the broader RMNCH financing trends by international donors to assess how the Global Strategy may have had an impact on these trends. Disbursement data come from the CRS database using the Muskoka methodology to estimate donor disbursements to RMNCH (see Chapter 3). In order to allow for a comparison with the Global Strategy's financing gap, the analysis is based on 2005 prices. For the first time, this analysis also takes into account unspecified regional and global disbursements.⁴⁹

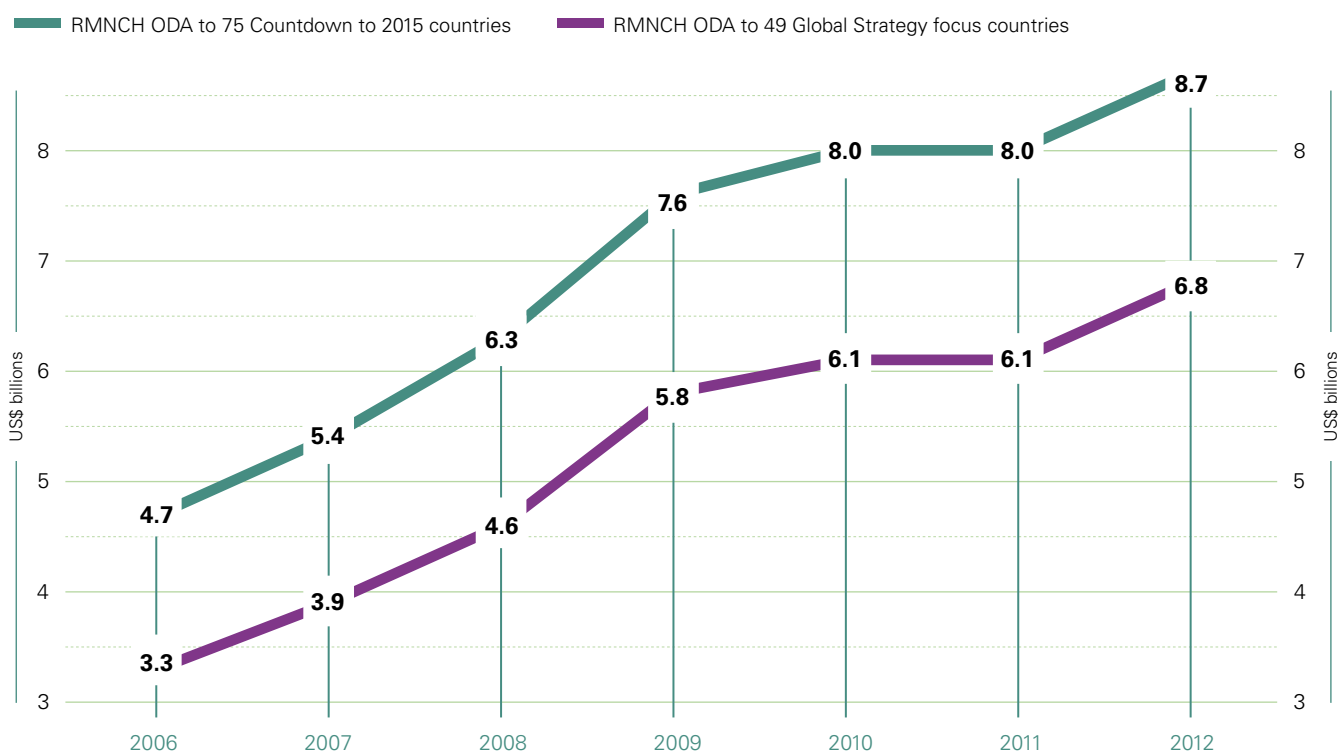
Since the launch of the Global Strategy, RMNCH disbursements for the 49 Global Strategy countries grew by 11.1%, from US\$6.1 billion in 2010 to US\$6.8 billion in 2012. In the 75 Countdown countries, disbursements rose from US\$8.0 billion in 2010 to US\$8.7 billion in 2012, an increase of 8.4% (Figure 4.1). Compared to Countdown's analysis of donor funding, the Muskoka method results in a 9.7% higher amount: Countdown estimates that 2011 donor disbursements for RMNCH to Countdown countries total US\$8.7 billion (calculated in 2012 prices which translates to US\$7.3 billion in 2005 prices, i.e. US\$700 million below the Muskoka estimate of US\$8.0 billion).⁵⁰

Figure 4.1 shows that the growth in RMNCH funding had already accelerated between 2006 and 2009 before the global financial crisis affected donor flows to global health and development more broadly. In 2010, RMNCH disbursements grew much less than in previous years. In 2011, funding remained almost flat compared to 2010 levels, with a growth rate of 0.2% for the 49 Global Strategy countries and a growth rate of 0.5% for the Countdown countries. Countdown found a small decrease in MNCH disbursements in 2011, whereas Institute for Health Metrics and Evaluation

Figure 4.1

RMNCH ODA disbursements based on the Muskoka methodology

2006–2012



Source: OECD CRS.

(IHME) found an increase in MNCH spending.⁵¹ These very different findings reflect differences in the methodology (Appendix 6 provides an overview of the different methodologies).


In 2012, donor disbursements to RMNCH started to grow again at a significantly faster rate: From 2011 to 2012, donor funding increased by 10.9% and by 7.8% to the 49 Global Strategy countries and the Countdown countries respectively. Why was there a delay of over one year between the launch of the Global Strategy and the sharp rise in funding for RMNCH? The most likely explanation is the long planning cycles of most donors and countries, leading to a time lag between commitments to the Global Strategy and actual disbursements.

Major spending by a number of bilateral donors and global health partnerships who are also major commitment-makers to the Global Strategy drove this increase in overall RMNCH disbursements (see Chapter 3). Five bilateral donors (Canada, Japan, Sweden, the UK, and the US) increased their bilateral RMNCH disbursements by over US\$0.5 billion compared with 2011. GAVI also increased its funding by US\$280 million funding in 2012, and the Global Fund also increased its fund-

ing for interventions that benefit women and children by an estimated US\$324 million.⁵² Funding data provided by key donors signal further growth in RMNCH funding in 2013. RMNCH disbursements from the UK totaled US\$2.6 billion in 2013, an increase of 57% relative to 2012 disbursements. Four other bilateral governments – the US, Canada, the Netherlands, and Norway – also augmented their RMNCH financing in 2013, amounting to a total increase of US\$350 million compared to 2012 levels.⁵³

This report provides the first analysis on 2012 RMNCH donor disbursements. Another estimate will be presented by Countdown in September 2014 based on Countdown's methodology. It will be important to compare Countdown's findings with those included in this report.

Geographical targeting of donor disbursements

FINDING  **There remain inequities in the geographical targeting of donor funding. Some LICs (including a number of francophone countries) with high numbers of deaths and/or very high mortality rates receiving comparatively less donor support.**

In absolute terms, RMNCH donor disbursements are targeted at populous countries with high numbers of maternal and child deaths. From 2010 to 2012, India and Nigeria, the two countries with the highest absolute numbers of maternal and child deaths worldwide, received the most RMNCH donor funding out of all Countdown countries. Of the 10 countries that received the highest disbursements for RMNCH per capita between 2010 and 2012, only four had a population larger than 10 million.

One of the key questions to be answered by this report is whether the implementation of Global Strategy commitments helped to target funding to those countries in the greatest need. Half (50.3%) of global under-five deaths occur in only five countries: India, Nigeria, Pakistan, the Democratic Republic of the Congo (DRC), and China.⁵⁴ Ten countries account for almost three-fifths (57.7%) of global maternal deaths: India, Nigeria, DRC, Ethiopia, Indonesia, Pakistan, Tanzania, Kenya, China, and Uganda.⁵⁵

Globally, India and Nigeria together accounted for over a third of neonatal deaths (36.7%) and under-five deaths (34.2%) in 2012, and for almost a third of maternal deaths (31.2%) in 2013. These two countries are also the two top recipients of RMNCH donor funding in absolute terms (Fig. 4.2). Ethiopia, Tanzania, Kenya, Uganda and DRC are also countries with very high numbers of child and maternal deaths and all of them are top 10 recipients of RMNCH donor funding. Most of the top recipients are countries that are traditionally focus countries of the UK, one of the major RMNCH donors, which indicates that aid is also driven by historical and political reasons rather than by need alone.

Indonesia and Pakistan are among the ten countries with the largest number of maternal and child deaths. Both countries are on the top 20 list in terms of RMNCH donor funding but they are not among the top 10. China and Angola are the only upper MICs on the list of high-burden countries, but both countries are not among the top 20 recipients of RMNCH donor funding. This shows that

income level also plays a role in the geographical targeting of donor funding, and that donors rightly focus on poorer countries with greater needs.

Figure 4.2 shows the 75 Countdown countries with the highest child mortality and maternal mortality and how they rank in terms of cumulative RMNCH ODA received from 2010–2012. The figure shows that – in absolute terms – RMNCH donor funding is targeted at populous countries with high numbers of maternal and child deaths. However, Figure 4.2 also shows that of the 20 countries with the highest maternal and under-five deaths, only 12 are among the top 20 recipients of RMNCH ODA. This means that eight of the countries with the highest numbers of maternal and child deaths are not among the 20 top recipients of RMNCH ODA, reflecting an imbalance between need and donor funding. These countries (with the exception of China and Angola) are also LICs that have limited capacity to cover costs themselves. Four of these eight countries are low-income francophone countries (Chad, Niger, Cote d'Ivoire, and Cameroon)

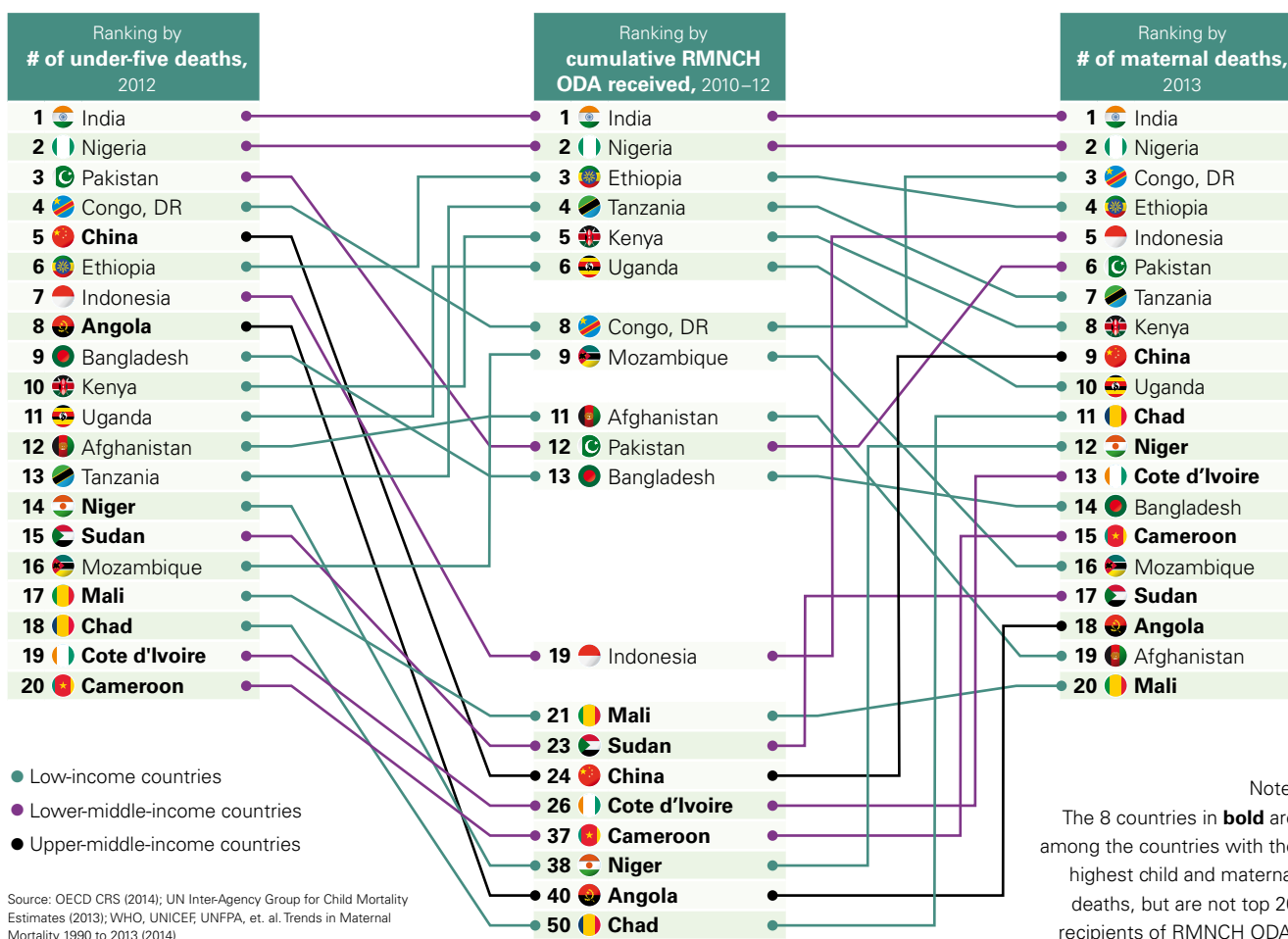
In acknowledgement of this financial gap, commitment-makers to the Global Strategy recently developed new programs specifically developed to increase funding for francophone countries. In November 2013, the World Bank announced a US\$200 million regional initiative in the Sahel focused on RMNCH commodities and human resources for health, especially rural midwives. This initiative is focused on Burkina Faso, Chad, Mali, Mauritania, Niger, and Senegal. However, additional support for francophone countries in Africa appears to be urgently needed. Both traditional francophone and new donors should give more attention to these states.

When donor funding is adjusted for population size – i.e. if per capita spending is assessed – the ranking changes.⁵⁶ Appendix 7 provides an overview of the countries with the highest child mortality and maternal mortality worldwide and how they rank in terms of mean per capita RMNCH ODA received from 2010–2012. Populous countries, such as Nigeria and India, decline to position 51 and 70 (out of 75 Countdown countries). The top three recipients per capita are very small countries (Solomon Islands, Swaziland, and Lesotho). Of the 10 countries with the highest disbursements per capita, only four had a population larger than 10 million (Haiti, Rwanda, Zambia, and Zimbabwe).

Appendix 7 also shows that only 7 of the 20 countries with the highest mortality rates are also among the top 20 donor recipients in terms of RMNCH per capita from 2012–2012. This shows that there are still inequities in the geographical targeting of donor funding, as already highlighted in previous PMNCH reports.⁵⁷

Figure 4.2

Alignment between RMNCH donor funding and maternal and child deaths



Source: OECD CRS (2014); UN Inter-Agency Group for Child Mortality Estimates (2013); WHO, UNICEF, UNFPA, et. al. Trends in Maternal Mortality 1990 to 2013 (2014)

The challenges are also particularly acute in countries that are experiencing civil conflict or political instability and have very high rates of poverty and undernutrition, such as Central African Republic, Mali, Somalia, and South Sudan. These countries also receive comparatively less funding, which indicates that the level of internal conflict also influences the targeting of donor funding.

FINDING While 9 of the 10 recipient countries that received the most ODA in 2010 were also among the top 10 recipients in 2012, funding for a number of high-burden countries has contracted between 2010 and 2012. This trend indicates that the launch of the Global Strategy did not systematically improve the geographical targeting of RMNCH ODA.

A comparison of RMNCH funding in 2010 and 2012 shows that nine of the 10 recipient countries that received the most RMNCH ODA in 2010 were also among the top 10

recipients in 2012 (Figure 4.3). However, Pakistan was no longer among the top 10 recipients in 2012 and was replaced by Zimbabwe. Six of the ten countries that received the least RMNCH donor funding in 2010 are also among the bottom 10 recipients in 2012.

Compared with 2010, three countries experienced an increase in funding of more than US\$100 million in 2012. Nigeria benefited from the largest increase in donor funding (US\$183 million, or a 36% increase). RMNCH donor funding for Zimbabwe nearly doubled from US\$174 million in 2010 to US\$345 million to 2012. Funding for Uganda increased from US\$335 million to US\$489 million (a 46% increase).

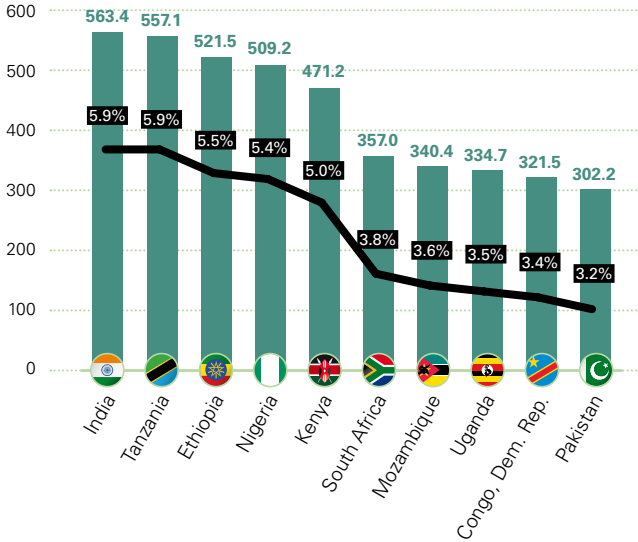
Four LICs experienced funding cuts of US\$30 million or more between 2010 and 2012 (expressed in percentages, these reductions were in the range of 30–50%): Benin, Cambodia, Chad, and Madagascar. In this period, four LMICs – Cote d'Ivoire, Egypt, Philippines, and Sudan – also experienced funding cuts of US\$30 million (however, the Philippines substantially increased domestic RMNCH spending, so the reduction in donor funding is offset by increased domestic funding; see page 36 for details).

Figure 4.3

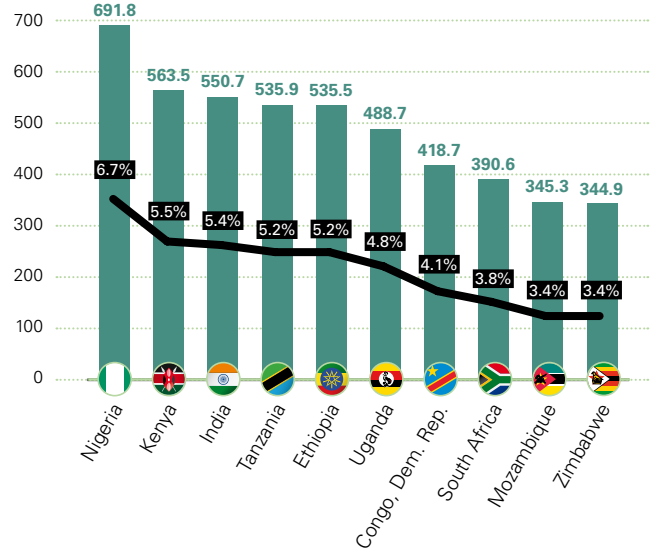
Top 10 and bottom 10 Countdown country recipients of RMNCH ODA, 2010 and 2012

■ Total US\$ millions — Share of funding for 75 Countdown countries

Top 10 Countdown to 2015 country recipients of RMNCH ODA – 2010

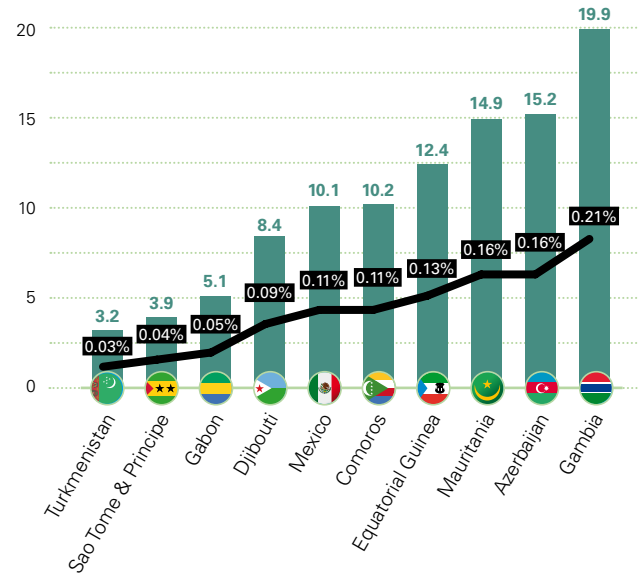


Top 10 Countdown to 2015 country recipients of RMNCH ODA – 2012

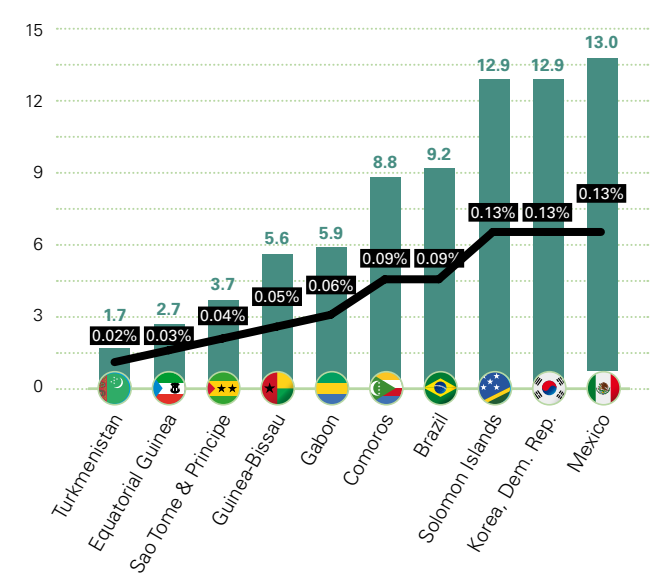


■ Total US\$ millions — Share of funding for 75 Countdown countries

Bottom 10 Countdown to 2015 country recipients of RMNCH ODA – 2010



Bottom 10 Countdown to 2015 country recipients of RMNCH ODA – 2012




Source: OECD CRS.

Funding for Sierra Leone, the country with the highest maternal mortality ratio and under-five mortality rate worldwide, decreased by US\$25.7 million (or 30%) from US\$85.6 million in 2010 to US\$59.9 million in 2012. Donor per capita funding for RMNCH in Sierra Leone decreased from US\$36.91 in 2010 to US\$25.83 in 2012 (a 43% decrease that takes into account population growth). With that level of funding, Sierra Leone ranked 22nd out

of all 75 Countdown countries on per capita donor spending in 2012 (in absolute terms, it ranked 42nd). Although care must be taken when comparing differences in funding between two years (because two years do not constitute a trend), the 2010–2012 comparison reinforces the finding from the previous section: some of the poorest countries with high mortality rates do not receive enough financial assistance from donors.

Alignment of RMNCH disbursements with the Global Investment Framework

FINDING  Donor disbursements for family planning in the Countdown countries grew from US\$382 million in 2010 to US\$561 million in 2012, an increase of 47%. In the 49 Global Strategy countries, donor funding for family planning grew by 52%, from US\$296 million in 2010 to US\$451 million in 2012. Our projections indicate that family planning funding is projected to increase by a total of US\$2.5 billion between 2011 and 2015. This increase would close 51% of the US\$4.9 billion financing gap for family planning identified in the Global Strategy and provide an estimated 22.1 million new users with access to family planning services in the period 2011–2015.

Funding for maternal and newborn health also grew but, like family planning, remains seriously underfinanced. While there has been little growth in HIV-related RMNCH funding, HIV continues to be the largest funding area in 2012. Following a decline in 2011, malaria funding increased in 2012. According to the latest available data, funding for child health decreased. GAVI funding for immunization grew steadily in recent years.

It is unlikely that the targets laid out in the Global Health 2035 report and in the GIF will be reached unless there is a significant rise in RMNCH investments.

The Global Strategy emphasizes that the vast majority of maternal, neonatal, and child deaths worldwide are avoidable: there are evidence-based, cost-effective interventions to save women's and children's lives. As previously described in this report, these evidence-based interventions form the foundation of the GIF, which recommends the scale-up of six packages of interventions (for details, see Box 1.1, page 13): (i) family planning; (ii) maternal and newborn health (MNH); (iii) malaria; (iv) HIV; (v) immunization; and (vi) child health.

Because the CRS database includes purpose codes for family planning, HIV, and malaria, funding for these three packages can be estimated using the Muskoka methodology. Tracking disbursements for the other three packages is more difficult because the CRS lacks purpose codes for maternal and newborn health, immunization, and child health. Since accounting systems of donors are aligned with this database, donors were also not able to provide data in the required format. However, the MNH

package matches closely with the CRS purpose code for reproductive health care (13020), which is thus used as proxy to estimate MNH funding (this purpose code excludes funding for family planning).⁵⁸ Given that a large share of immunization funding is disbursed by GAVI and the Global Polio Eradication Initiative (GPEI), disbursements from these two global health partnerships are used to estimate funds for the immunization package. An overview of investments for the child health package cannot be provided based on the Muskoka methodology, but Countdown estimated 2011 disbursements for child health, so these data will be used.⁵⁹

When considering the direct additional costs for the six intervention packages estimated in the Global Investment Framework, these account for 47% of total additional costs (for the high scenario compared to the low scenario). Costs for health systems strengthening, conditional cash transfers and program management are excluded.

Disbursements for family planning

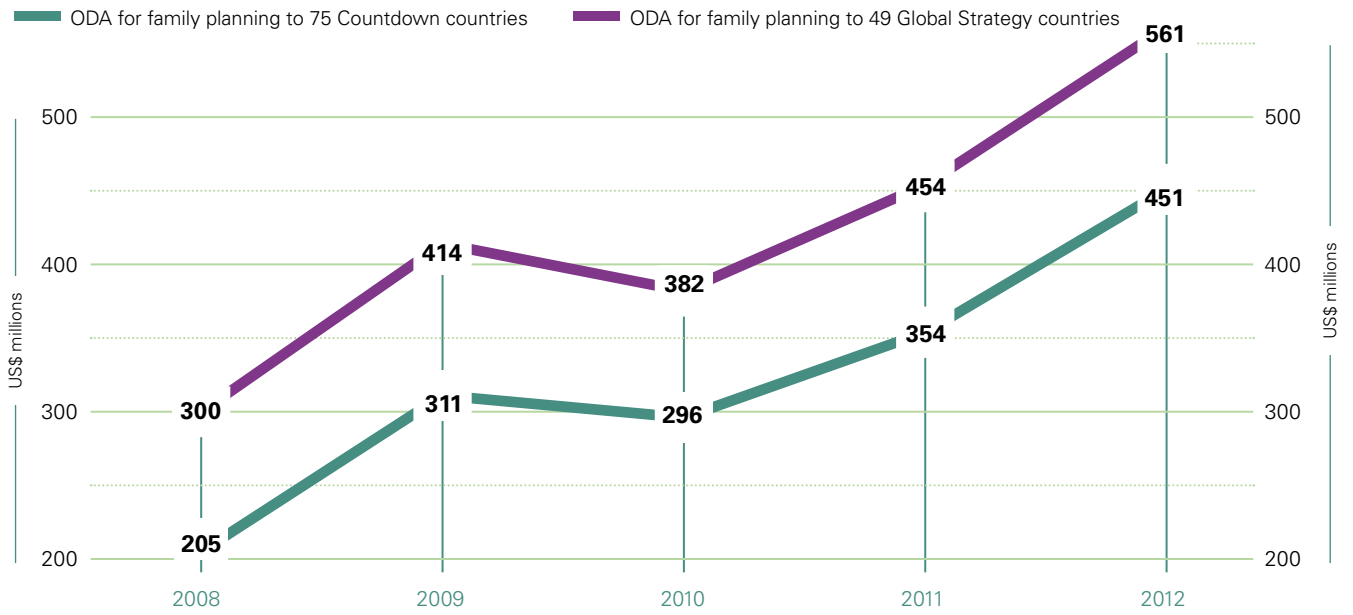
As highlighted by the GIF, addressing the unmet need for effective contraception across the 74 GIF countries would reduce unsafe abortions, unintended and high-risk pregnancies, thereby averting an estimated 54% of the maternal deaths and 47% of child deaths. Family planning services can also help improve newborn and child survival by lengthening inter-pregnancy intervals. According to Countdown's 2014 report, median coverage of demand for family planning satisfied is 64% in the 53 Countdown

countries with available survey data (2008–2012).⁶⁰ However, there is a very large range across countries (13–95%). Countdown countries in West and Central Africa continue to have very low levels of family planning coverage and high levels of unmet need.⁶¹

Figure 4.4 shows that donor disbursements for family planning in the Countdown countries grew from US\$382 million in 2010 to US\$561 million in 2012, an increase of 47%.

Figure 4.4

ODA for family planning to 49 Global Strategy and 75 Countdown countries, 2008–2012



Note: Gross disbursements in US\$ millions – 2005 prices.

Source: CRS database.

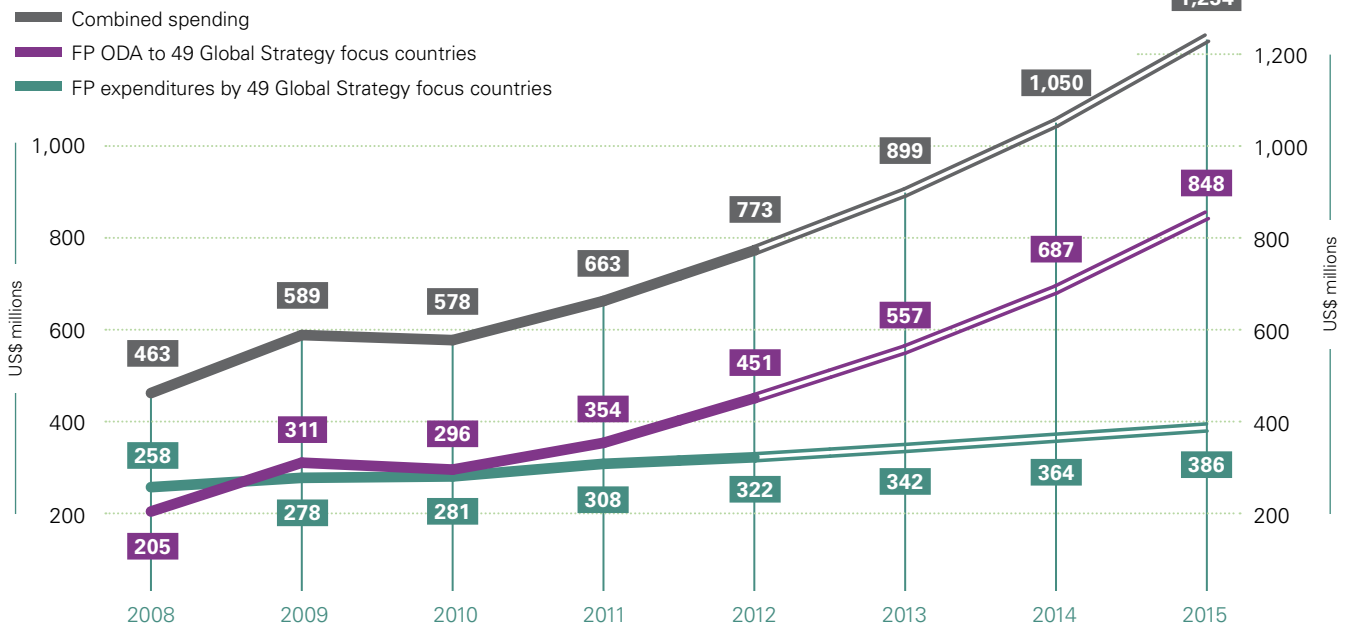
The 49 Global Strategy countries experienced an increase of 52%, up to US\$451 million in 2012 relative to 2010.

According to the Global Strategy, 43 million new users would have access to family planning services in 2015 alone if the financing gap identified by the Global Strategy were closed. The estimated additional programme costs for the period 2011–2015 for scaling up services related to family planning in the 49 Global Strategy countries are estimated at US\$4.9 billion.

Our projections based on funding trends between 2008 and 2012 indicate that donor disbursements for family planning will total an additional US\$1.9 billion between 2011 and 2015, reaching US\$847.7 million in 2015. If donor funding is combined with government expenditures in LICs and MICs, family planning funding is projected to increase by a total of US\$2.5 billion between 2011 and 2015.⁶² Such an increase would close 51% of the US\$4.9 billion financing gap for family planning identified in the Global Strategy and provide

Figure 4.5

Projection of family planning spending trends to 2015



Domestic expenditures and gross ODA disbursements in US\$ millions - 2005 prices. Calculations based on data from CRS database and NHA.

an estimated 22.1 million new users with access to family planning in 2015.

While this would be very significant progress, this projection also shows that additional funding is still needed to achieve the Global Strategy goal on family planning (43 million new users). Investments would also need to increase significantly (a total of US\$12.8 billion in additional funding is needed) between 2013 and 2035 to achieve the goal of preventing 147 million child deaths, 32 million stillbirths, and five million maternal deaths as articulated by the GIF.

In the key informant interviews conducted for this report, commitment-makers from all groups reported that one reason for the remaining funding shortfall is insufficient

political leadership at both the national level and at sub-national (state) level. Commitment-makers from all constituency groups identified the lack of in-country leadership for family planning as a key challenge in the implementation of commitments. High-level political commitment is needed to support interventions to increase both the supply of family planning information and service programs, as well as to address social, cultural and behavioral factors that inhibit women, girls, and couples from accessing family planning services. Furthermore, donors reported that they face challenges in incentivizing support for new family planning projects due to insufficient commitment for family planning of policy-makers at country level.

Disbursements for maternal and newborn health

Under MDG 5a, countries committed to reducing maternal mortality by three quarters between 1990 and 2015. While maternal deaths worldwide have dropped by 45% since 1990, the global maternal mortality ratio fell by only 2.6% per year. This fall is far from the annual decline of 5.5% required to achieve MDG5 (Appendix 9).⁶³ In 2013, 289,000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, and most could have been prevented.

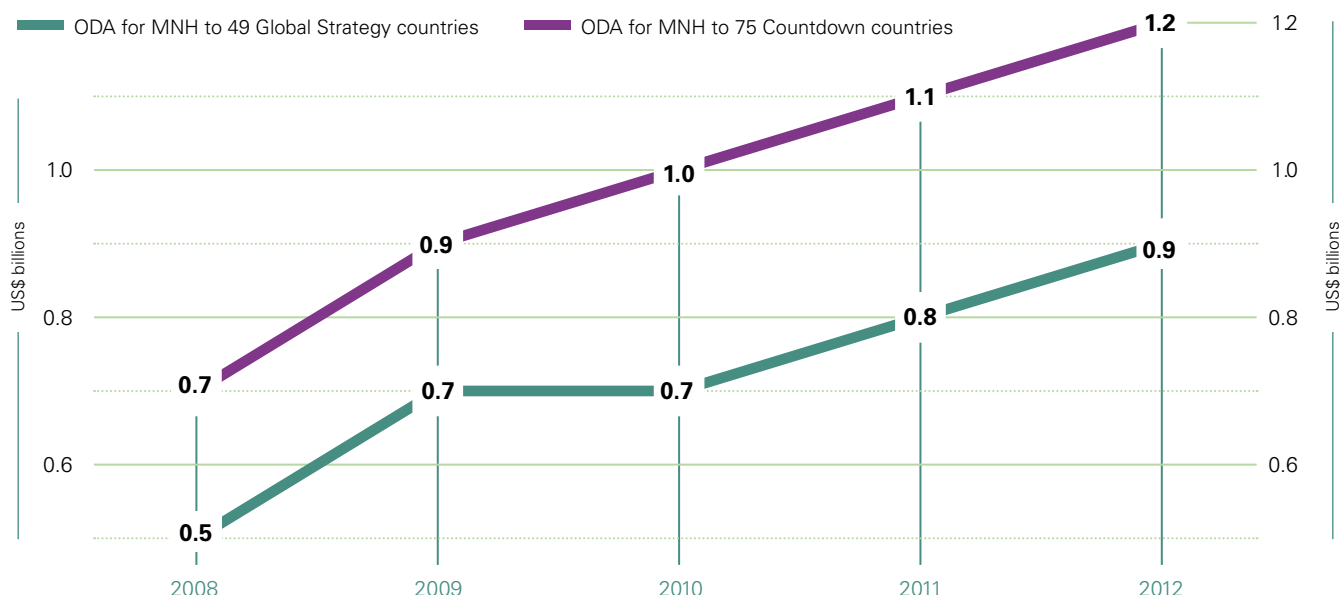
Furthermore, the proportion of under-five deaths that occur during the neonatal period is increasing as under-five mortality declines. Because declines in the neonatal

mortality rate are slower than those in the mortality rate for older children, worldwide, the share of neonatal deaths among under-five deaths increased from 37% 1990 to 44% in 2012, and the trend is expected to continue.⁶⁴ Thus neonatal mortality has become increasingly important as a cause of child deaths (see Appendix 9 on the causes of child and maternal deaths). And prematurity is now the number one cause of newborn deaths worldwide.

As documented by Countdown to 2015, service coverage remains low during childbirth and the neonatal period, when maternal and neonatal mortality is highest. Median

Figure 4.6

Disbursements for MNH to 49 Global Strategy and 75 Countdown countries, 2008 – 2012



Note: Gross disbursements in US\$ billions – 2005 prices.

Source: CRS database.

coverage of skilled attendance at birth in Countdown countries with available data is at 63%, while median coverage for postnatal care for the mother is 45%, and is 30% for the 17 countries with data for postnatal care for the baby.⁶⁵

According to our analysis of CRS data, donor flows for MNH increased by 22% in the Countdown countries since the launch of the Global Strategy, from US\$1.0 billion in 2010 to US\$1.2 billion in 2012. The 49 Global Strategy countries experienced a similar growth rate of 24%, with funding amounting to US\$903.5 million in 2012 from US\$731.6 in 2010 (Figure 4.6). According to a recent, more detailed Countdown analysis, which specifically estimates MNH funding through a project-by project analysis of the CRS database, donor disbursements are somewhat higher and stood at US\$1.7 billion for MNH in 2011, the latest year for which preliminary Countdown data are available (Countdown uses 2012 prices which converts to US\$1.5 billion in

2005 prices used by this report – i.e. the difference with Countdown’s analysis is US\$300 million).

In the future, more investments are required to finance the MNH package. MNH funding is insufficient to close the financing gap estimated by the Global Strategy for maternal health of US\$7.8 billion between 2011 and 2015 (this gap relates to the programmatic costs only and excludes the substantial health systems costs; the gap also excludes funding for newborn health as it was not calculated by the Global Strategy, so the real gap is larger).

It is also unlikely that the targets laid out in the Global Health 2035 report and in the GIF will be reached unless there is a significant rise in investments in MNH. The GIF estimates that US\$70.2 billion in additional funding is needed for MNH in the period 2013–2035. Overall, a much steeper growth in funding is needed to meet the 2035 targets.

HIV disbursements

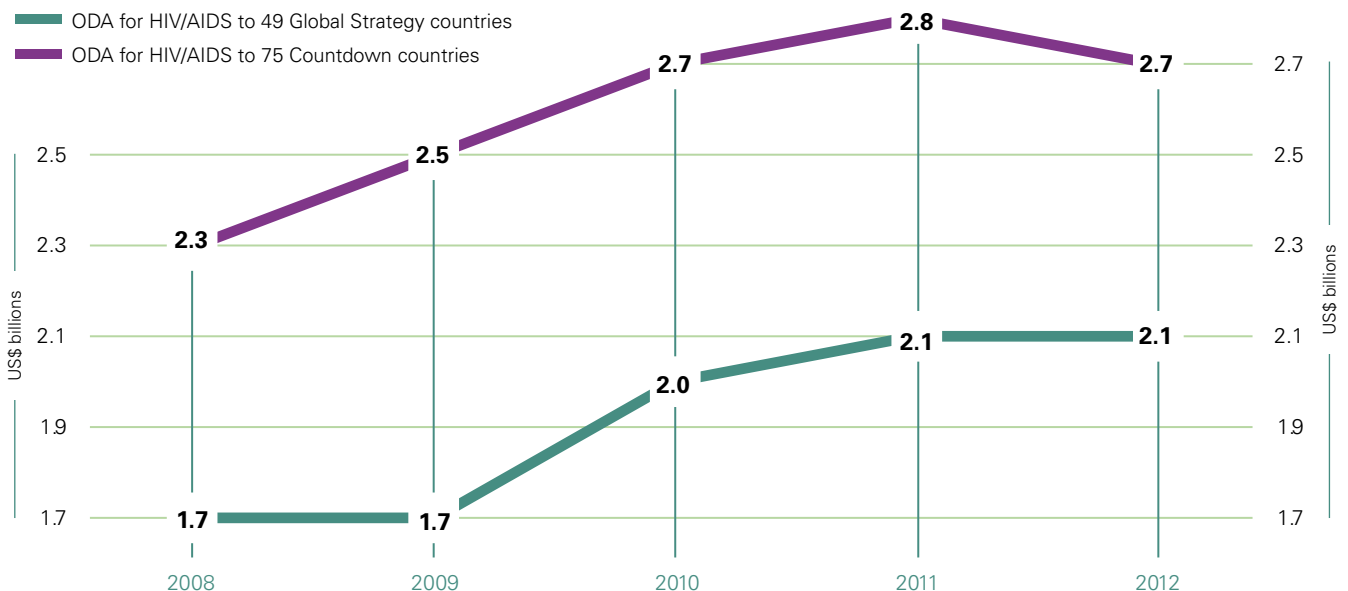
According to the WHO, 757,400 women (ages 15 and above) and children (both sexes, under 5) died of HIV/AIDS in 2010. Globally, young women (15–25 years of age) are twice as likely to be at risk of HIV infection, as compared to young men in the same age group.⁶⁶ However, there are a range of HIV interventions that can benefit the health of women and children. Examples include testing, treatment, and care of sexually transmitted infections, including HIV; preventing mother-to-child

transmission; and comprehensive approaches to ensure HIV-free survival of children born to HIV positive women, including early infant diagnosis and treatment. According to the Muskoka method, 46.1% of all HIV funding contributes to the health of women and children.

Figure 4.7 shows estimated disbursements for HIV that support women and children. Between 2010 and 2012, there was a very small rise in donor disbursements to

Figure 4.7

Disbursements for HIV that support women and children to 49 Global Strategy and 75 Countdown countries, 2008–2012



Note: Gross disbursements in US\$ billions – 2005 prices.

Source: CRS database.

the 49 Global Strategy countries (from US\$2.0 billion to US\$2.1 billion). For the 75 Countdown countries, funding increased up to 2011 followed by a small decline in 2012. Funding totaled US\$2.7 billion in 2012, an increase of just 2% compared to 2010 levels. While growth rates

are much slower for HIV than for FP and RH, in absolute terms HIV remains the most significant funding area, accounting for 31% of RMNCH funding in 2012. If recent funding trends continue, HIV will remain the package that receives the largest amount of financing.

Malaria disbursements

Malaria is one of the leading causes of child mortality, accounting for 9% of global under-five deaths in 2012 (Appendix 9). According to Countdown’s 2014 report, median coverage for key malaria interventions is low but has been increasing at a rapid pace in recent years. Median coverage of intermittent preventative treatment of malaria for pregnant women (IPTp) is 22%; median coverage with effective malaria treatment stands at just 32%. Only 38% of children in malaria-endemic countries sleep under an insecticide-treated bed net.⁶⁷

In 2011, donors disbursed US\$810.8 million for malaria to the 49 focus countries of the Global Strategy, a decrease of 20% compared to 2010. Disbursements for the Countdown countries also fell by 20% in 2011 relative to 2010, decreasing to US\$976.6 million (Figure 4.8). This decline in malaria funding largely goes back to a decrease in disbursements for malaria by the Global Fund, the largest international malaria funder. Total malaria funding from the Global Fund contracted from US\$938.6 million in 2010 to US\$640.8 million in 2011, a decrease of US\$297.8 million. This contraction reflects slower disbursement processes at the Global Fund which resulted from efforts to improve the Global Fund’s funding mechanism at

that time. Other funders, including the UK government, increased their malaria investments in 2011, but were not able to compensate for this reduction in malaria funding.

By 2012, the Global Fund’s malaria funding had grown again to US\$989 million, a 33% rise from 2011. This increase contributed to an increase in malaria funding in 2012 to the Countdown countries. Overall malaria disbursements to the Countdown countries totaled US\$1.3 billion. From 2011 to 2012, funding for the Global Strategy focus countries also grew by 38% to US\$1.1 billion. In 2013, Global Fund investments for malaria increased further to US\$1.1 billion. While this is significant additional malaria funding (a total of US\$860 million in 2011 and 2012 compared to baseline spending), more funding is needed to increase coverage with key malaria interventions. The GIF estimates that US\$31 billion in additional investment are required between 2013 and 2035 (US\$1.4 billion per year on average).

Figure 4.8

Disbursements for malaria that support women and children to 49 Global Strategy and 75 Countdown countries, 2008 – 2012



Note: Gross disbursements in US\$ billions – 2005 prices.

Source: CRS database.

Disbursements for immunization

Immunization has received significant attention in recent years. This attention includes the Global Vaccine Action Plan (GVAP) 2011–2020, which established a framework to achieve the Decade of Vaccines vision of preventing millions of deaths by 2020 through increased access to vaccinations.⁶⁸

Although immunization coverage rates are high compared with other maternal and child health interventions, many children still die from easily preventable diseases, including pneumonia and diarrhea.⁶⁹ New pneumococcal and rotavirus vaccines now exist to prevent these disorders.

RMNCH ODA delivered through GAVI and GPEI targets the immunization package. GAVI more than doubled its overall disbursements from US\$651 million in 2010 to US\$1.4 billion in 2013. The growth rate accelerated from 6% in 2010–2011 (an increase of US\$39 million) to 41% in 2011–2012 (an increase of US\$280 million), and to 42% in 2012–2013 (an increase of US\$409 million). The increased disbursements in 2011–2013 result from increased country demand and the rollout of new GAVI programs that were approved in 2011. In 2011, a record of 55 new programs had been approved, of which more than 30 target pneumococcal or rotavirus vaccines.

GPEI funding declined from US\$615 million in 2010 to US\$559 million in 2011 (a 9% decrease compared to 2010), but grew to US\$639.8 million in 2012 (a 14% increase compared to 2011), and to US\$822.8 million in 2013 (a 29% increase compared to 2012).

Figure 4.9 shows the combined GPEI and GAVI spending for the 49 Global Strategy countries and the 75 Countdown countries for the period 2008–2012.⁷⁰

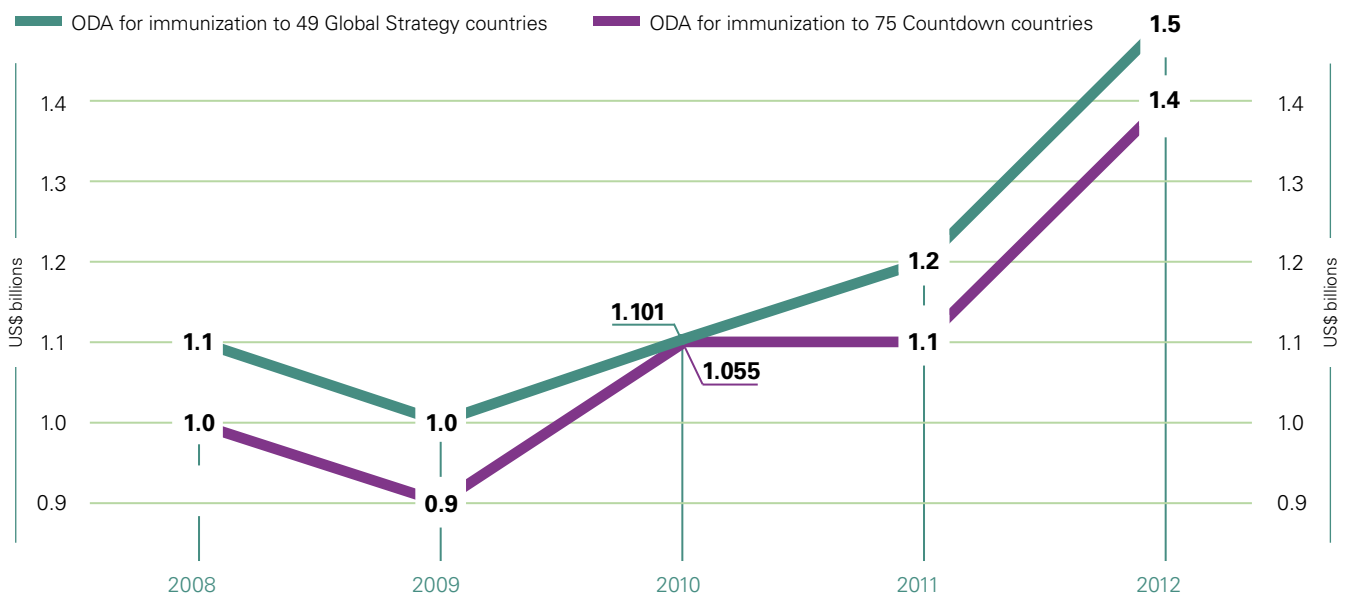
The Global Strategy calculated a US\$5 billion funding gap for immunization for 2011–2015. Between 2011 and 2013, GAVI, the major multilateral mechanism for financing vaccines, and the GPEI increased their disbursements to 49 Global Strategy countries by a total of US\$1.3 billion over 2008 spending levels.⁷¹ Making conservative assumptions that funding for immunizations by other donors remained at 2008 levels and that GAVI’s and GPEI’s disbursement in 2014 and 2015 continued at 2013 levels, an additional US\$3.1 billion would be disbursed for immunization. This corresponds to 62% of the estimated funding gap and would result in an additional 9.5 million fully immunized children.⁷²

At the Global Vaccine Summit in April 2013, global stakeholders also pledged over US\$4 billion towards the Polio Eradication and Endgame Strategic Plan 2013–2018, showing ongoing donor support for immunization.

The GIF estimates that the amount of additional investments required for immunizations is as large as the one for MNH (US\$70 billion for 2013–2035). Thus immunization funding needs to increase further. Global health donors will have the opportunity to make additional pledges at the next GAVI replenishment in Germany in 2015.

Figure 4.9

Disbursements for immunization to 49 Global Strategy and 75 Countdown countries, 2008–2012



Note: Gross disbursements in US\$ billions – current prices.

Source: GAVI, WHO & UNICEF data.

Disbursements for child health

As the CRS database includes no specific purpose code for child health, the Muskoka methodology cannot be used to estimate child health disbursements. Countdown estimates that donor disbursements decreased by a small amount, from US\$4.0 billion in 2010 to US\$3.9 billion in 2011. Data for 2012 will become available only later this year.

As this report, based on the Muskoka methodology, found a significant increase in overall RMNCH funding from 2011 to 2012 (see above), it is likely that funding for child health will increase again in 2012. This is particularly likely as Countdown identified declining malaria and immunization funding as drivers of the decrease in child

health funding in 2011. As discussed above in this section, there is strong evidence that funding for these two areas increased again in 2012.

The Global Strategy does not specify a funding gap for child health, but the GIF states that additional investments are needed. Looking forward at the 2013–2035 time period it estimates that a total of US\$100 billion will be needed in additional funding to meet the objectives articulated by the GIF, the greatest incremental investment amongst all packages. Countdown's estimates show that massive increases in child health funding will be needed to meet the longer-term targets of the GIF.

Box 4.1

Progress on nutrition

Undernutrition contributes to almost half of all child deaths. Levels of stunting, a form of growth failure resulting from chronic undernutrition, are very high in virtually all 75 Countdown to 2015 countries. As a cross-cutting area, nutrition-related interventions are included in two of the six packages of the GIF, the MNH and child health packages.

Previous PMNCH reports found that Global Strategy commitments have not adequately focused on determinants of health outside the health sector, such as nutrition and food security, safe drinking water, sanitation and hygiene. However, there have been multiple international events related to nutrition, which are outside the scope of this report (as they are not directly linked to the Global Strategy), that have helped the issue to gain momentum. Since 2010, there has been an annual meeting held during the UNGA to encourage greater support for the efforts of the Scaling Up Nutrition (SUN) Movement.

In June 2013, there was a high-level Nutrition for Growth meeting hosted by the UK, which resulted in global leaders signing an agreement to reduce undernutrition. This event led to a significant increase in funds committed for nutrition. Fourteen SUN country governments committed to increasing their domestic resources invested in scaling up national nutrition plans. New commitments were made of up to US\$4.15 billion for specific nutrition interventions and an estimated US\$19 billion for nutrition-sensitive activities up to 2020.

In signing the Global Nutrition for Growth Compact, an agreement aimed at reducing undernutrition by 2020, a range of partners committed to: improving nutrition

for 500 million pregnant women and children, reducing the number of children who are stunted by 20 million and saving the lives of at least 1.7 million children by preventing stunting, increasing breastfeeding and providing better treatment for malnutrition.

This increased attention to nutrition preceded as well as followed the Nutrition summit. Donor funding for basic nutrition (as defined by the CRS⁷³) to the 49 Global Strategy focus countries grew by 40% between 2010 and 2012, from US\$232.4 million in 2010 to US\$325.7 million in 2012. Following a small fall from 2010 to 2011, funding to the 75 Countdown countries also increased by 40% from 2011 to 2012, rising to US\$451.1 million. This increase results from additional funding provided by key bilateral donors. Canada doubled disbursements for basic nutrition from US\$29 million in FY2010/11 to US\$58 million in FY2012/13. The US government increased funding from US\$31 million in 2011 to US\$51 million in 2012 and then further increased its funding in 2013 to US\$97 million. From 2010–2013, the World Bank more than doubled its commitments for nutrition (from US\$174.4 million in FY 2012 to US\$378.7 million in FY 2013), a sign of further growth in nutrition funding for 2013.

Most recently the US government reaffirmed its commitment to global nutrition efforts by launching USAID's 2014–2025 Multisectoral Nutrition Strategy (May 2014), which seeks to reduce malnutrition in women of reproductive age and children under five. Overall, these developments show that nutrition has received significantly more attention than in previous years.

Government RMNCH expenditures in low- and middle-income countries

FINDING **Domestic RMNCH expenditures were calculated based on the assumption that 25% of LIC and MIC government expenditures flow to RMNCH. RMNCH expenditures from the governments of the 49 Global Strategy countries grew to a total of US\$2.7 billion in 2012, a 15% increase from 2010. Domestic funding for RMNCH of the 75 Countdown countries grew by 21% between 2010 and 2012. However, if funding of four large MICs from the group of Countdown countries is discounted, the resulting growth rate of 14% (from US\$9.1 billion in 2010 to US\$10.4 billion in 2012) is comparable to that of the 49 Global Strategy countries.**

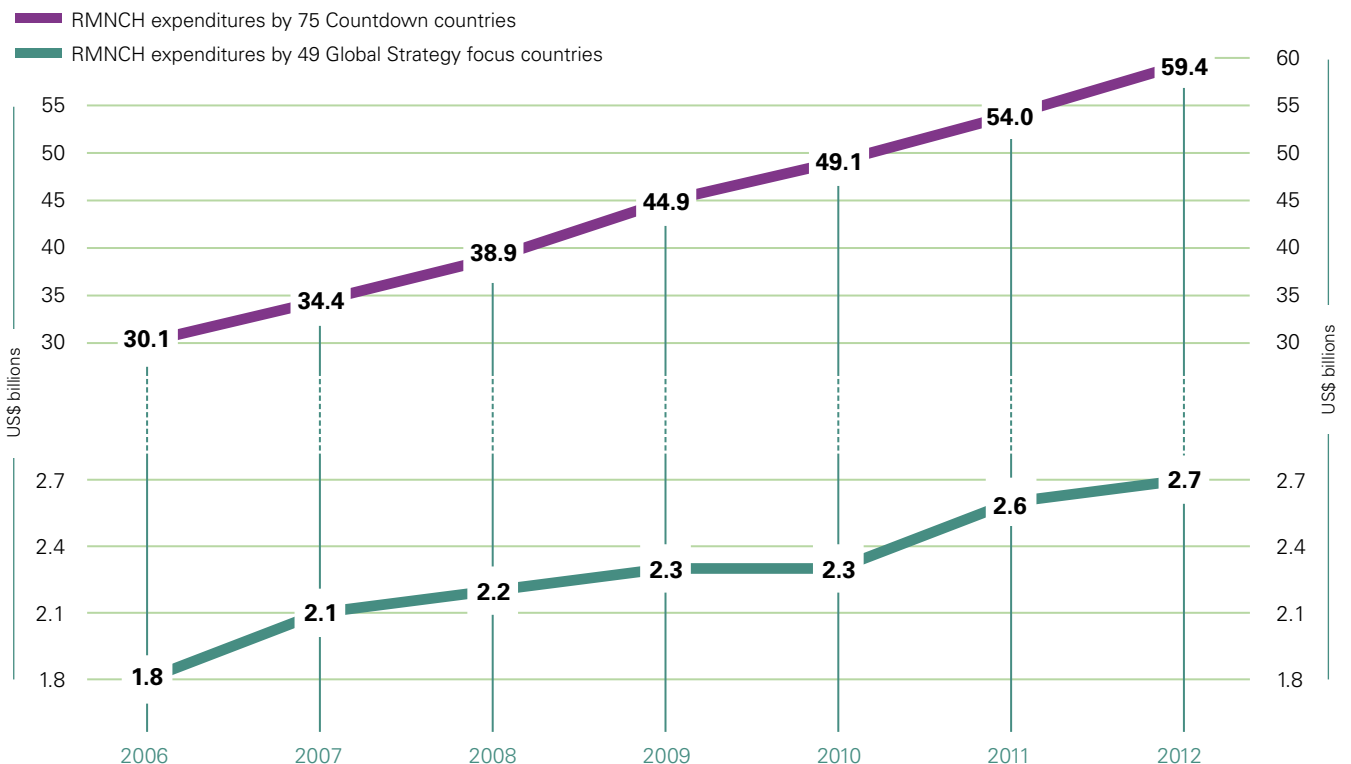
In accordance with the assumption laid out in the financial estimates in the Global Strategy, government RMNCH expenditures in LICs and MICs were calculated assuming that they would constitute 25% of total government health expenditures.⁷⁴ Given that the 25% is only a rough proxy, results need to be taken with caution. RMNCH

expenditures from the governments of the 49 Global Strategy countries increased to a total of US\$2.7 billion in 2012 (in order to estimate the actual domestic spending by LIC and MIC governments, the total of US\$2.7 excludes funding from external resources⁷⁵). RMNCH expenditures in 2012 by LICs and LMICs therefore increased by 50.3% from 2006 levels and 14.6% from 2010 levels (Figure 4.10). Mean RMNCH spending per capita in these 49 countries increased from US\$6.38 in 2010 to US\$7.52 in 2012, an increase of 18% (Figure 4.11).⁷⁶

Total RMNCH funding by the Countdown countries for which data were available totaled US\$59.4 billion in 2012, up from US\$49.1 billion in 2010 (excluding funding from external sources), an increase of 20.9%. Three large upper MICs – Brazil, China and Mexico – accounted for more than three quarters (76% or US\$45.1 billion) of the total funding in 2012. India, a lower MIC, accounted for another 6% in 2012 (US\$3.8 billion). Discounting the RMNCH expenditures of these four countries, overall spending only increased by 14% from 2010–2012, from US\$9.1 billion in 2010 to US\$10.4 billion in 2012. This analysis shows that the four large MICs have significantly increased their domestic spending, while poorer countries, in contrast, have struggled to increase their domestic expenditures for health.

Figure 4.10

Government RMNCH expenditures in low- and middle-income countries, 2006–2012



Note: Expenditures in US\$ billions – constant 2005 prices.

Source: GHED and CRS database.

Figure 4.11

Average domestic RMNCH spending per capita, Global Strategy and Countdown countries, 2010–2012



Note: The figure shows RMNCH spending per capita in the 49 Global Strategy countries and the 75 Countdown countries. For the 75 Countdown countries (right part of the figure) the per capita spending by country income group is also shown. For this analysis, per capita refers to persons in the target population (women of reproductive age [females, ages 15–49] and children [both sexes, ages 0–4]).

This trend is also shown by the per capita spending. Mean RMNCH spending per capita in the Countdown countries increased by 12% between 2010 and 2012, from US\$23.99 to US\$26.87 (Figure 4.11). However, as shown in Figure 4.11, funding by upper MICs & HIC (i.e. Equatorial Guinea) increased by US\$7.15 per capita, but only by US\$0.58 in LICs.

In Africa, most countries are still far from reaching the Abuja commitment. In 2001, 55 African Union (AU) member states signed the Abuja commitment, agreeing to dedicate at least 15% of their domestic budgets to health. Only six AU Member States (Liberia, Madagascar, Malawi, Rwanda, Togo and Zambia) have achieved this

target, although four other countries (Djibouti, Ethiopia, Lesotho, and Swaziland) are within reach of the 15% target. Thus 45 AU member states have not yet come close to meeting their commitments. Global Health 2035 projected that LICs and LMICs are on course to experience very significant economic growth, which will create larger domestic fiscal space for health financing.⁷⁷ Countries should be encouraged to use this fiscal space to improve the health of women and children.

Projection of RMNCH disbursements until 2015

FINDING



For 2011–2015, the period of the Global Strategy, this report estimates that a total of US\$18.7 billion in additional funding will be available for RMNCH in the 49 focus countries. This estimate is based on combining actual disbursements for 2011 and 2012 with projected RMNCH disbursements for the years 2013–2015 (based on spending trends from 2008–2012). The US\$18.7 billion would cover 21.1% of the financing gap articulated in the Global Strategy.

ODA combined will reach US\$12.4 billion in the year 2015. For the period 2011 to 2015, the amount of additional funding for RMNCH over the 2008 baseline would amount to US\$18.7 billion. This would cover 21.1% of the financing gap identified by the Global Strategy (Figure 4.12). However, our analysis only included financial commitments. The non-financial commitments (e.g. to support service delivery) are likely to have a substantial monetary value. So in practice, the true amount of additional funding for RMNCH for 2011–2015 probably exceeds US\$18.7 billion, covering more than 21.1% of the financing gap.

The Global Strategy estimated that US\$88 billion in additional financing would need to be made available between 2011 and 2015 in order to reach the objectives articulated in the strategy. As the year 2015 approaches, a key question to answer is: how far has the international community come in closing the RMNCH financing gap?

Of this additional funding of US\$18.7 billion, we estimate that US\$3.5 billion will come from domestic resources of the 49 Global Strategy countries. By 2015, total RMNCH expenditures by the 49 Global Strategy countries are estimated to rise to US\$3.2 billion (in constant 2005 prices and excluding external resources).

Disbursements for 2011 and 2012 amounted to US\$18.2 billion. In addition, our projections of disbursements for 2013–2015, based on 2008–2012 spending trends, suggest that disbursements by the 49 countries and RMNCH

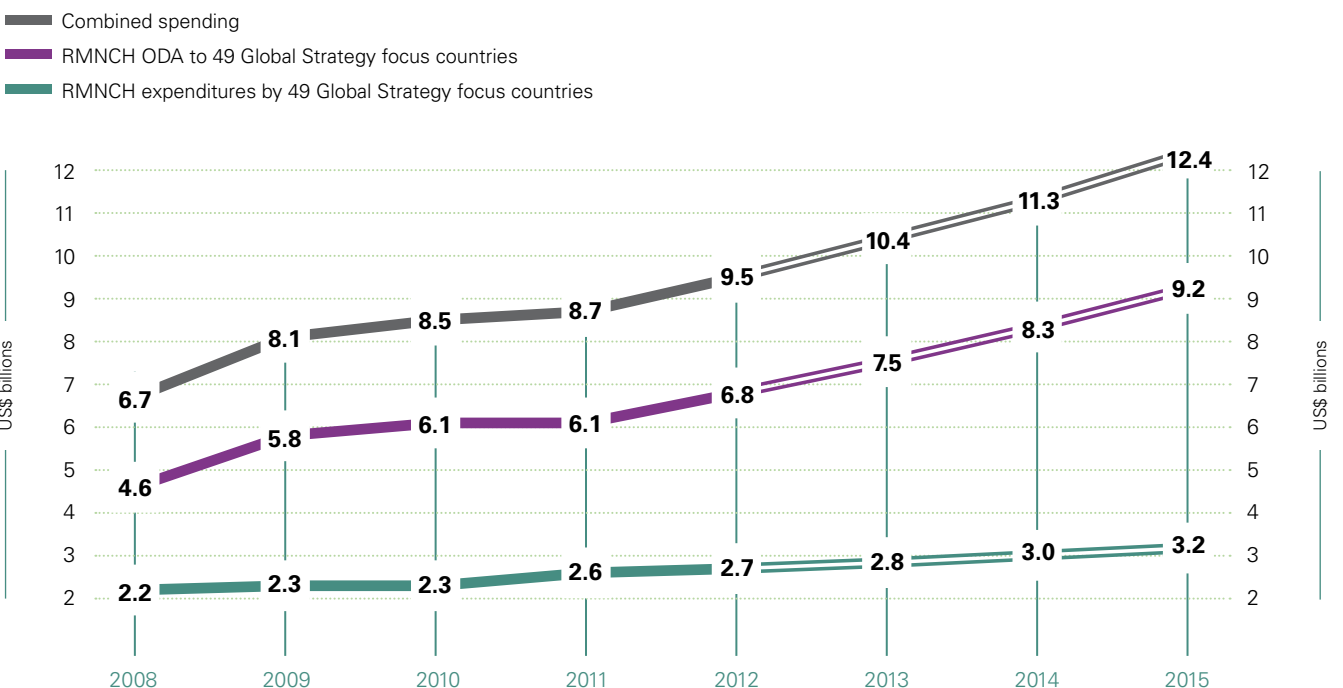
We estimate that the remainder of the additional RMNCH funding, US\$15.2 billion, will come from bilateral and multilateral donors. Additional ODA for RMNCH over the 2008 baseline was calculated using the mean of the disbursement estimates based on the Muskoka methodology and the estimates calculated by Countdown. RMNCH ODA to the 49 countries is estimated to reach a total of US\$7.3 billion by 2015 (in constant 2005 prices).

Figure 4.12

RMNCH disbursements in the 49 Global Strategy countries with projections until 2015

(based on mean annual change, 2008–2012)

Domestic expenditures & gross ODA disbursements in US\$ billions – 2005 prices



Calculations based on data from CRS database, GHED, and Countdown to 2015.



Conclusions and recommendations

Conclusion

This report assessed the value of and progress in disbursing the financial commitments made to the Global Strategy. It also attempted to estimate the impact of these financial commitments on overall RMNCH financing trends and the degree of alignment with the six packages of the GIF. A number of the report's findings are encouraging. The Global Strategy has amassed unprecedented support. Three hundred stakeholders have made commitments to the Global Strategy since its launch in September 2010 (up to May 2014). Of these 300 commitment-makers, 118 have made financial commitments, valued at US\$41.1–45.1 billion if double-counted commitments are excluded.

Of this amount, US\$18.2–22.3 billion is new and additional funding – with US\$12.9–16.8 billion targeted at the 49 focus countries of the Global Strategy. This amount represents 14.6–19.1% of the US\$88 billion funding gap estimated by the Global Strategy in 2010. However, it is highly complex to estimate the significant financial value of all the policy, advocacy, service delivery and other commitments that were not expressed in explicit financial terms. These also contribute significantly to narrowing the financing gap. Nevertheless, the analysis shows that additional financing is still urgently needed to achieve the goals of the Global Strategy, as well as the targets outlined by the GIF and the Global Health 2035 report.

Another challenge relates to the geographic targeting of commitments: some countries with high mortality burden receive too little attention from donors. In addition, some of the key RMNCH packages recommended by the GIF receive comparatively less investments than other packages. The MNH package, which includes key interventions to avoid maternal and neonatal deaths and illness, remains seriously underfunded. If investments continue as per current trends, HIV/AIDS will continue to be the most-funded package, followed by immunization.

A very encouraging finding from this report is that funding for family planning has increased by 47% in the Countdown countries since 2010, and the 49 Global Strategy countries experienced an increase of 52%. Increasing coverage with modern, effective contraceptives from current rates of 30% to 50% coverage on average across these countries would avert an estimated 54% of maternal deaths and 47% of child deaths between 2013 and 2035. However, in the implementation of their commitments to family planning, commitment-makers from all groups interviewed for this report identified insufficient political leadership in support of family planning as a remaining constraint. Scaling up access to family planning services will be difficult to achieve without stronger high-level political leadership at the country level.

Recommendations

This report makes seven recommendations:

RECOMMENDATION

1 **Efforts to mobilize additional resources from international and domestic sources for RMNCH need to be continued and must be kept high on the political agenda.**

It will be imperative to ensure that RMNCH remains central in the post-2015 development framework. This framework should include clear realistic targets to end preventable maternal, newborn and child mortality and to improve access to sexual and reproductive information and services and ensure the realization of sexual and reproductive health and rights.

The targets set out in the GIF and the Global Health 2035 report can only be met through scaled-up investments. Both the GIF and Global Health 2035 found that such investments would yield very large economic and social returns.⁷⁸ Given the unprecedented support catalyzed by the Global Strategy, a new mobilization and advocacy effort similar to the Global Strategy should be considered for the post-2015 era to finance the unfinished agenda of MDGs 4–6 and achieve a “grand convergence” in global health.

RECOMMENDATION

2 **Funding should be focused on the most cost-effective, evidence-based intervention packages that have the largest impact on reducing mortality and that are currently receiving too little attention.**

Donors and countries alike should refer to the Global Investment Framework for Women’s and Children’s Health to guide their investments, which should be particularly targeted at the most underfunded of the six GIF packages and those with the largest impact. The child health, MNH, and immunization packages require the largest additional investments alongside the other packages. The family planning package has the potential to have the largest impact on reducing mortality.

ENAP, developed and officially launched in June 2014, provides a new opportunity for international and national stakeholders to invest in neonatal health, a consistently neglected issue. Global health donors will also be given the opportunity to make additional pledges for immunization at the next replenishment of the GAVI Alliance in 2015 (among other occasions).

RECOMMENDATION

3 **Funding needs to be better matched with mortality burden to achieve equitable progress among countries and healthy lives for all.**

Funding should become more closely aligned with mortality burden so that countries in greatest need receive sufficient donor support. Stakeholders should use existing global platforms, and consider new platforms, such as the potential RMNCH Global Financing Facility, to better coordinate their RMNCH investments to increase efficiencies in their allocations to countries.

RECOMMENDATION

4 **Countries need to further prioritize and strengthen efforts to self-finance their RMNCH needs.**

More domestic resources from MICs are required for RMNCH to free up donor funding for the poorest countries, but LICs also need to strengthen their efforts to self-finance their RMNCH needs.

As highlighted by the Global Investment Framework for Women’s and Children’s Health and the Global Health 2035 report, every dollar spent on RMNCH and health more generally is a good investment. Global Health 2035 projected that LICs and LMICs are on course to experience substantial economic growth, which will create greater domestic fiscal space for health financing. Thus, more emphasis on countries to expand their fiscal space for health and increase public funding for the poor and vulnerable populations, particularly women and children, is urgently needed. Donors need to work with governments to create opportunities for increased domestic health and RMNCH spending.

RECOMMENDATION

5 Strengthen political leadership for family planning at country level to create support for contraception and sexual and reproductive health and rights.

The GIF and Global Health 2035 targets cannot be achieved without a very large increase in coverage with modern, effective contraceptive methods, and both of these frameworks argue that family planning deserves particularly high, early prioritization.

While there is substantial global attention focused on supporting family planning, more political leadership is needed at country level. Domestic leadership should be directed at supporting interventions to increase both the supply of contraceptive information and service programs, and to address social, cultural and behavioral factors that inhibit women, girls and couples from accessing available services.

RECOMMENDATION

6 Initiate a major final Global Strategy accountability reporting session at the United Nations General Assembly in September 2015 to ensure accountability right up to the finish line.

A major final Global Strategy accountability reporting session should be initiated to ensure accountability right up to the finish line for all commitment-makers. Without such a process, there is a risk of “slippages” in accountability. The UNGA in September 2015 would be a timely high-level event for this final reporting session, although data for the entire period of the Global Strategy will only be available in 2016 or even later.

RECOMMENDATION

7 To strengthen accountability for RMNCH beyond 2015, a harmonized method should be agreed on to track progress against the post-2015 targets for RMNCH.

While efforts are ongoing to include RMNCH targets in the post-2015 development framework, the RMNCH community should also agree on an approach for ensuring accountability towards these goals. This approach would involve agreeing on one method for assessing progress towards closing the RMNCH funding gap estimate that was established by the Global Investment Framework for Women’s and Children’s Health.⁷⁹

Given the focus of the post-2015 agenda on universality across all countries and equity among poor populations within countries, tracking resources and progress for a larger group of countries (i.e. beyond the Countdown countries) and beyond the health sector, so as to better cover the broader determinants of health, would be worth exploring.

As current reporting efforts are constrained by slow accounting systems, commitment-makers should also consider ways to improve their accounting system in order to provide financial data in a more timely manner. A stronger focus on impact assessment would also be needed to ensure that investments achieve the desired results.





Appendices

Appendix 1 The Global Strategy's goals

The overall goal of the Global Strategy is to save 16 million lives by 2015. Assuming the funds needed each year between 2011 and 2015 are made available, implementing the Global Strategy would dramatically improve access to life-saving interventions for the most vulnerable women and children in the 49 poorest countries. In 2015 alone:

- 43 million new users would have access to family planning
- 19 million more women would give birth supported by a skilled birth attendant
- 2.2 million additional neonatal infections would be treated
- 21.9 million more infants would be exclusively breastfed for the first six months of life
- 15.2 million more children under the age of one would be fully immunized
- 117 million more children under the age of five would receive vitamin A supplements
- 40 million more children would be protected from pneumonia.

This funding would also significantly improve the health infrastructure available to the world's poorest women and children. In 2015 it would contribute to:

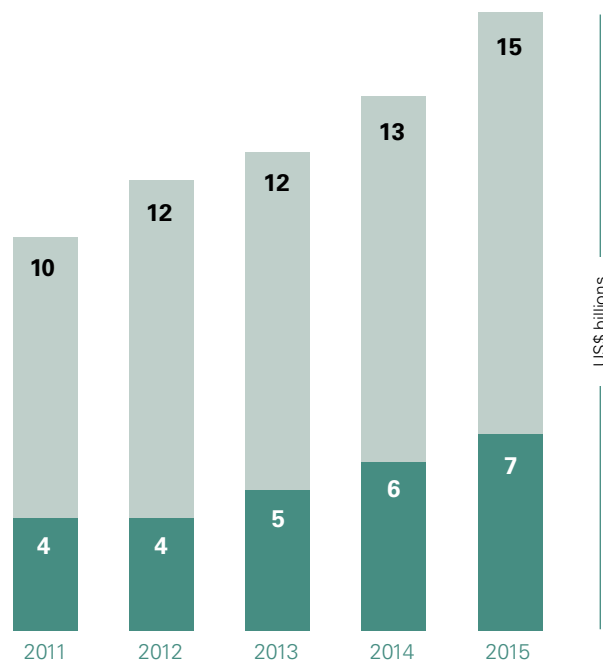
- 85,000 additional health facilities (including health centres, and district and regional hospitals)
- Between 2.5 and 3.5 million additional health workers (including community health workers, nurses, midwives, physicians, technicians and administrative staff).

Appendix 2 Estimated annual funding gap

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

- Health systems costs of programs targeting women and children
- Direct costs for programs targeting women and children

Estimated annual funding gap in US\$ billions – 2005 prices



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

Appendix 3 Commitment-makers that provided information

Commitment-makers that provided information on financial commitments through semi-structured interviews and/or written information

- African Medical and Research Foundation
- Australia
- Bill and Melinda Gates Foundation
- Burundi
- Canada
- France
- Germany
- Ghana
- Global Fund
- GAVI Alliance
- India
- Indonesia
- Japan
- John Snow, Inc.
- J&J
- Marie Stopes International
- Merck/Merck for Mothers
- Netherlands
- Niger
- Nigeria
- Norway
- Pakistan
- Philippines
- Population Services International
- Save the Children
- Senegal
- Sweden
- United Kingdom
- United States of America
- World Bank
- World Vision International
- Zambia

Appendix 4 Method for calculating the total financial commitments of LOCs

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

(1) Unless otherwise specified, and following the method used by Countdown to 2015, it was assumed that 25% of government health spending will benefit RMNCH. Where a specific proportion was specified in the commitment, this figure was used instead: for example, 30% for the Central African Republic.

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

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

The total additional government health spending on RMNCH in 2011–2015 (the two lighter areas in the figure below) is the estimated value of governments’ financial commitments. The figure also shows the expected share of funding that is potentially subject to “double-counting”.

Government health spending on RMNCH in 25 low-income countries, with and without financial commitments to the Global Strategy, 2011–2015⁸⁰



Appendix 5: Controlling for double-counting

Controlling for double-counting in Global Strategy commitments is essential to avoid artificially increasing the funding figures. To avoid double-counting of commitments made by international stakeholders, financing sources were differentiated from financing channels, a differentiation introduced by the IHME. One important instance of double-counting occurs when a source of international financing (for example, a bilateral agency or foundation) channels funding through multilateral organizations, global health partnerships or NGOs, and when both – the source and the channel – count this funding as part of their commitment.⁸¹

One particular challenge in this context was to estimate the funding channeled through NGOs. While good data were available for global health partnerships and multilateral agencies, only a small number of NGOs were able to

estimate the extent to which their commitment relied on financial resources from international donors (and donors were also unable to specify the proportion of their commitment channeled through NGOs). As described in the table below, a different approach had to be used to estimate the extent to which NGOs' commitments are double-counted.

While LIC and MIC governments are also a potential source of funding (i.e., they generate new resources for health, e.g. through taxes), their commitments are likely to be financed partly by external resources, which means that their commitments could also overlap with commitments by international sources.

Table: Approaches to controlling for double-counting

Multilateral agencies and global health partnerships	<p>Commitments by bilateral and private donors channeled through multilateral organizations and global health partnerships were counted.</p> <p>Donor commitments were then subtracted from the amounts pledged by the different multilaterals and global health partnerships.</p>
NGOs	<p>NGOs were asked to provide information on the extent to which their commitment relied on funding from international donors.</p> <p>To fill data gaps, relevant documents were reviewed to estimate the share of donor funding that was channeled through NGOs (e.g. annual reports, IHME data).</p> <p>On average, we estimated that about 60% of NGO commitments were subject to double-counting.⁸²</p>
LICs	<p>In order to estimate the amount of external resources for health provided to the government budget of LICs, we calculated ODA for health channeled through the public sector for the 27 LICs that made financial commitments for 2007–2011 (source: CRS data).</p> <p>Considering a one-year time lag between donor disbursements and expenditure by recipient countries, we calculated ODA for health channeled through the public sector for the 27 LICs that made financial commitments (source: CRS data).</p> <p>The proportion of these external resources for health in total government health expenditures in the 27 LICs was calculated (for each LIC, the mean for 2008–2012 was drawn, source: GHED).</p> <p>Subsequently, the interquartile range (IQR) for the 27 LICs was calculated. The IQR is the range of the middle 50% of the data, excluding extreme values (“outliers”). The IQR is considered a more robust statistical measure than the range.</p> <p>The calculated IQR (15% and 54% of LIC commitments) was subtracted from projected LIC spending.</p>
MICs	<p>In order to estimate the amount of external resources for health provided to the government budget of MICs, ODA for health channeled through the public sector was calculated for the three MICs that made financial commitments (source: CRS data).⁸³</p> <p>The share of these external resources for health of total government health expenditures in the three MICs was calculated (for each MIC, the mean for 2008–2012 was drawn, source: GHED).</p> <p>Subsequently, the median for the three MICs was calculated.</p> <p>The calculated median of 2.7% was subtracted from the amount committed by the MICs.</p>

Appendix 6:

Overview of different methods to track spending on reproductive, maternal, newborn and child health

Muskoka methodology

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

For a detailed list of the imputed percentages as well as the purpose codes and multilateral organizations which contribute to RMNCH according to the "Muskoka Methodology for Calculating Baselines and Commitments: G8 Member Spending on Maternal, Newborn and Child Health", please see: <http://www.canadainternational.gc.ca/notfound.aspx?404%3B/g8/summit-sommet/2010/muskoka-methodology-muskoka.aspx>.

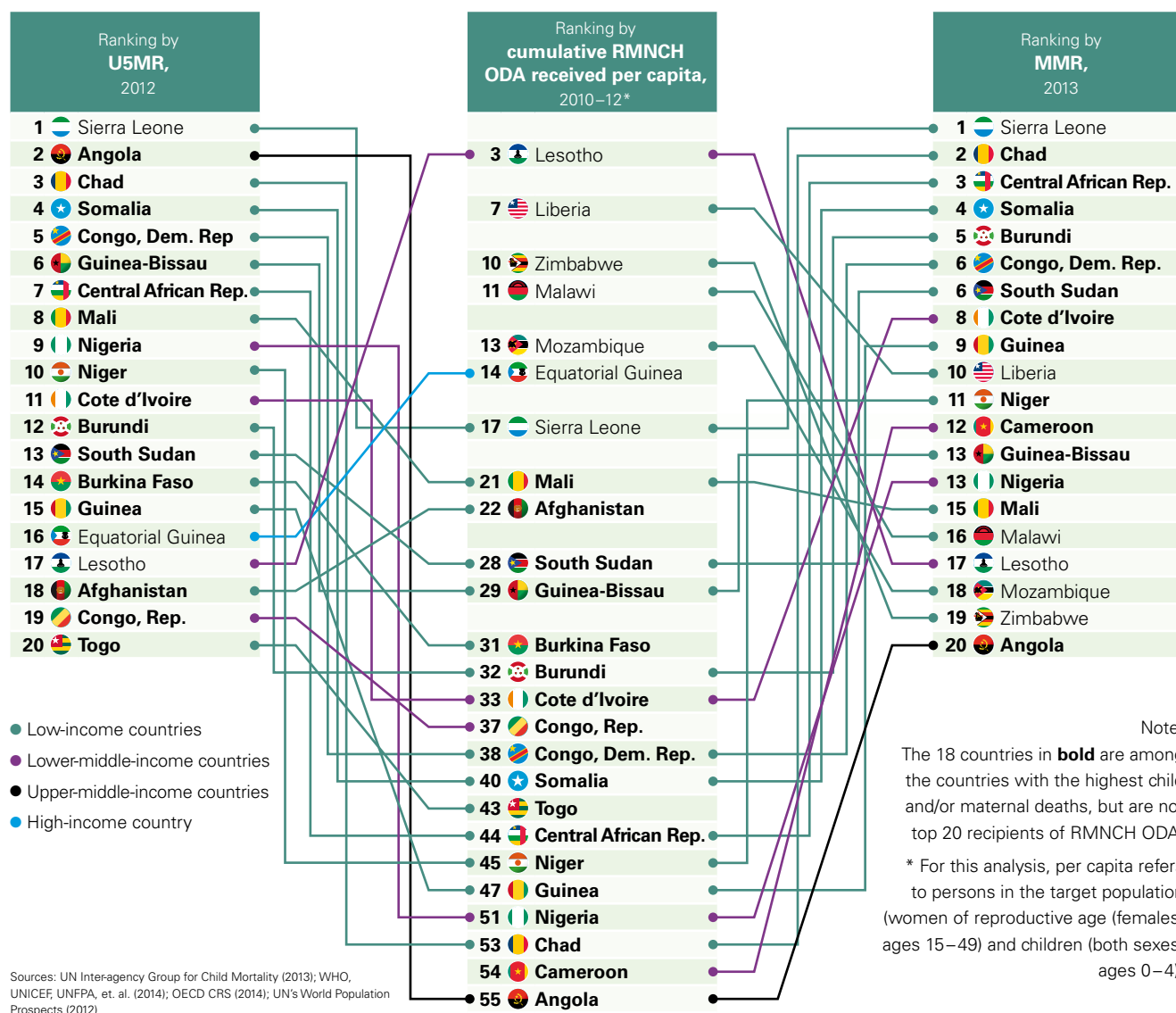
IHME's approach

IHME tracks Development Assistance to Health (DAH). DAH includes financial and in-kind contributions from all donors reporting to CRS and NGOs delivered to low- and middle-income countries, as classified by the World Bank. DAH differs from ODA as DAH includes both private and public transfers, while ODA includes only public resources. The approach draws on data from the OECD CRS, donor databases, NGO databases and data obtained directly from donors. It relies on an automated keyword search of project descriptions reported under health and population sector codes. IHME's method largely avoids overlaps between MNCH funding and other DAH categories such as HIV/AIDS and malaria. It only captures funding explicitly earmarked for MNCH, e.g. pooled funding or health systems funding are not included. Please refer to the method annex of IHME's 2014 Report Financing Global Health 2013: Transition in an Age of Austerity.

Countdown to 2015's approach

Countdown to 2015 analyses data reported to the OECD's CRS. The method assesses project descriptions that donors report to the OECD. Based on its own classification of RMNCH activities Countdown screens the CRS database for RMNCH financing. Projects are manually reviewed based on project title and descriptions, and categorized accordingly. For projects that specifically target the health of women and children, such as child immunization, the entire disbursement would be included in the RMNCH financing estimate. For other activities such as funding reported under HIV and malaria purpose codes as well as pooled funding and health systems funding, Countdown assesses the extent to which these activities contribute to RMNCH. Please refer to the latest Lancet articles on RMNCH resources by Countdown to 2015 of 2012 and of 2013 for further details on Countdown to 2015's methodology.

Appendix 7: Geographical targeting of per capita RMNCH donor funding



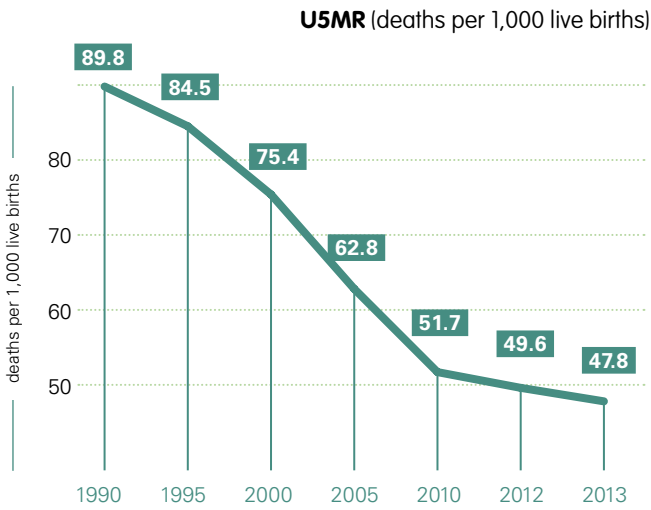
Top 10 countries by RMNCH ODA received per capita (under 5 and female 15–49), 2010–12 US\$

Ranking	Country	RMNCH ODA per under 5 and female 15–49
1	Solomon Islands	294.5
2	Swaziland	244.5
3	Lesotho	220.0
4	Sao Tome & Principe	205.0
5	Botswana	167.5
6	Zambia	154.7
7	Liberia	151.1
8	Rwanda	149.8
9	Haiti	132.3
10	Zimbabwe	128.5

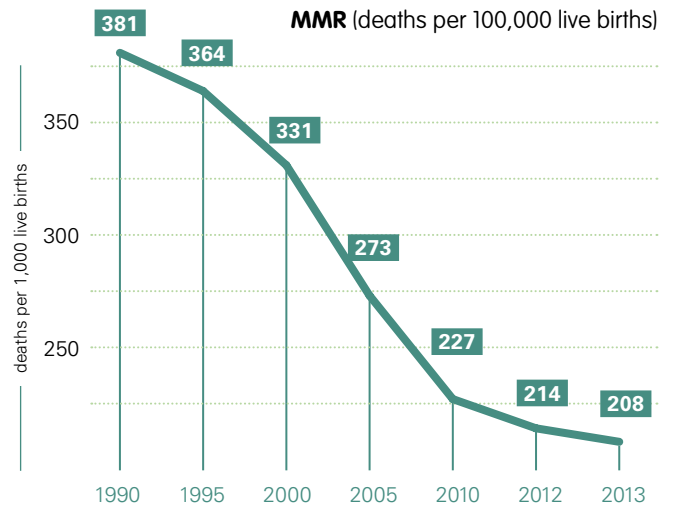
Bottom 10 countries by 2010–12 RMNCH ODA per capita (under 5 and female 15–49), US\$

Ranking	Country	RMNCH ODA per under 5 and female 15–49
66	Uzbekistan	7.3
67	Indonesia	6.4
68	Iraq	6.3
69	Korea, Dem. Rep.	6.1
70	India	4.2
71	Turkmenistan	3.9
72	Egypt	3.4
73	China	0.8
74	Mexico	0.8
75	Brazil	0.8

Appendix 8: Progress towards MDGs 4 and 5a



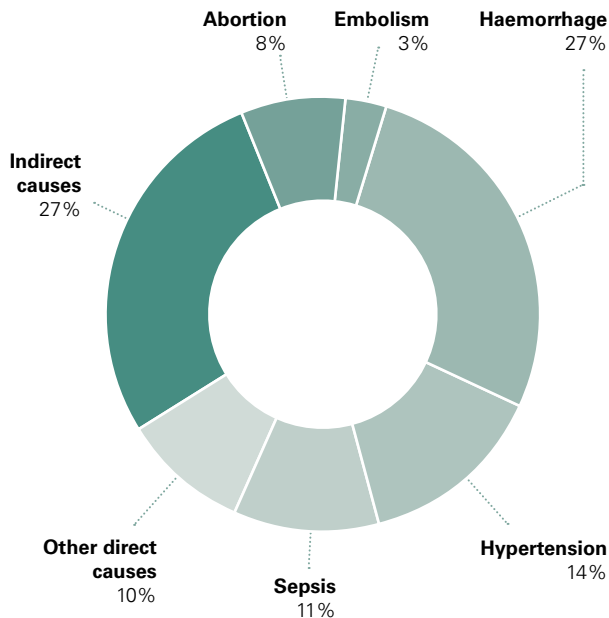
Source: UNICEF/Childinfo (2013), Trends in under-five mortality rates, 1960–2012



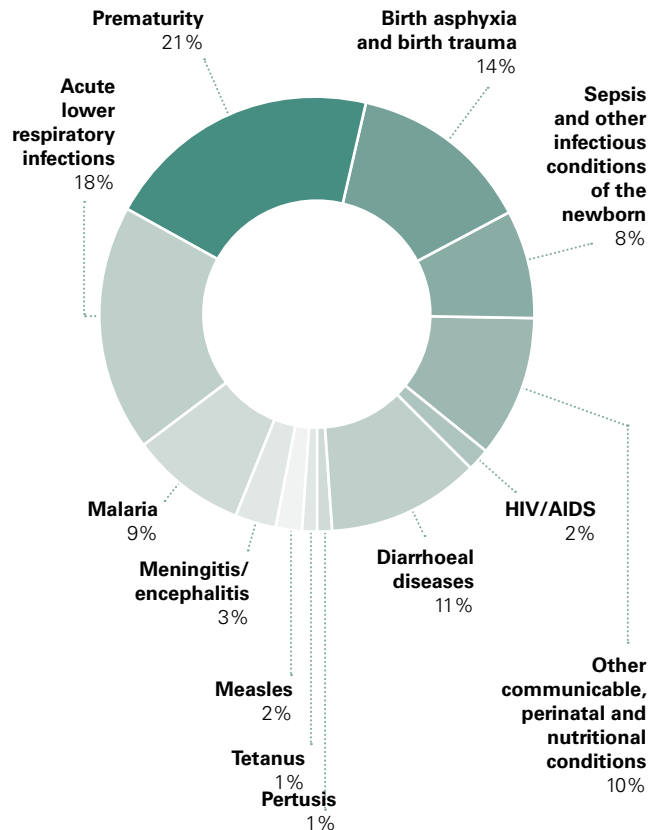
Source: WHO, UNICEF, UNFPA, WB, UNPD (2014), Trends in Maternal Mortality 1990 to 2013

Appendix 9: Causes of maternal and child deaths

Global causes of maternal deaths, 2003–09



Global causes of deaths among children ages 0–4 years, 2012



Source: WHO (2014) – Global causes of maternal death: a WHO systematic analysis & WHO (2013): Global Health Observatory Data Repository

Acronyms

AU	African Union	NGOs	Non-Governmental Organizations
BMGF	Bill and Melinda Gates Foundation	MNH	Maternal and Newborn Health
CIH	The Lancet Commission on Investing in Health	MICs	Middle-Income Countries
COIA	Commission on Information and Accountability for Women's and Children's Health	MDGs	Millennium Development Goals
CRS	Creditor Reporting System	ODA	Official Development Assistance
DAH	Development Assistance to Health	OECD	Organisation for Economic Co-operation and Development
DRC	Democratic Republic of the Congo	PMNCH	Partnership for Maternal, Newborn and Child Health
ENAP	Every Newborn Action Plan	RMNCH	Reproductive, Maternal, Newborn, and Child Health
EWEC	Every Woman Every Child	SUN	Scaling Up Nutrition
GAVI	GAVI Alliance	UNSG	United Nations Secretary-General
Global Fund	Global Fund to Fight AIDS, Tuberculosis & Malaria	UNGA	United Nations General Assembly
GHED	Global Health Expenditure Database	WHO	World Health Organization
GIF	Global Investment Framework for Women's and Children's Health		
Global Strategy	Global Strategy for Women's and Children's Health		
GVAP	Global Vaccine Action Plan		
HICs	High-Income Countries		
iERG	independent Expert Review Group		
IHME	Institute for Health Metrics and Evaluation		
IPTp	Intermittent Preventative Treatment of Malaria for Pregnant Women		
IQR	Interquartile Range		
FP2020	London Summit on Family Planning		
LICs	Low-Income Countries		
LMICs	Lower Middle-Income Countries		
NHA	National Health Accounts		

Endnotes

- 1 United Nations Secretary-General. The Global Strategy for Women's and Children's Health. New York, United Nations, 2010.
- 2 Commitments to the Global Strategy are listed on the EWEC website, <http://www.everywomaneverychild.org/> (accessed 01 May 2014).
- 3 These numbers are based on an analysis of commitments on the EWEC website, <http://www.everywomaneverychild.org/> (accessed 01 May 2014).
- 4 World Health Organization. Every Newborn: an action plan to end preventable deaths. Geneva, WHO, 2014.
- 5 The 49 Global Strategy focus countries were the 49 lowest-income countries according to the World Bank list of economies as of April 2008. These countries were in the focus of work of the Taskforce on Innovative International Financing for Health Systems and then became the focus countries of the Global Strategy. These countries are: Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Cote d'Ivoire, Eritrea, Ethiopia, The Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, Kenya, Democratic Republic of Korea, Kyrgyz Republic, Lao PDR, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, Tajikistan, Tanzania, Togo, Uganda, Uzbekistan, Vietnam, Yemen, Zambia and Zimbabwe.
- 6 The Muskoka methodology was used to calculate Official Development Assistance (ODA) for RMNCH. For background on the Muskoka method, refer to <http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html> (accessed 31 July 2014).
- 7 Countdown priority countries account for more than 95% of global maternal and child deaths. The 49 Global Strategy countries are a subset of the 75 Countdown countries. For a complete list of the Countdown priority countries, please refer to: <http://www.countdown2015mnch.org/country-profiles> (accessed 31 July 2014).
- 8 The PMNCH 2013 Report also found that certain countries received comparatively little support from donors. The Partnership for Maternal, Newborn & Child Health. Analyzing Progress on Commitments to the Global Strategy for Women's and Children's Health: The PMNCH 2013 Report. Geneva, PMNCH, 2013.
- 9 The MNH funding gap is a subset of the US\$88 billion funding gap for women's and children's health. See: Global Strategy Finance Working Group. Background paper for the Global Strategy for Women's and Children's Health: Financial estimates in the Global Strategy. New York, United Nations, 2010.
- 10 This corresponds with the "ensure healthy lives" goal suggested for the post-2015 agenda. The Open Working Group on Sustainable Development Goals. The Proposal of the Open Working Group for Sustainable Development Goals. New York, United Nations Department of Economic and Social Affairs, 2013: <http://sustainabledevelopment.un.org/focussdgs.html> (accessed 31 July 2014). Please also refer to PMNCH: The 2014 Partners' Forum Communiqué. Ensuring the health and well-being of every woman, child, newborn and adolescent. 2014.
- 11 United Nations Secretary-General. The Global Strategy for Women's and Children's Health. New York, United Nations, 2010.
- 12 MDG 5 has two targets. Target 5A is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; target 5B is to achieve, by 2015, universal access to reproductive health.
- 13 Please refer to: <http://www.everywomaneverychild.org> (accessed 01 May 2014).
- 14 For more information, please refer to: <https://lifesavingcommodities.org/> (accessed 01 May 2014).
- 15 For more information, please refer to: <http://familyplanning2020.org> (accessed 01 May 2014).
- 16 Commission on Information and Accountability for Women's and Children's Health. Keeping Promises, Measuring Results. Geneva, 2011.
- 17 Every Women, Every Child: From commitments to action. The First Report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health. Geneva, WHO, 2012; Every Women, Every Child: Strengthening Equity and Dignity through Health. The Second Report of the iERG on Information and Accountability for Women's and Children's Health. Geneva, WHO, 2013.
- 18 The Partnership for Maternal, Newborn & Child Health. Analyzing Commitments to Advance the Global Strategy for Women's and Children's Health: The PMNCH 2011 Report. Geneva, PMNCH, 2011; The Partnership for Maternal, Newborn & Child Health. Analyzing Progress on Commitments to the Global Strategy for Women's and Children's Health: The PMNCH 2012 Report. Geneva, PMNCH, 2012; The Partnership for Maternal, Newborn & Child Health. Analyzing Progress on Commitments to the Global Strategy for Women's and Children's Health: The PMNCH 2013 Report. Geneva, PMNCH, 2013.
- 19 Stenberg, Karin et al. (on behalf of the Study Group for the Global Investment Framework for Women's and Children's Health). Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. *Lancet*, 2014, 383: 1333–1354.
- 20 Jamison, Dean et al. Global health 2035. A world converging within a generation. *Lancet*, 2013, 382: 1898–1955.
- 21 Given that the analysis of this report is conducted along the GIF packages, it does not provide an in-depth analysis on the broader determinants of health, such as education, safe drinking water, and sanitation and hygiene.
- 22 While the "low" scenario maintains coverage levels as they are at present, the other two scenarios estimate benefits of accelerating the level of investment: the "medium" assumes increased levels of coverage based on historical country trends; the "high" applies the best performance trends seen in coverage from 1990–2010.
- 23 Commitments to the Global Strategy are listed on the EWEC website, <http://www.everywomaneverychild.org/> (accessed 01 May 2014).
- 24 Every Women, Every Child: Commitments to support Every Newborn; WHO and A Promised Renewed. Geneva, WHO, 2014.
- 25 Double-counting relates to funding committed twice by different stakeholders. New and additional funding relates to investments that stakeholders committed in addition to their RMNCH spending levels prior to the Global Strategy.
- 26 Global Strategy Finance Working Group. Background paper for the Global Strategy for Women's and Children's Health: Financial estimates in the Global Strategy. New York, United Nations, 2010.
- 27 Some of these commitment-makers preferred to provide information in writing.
- 28 Organisation for Economic Co-operation and Development. Development Co-operation Directorate. Creditor Reporting System Database. Paris: 2013: <http://stats.oecd.org/Index.aspx?datasetcode=CRS1> (accessed April 15, 2014).

- 29** World Health Organization. Global Health Expenditure Database. Geneva, WHO, 2013: <http://apps.who.int/nha/database/DataExplorerRegime.aspx> (accessed April 15, 2014).
- 30** <http://www.everywomaneverychild.org> (accessed 01 May 2014).
- 31** For example: An update on World Vision's commitments to the UN Secretary General's Global Strategy for Women's and Children's Health, 'Every Woman Every Child'. Child Health Now, 2014. GAVI Alliance Progress Report 2013. Geneva, GAVI, 2014: <http://www.gavialliance.org/library/> (accessed 19 June 2014).
- 32** Organisation for Economic Co-operation and Development. Converged statistical reporting directives for the creditor reporting System (CRS) and the annual DAC questionnaire: Addendum 3. Paris, OECD, 2014.
- 33** March of Dimes, PMNCH, Save the Children, WHO. Born Too Soon: The Global Action Report on Preterm Birth. Geneva, WHO, 2012.
- 34** Every Women, Every Child. Commitments to support Every Newborn; WHO and A Promised Renewed. Geneva, WHO, 2014. See: http://www.who.int/pmnch/about/governance/partnersforum/enap_commitments.pdf (accessed 31 July 2014).
- 35** On May 29, 2014, at the Saving Every Woman Every Child summit in Toronto, Canada committed US\$3.5 billion to maternal and child health for the period of 2015–2020.
- 36** The categorization of countries in terms of income status is in line with previous PMNCH reports, including the PMNCH 2011 report. It states that the classification is based on "income status as of Sept. 22, 2010, when the Global Strategy was launched". See: http://www.who.int/pmnch/topics/part_publications/Web_Annex_1_-_29_09_2011.pdf (accessed 31 July 2014).
- 37** These countries are Indonesia, India, the Philippines, and Russia. The first three MICs pledged to increase domestic funding. Russia pledged funding in support to other countries.
- 38** <http://www.everywomaneverychild.org> (accessed 01 May 2014).
- 39** These two partnerships account for 99% of all funding committed by global health partnerships. Two smaller financial commitments were made by "The Global Alliance for Clean Cookstoves" and "Countdown to Zero".
- 40** This estimate is based on the assumption that 61% of all commitments by international stakeholders (US\$17.7 billion) benefit the 49 Global Strategy priority countries (in accordance with Countdown to 2015's analysis on ODA for RMNCH in 2012). In addition, an estimated US\$5.0–8.9 billion is being provided by the 49 Global Strategy priority countries' domestic resources.
- 41** This is because only 3% of the commitments made by MICs rely on external financing, but over 60% of funding provided by NGOs come from donors that potentially count their funding to these NGOs as part of their Global Strategy commitment.
- 42** "Previously existing funding" relates to pre-Global Strategy spending levels for RMNCH that stakeholders committed to sustain and that have been brought under the umbrella of the Global Strategy. For example, the United Kingdom counts all disbursements to RMNCH made between April 2010, the start of UK fiscal year 2010/11, and March 2015, the end of fiscal year 2014/15, as part of its Global Strategy commitment (so the UK commitment includes existing and additional funding). In contrast, Germany counts only additional RMNCH expenditures as part of its commitment. With respect to additional funding, it should be noted that the baselines for calculating additional funding vary between different stakeholder groups. The G8 members of the Muskoka Initiative equated additional funding with RMNCH-related investments above baseline spending in 2008 (this baseline year was chosen due to lack of more up-to-date data by the time the Muskoka commitments were made). Additional funding committed by other stakeholder groups was calculated using 2010 as the baseline.
- 43** It should be noted that the US\$88 billion financing gap was calculated in constant prices (constant 2005 US\$) while the commitments to the Global Strategy refer to funding in current prices, i.e. they do not account for inflation. If the financing gap is converted in 2010 prices (i.e. the year most Global Strategy commitments were made), the commitments to the Global Strategy referring to additional funding for the 49 focus countries would cover 12.6%–16.4% of the funding gap.
- 44** For a detailed list of the imputed percentages as well as the purpose codes and multilateral organizations which contribute to RMNCH according to the "Muskoka Methodology for Calculating Baselines and Commitments: G8 Member Spending on Maternal, Newborn and Child Health"; please see: <http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html>.
- 45** United Nations Global Strategy Finance Working Group. Background paper for the Global Strategy for Women's and Children's Health: Financial estimates in the Global Strategy. New York, UN, 2010; see also: Greco et al. Countdown to 2015: the Financing Gap for Scaling up Child, Newborn and Maternal Health. London, LSHTM, 2012. Private sources, such as insurance and out-of-pocket expenditures, are excluded.
- 46** Canada, France, the Gates Foundation, the Netherlands, Norway, Sweden, the UK and the US provided data up until 2013. Australia, Germany, Japan and Russia provided data until 2012.
- 47** Non-donor commitment-makers were less likely to report on disbursements through 2013.
- 48** The most common reason for being unable to classify disbursements was because commitment-makers only provided a lump sum of their disbursements rather than a more detailed breakdown by target area.
- 49** RMNCH disbursements are thus higher compared to those in last year's report. Unspecified commitments have been allocated to individual recipient countries based on the share of all allocated disbursements in each year.
- 50** Countdown to 2015. Fulfilling the Health Agenda for Women and Children: The 2014 Report (Conference draft). Geneva, UNICEF & WHO, 2014.
- 51** Countdown to 2015. Fulfilling the Health Agenda for Women and Children: The 2014 Report (Conference draft). Geneva, UNICEF & WHO, 2014; see also: Hsu J, Pitt C, Greco G, Berman P, and Mills A. Countdown to 2015: changes in official development assistance to maternal, newborn and child health in 2009–10 and assessment of progress since 2003. *Lancet*, 2013, 381:1772–1782; Hsu J, Pitt C, Berman P, and Mills A. Reproductive health priorities: Evidence from disbursements of official development assistance in 2009 and 2010. *Lancet*, 2013, 381:1157–1168; Institute for Health Metrics and Evaluation. Financing Global Health 2013: Transition in an Age of Austerity. Seattle, IHME, 2014.
- 52** The Global Fund provides funding for HIV/STI and malaria-related interventions (GIF packages 3 & 4). With some exceptions, it does not support interventions in other GIF-defined packages.
- 53** In 2013, GAVI funding increased by 42% over 2012 levels, with disbursements of US\$1.4 billion in 2013. Global Fund disbursements benefitting the health of women and children reached an estimated US\$2.1 billion in 2013, a 14% increase over 2012 levels. The World Bank substantially increased commitments for RMNCH in its fiscal year (FY) 2013, and about US\$1 billion is currently in the funding pipeline in FY 2012.
- 54** These five countries also account for 53.5% of global neonatal deaths. See: United Nations Inter-agency Group for Child Mortality Estimation. Levels and trends in child mortality: Report 2013. New York, UN, 2013: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf (accessed 16 June 2014).
- 55** WHO, UNICEF, UNFPA, World Bank. Trends in Maternal Mortality: 1990 to 2013. Geneva, WHO, 2014: <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en> (accessed 2 May 2014).

- 56** Population size refers to the combined population of children (both sexes, ages 0–4) and females (ages 15–49) in 2010 (based on UN's World Population Prospects: the 2012 Revision data).
- 57** The PMNCH 2013 Report also found that certain countries received comparatively little support from donors. The Partnership for Maternal, Newborn & Child Health. Analyzing Progress on Commitments to the Global Strategy for Women's and Children's Health: The PMNCH 2013 Report. Geneva, PMNCH, 2013.
- 58** We also added the purpose code for personnel development for population and reproductive health to this analysis. Descriptions of these two purpose codes: Reproductive health care (CRS purpose 13020): Promotion of reproductive health; prenatal and postnatal care including delivery; prevention and treatment of infertility; prevention and management of consequences of abortion; safe motherhood activities. Personnel development for population and reproductive health (CRS purpose code 13081): Education and training of health staff for population and reproductive health care services.
- 59** Countdown will publish 2012 estimates in September 2014.
- 60** Demand for family planning satisfied is calculated by dividing the number of women who are married or in union and currently using any method of contraception by the number of women who are married or in union and who are currently using any method of contraception or who are fecund, not using any method of contraception but report wanting to space their next birth or stop childbearing altogether, as defined in: Countdown to 2015. Fulfilling the Health Agenda for Women and Children: The 2014 Report (Conference draft). Geneva, UNICEF & WHO, 2014.
- 61** Countdown to 2015. Fulfilling the Health Agenda for Women and Children: The 2014 Report (Conference draft). Geneva, UNICEF & WHO, 2014.
- 62** The additional funding available for family planning was projected for the period 2011–2015 based on the mean annual increases of ODA for family planning (CRS sector code 13030) between 2008 and 2012 and domestic expenditures for family planning by the 49 Global Strategy focus countries (assuming that 3% of total government expenditures for health is used for family planning interventions).
- 63** WHO, UNICEF, UNFPA, World Bank. Trends in Maternal Mortality: 1990 to 2013. Geneva, WHO, 2014: <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/> (accessed 2 May 2014).
- 64** See: United Nations Interagency Group for Child Mortality Estimation. Levels and trends in child mortality: Report 2013. New York, UN, 2013: http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf (accessed 2 May 2014).
- 65** Countdown to 2015. Fulfilling the Health Agenda for Women and Children: The 2014 Report (Conference draft). Geneva, UNICEF & WHO, 2014.
- 66** World Health Organization. Global Health Observatory Data Repository. Geneva, WHO, 2014: <http://apps.who.int/gho/data/node.main.CODWORLD?lang=en> (accessed 2 May 2014).
- 67** Countdown to 2015. Fulfilling the Health Agenda for Women and Children: The 2014 Report (Conference draft). Geneva, UNICEF & WHO, 2014.
- 68** World Health Organization. Global Vaccine Action Plan (GVAP) 2011–2020. Geneva, WHO, 2013: http://www.who.int/immunization/global_vaccine_action_plan/en/ (accessed 31 July 2014).
- 69** Countdown to 2015. Fulfilling the Health Agenda for Women and Children: The 2014 Report. Geneva, UNICEF & WHO, 2014.
- 70** Figures include funding provided by GAVI to the 75 Countdown and the 49 Global Strategy countries and funding provided by GPEI (excluding indirect costs). To estimate the share of GPEI funding that went to the 75 Countdown and the 49 Global Strategy countries a proxy was used. The proxy is based on the share of GAVI funding that went to the 49 Global Strategy countries.
- 71** The funding gap in the Global Strategy was calculated based on spending in 2008 (latest data available at that time).
- 72** It should be noted that GAVI and GPEI reported their expenditures in current prices whereas the Global Strategy funding gap for immunization was calculated in 2005 prices. The calculation therefore overestimates the extent to which GAVI and GPEI contribute to closing the funding gap for immunization.
- 73** Direct feeding programs (maternal/child/school feeding, breastfeeding & weaning foods); determination of micronutrient deficiencies; provision of vitamin A, iodine, iron etc.; monitoring of nutritional status; nutrition and food hygiene education; household food security.
- 74** United Nations Global Strategy Finance Working Group. Background paper for the Global Strategy for Women's and Children's Health: Financial estimates in the Global Strategy. New York, 2010.
- 75** External funding was excluded by discounting the mean share of external resources of total government expenditures for health received by the 49 focus countries in the period 2008–2012.
- 76** For this analysis, per capita refers to per person in target population (i.e. women of reproductive age (females, ages 15–49) and children (both sexes, ages 0–4). Source: OECD CRS (2014); UN's World Population Prospects (2012).
- 77** Jamison, Dean et al. Global health 2035. A world converging within a generation. *Lancet*, 2013, 382: 1898–1955.
- 78** Every dollar invested between 2015–2035 in achieving a grand convergence in LICs and lower MICs would return about US\$9–20.
- 79** Given that the funding gap calculated for the GIF has timeframe of 2013–2035, it is also possible that a RMNCH funding gap would be established that aligns with the 2030-timeframe of the post–2015 era.
- 80** Only 25 of the 27 LIC committed to increase their government health expenditure as part of their Global Strategy commitment and are therefore included in this figure.
- 81** It is legitimate that both the source and the channel count the funding as part of their commitment.
- 82** This estimate is based on an analysis using a mixed methodology of reviewing interviews responses and other information provided by the NGO, such as annual reports.
- 83** The fourth MIC, Russia, is not included in this analysis as its commitment is part of the G8 Muskoka commitment.

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Advisory Group

The Advisory Group of PMNCH Partners played an important role in the development of the report. Its objectives were: first, to comment and advise on the proposed methodology; second, to review any initial and emerging findings and drafts of the report; and third, to advise on how the relevance and impact of the report's analysis and findings can be maximized to improve the delivery and impact of commitments to the Global Strategy.

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