11.3 Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)

Contents

In focus

EB140/34 is submitted in line with resolution WHA69.2 (2016), in which the Health Assembly requested regular reports on progress towards women's, children's and adolescents' health. This report has a special focus on adolescent health. The report also highlights progress made in monitoring and accountability.

Background

The field of global action for women's, children's and adolescents' health is complicated by a complex mix of different bureaucracies, different stakeholders, different commitments and different goals, targets and indicators. In this background note an introduction is provided to:

- health status: the present situation,
- the Global Strategy itself,
- the development of the Global Strategy,
- finance,
- human rights,
- the multi-stakeholder partnership.

Health status: the present situation

The present health situation for women, children and adolescents globally is summarised in EB140/34. More detail is provided in the first report (2016) of the Independent Accountability Panel. This is summarised in more dramatic form in the IAP online report.

The Global Strategy (2016-2030)

The Global Strategy for Women's Children's and Adolescents' Health (2016-2030) identifies nine action areas (from page 46):

1. Country leadership
2. Financing for health
3. Health system resilience
4. Individual potential
5. Community engagement
6. Multisector action
7. Humanitarian and fragile settings
8. Research and innovation
9. Accountability for results, resources and rights

The logic of the Strategy links the action, in each of the nine *action areas,* to the implementation of a suite of *evidence based health interventions* set out in Annex 2 from page 88 of the global strategy. Interventions are listed separately for women, children and adolescents.

The technical interventions are in turn linked to *health system policies and structures* needed to ensure their implementation. These are summarised in Annex 3 from page 92. Annex 4 from page 95 lists the *other sector policies and interventions* which would also be needed.

Chapter 6, which deals with implementation, speaks of three interconnected pillars which will underpin the delivery of the Global Strategy:

1. Country planning and implementation,
2. Financing for country plans and implementation, and
3. Engagement and alignment of global stakeholders.

The chapter highlights the concrete explicit commitments which are expected of different stakeholder groups. See 'Committing to Action' from page 80 of the Global Strategy.

The development of the Global Strategy

In seeking to understand the processes and bureaucracies associated with the Global Strategy it is necessary to review some history. The infographic in Annex 1 of the Global Strategy (from page 88) traces out some of this history.

The first Global Strategy (for Women's and Children's Health) was launched by the UN Secretary-General in September 2010. This was in large part a response to the lack of progress in MDGs 4 & 5 on child and maternal health. The strategy was developed under the auspices of the United Nations Secretary-General with the support and facilitation of the Partnership for Maternal, Newborn & Child Health, based in WHO. An overview of the history and role of the PMNCH is here.

As part of this first global strategy WHO was asked to coordinate a process to determine the most effective arrangements for global reporting, oversight and accountability on women's and children's health. In response, the Director-General established the Commission on Information and Accountability for Women's and Children's Health which reported in 2011 (*Keeping promises, measuring results*).

The ten recommendations from the UN Commission on Information and Accountability for Women's and Children's Health (as revised in 2016) are set out in Annex 5 of the Global Strategy from page 97 and deal with:

- better information for better results,
- better tracking of resources for women's, children's and adolescents' health,
- better oversight of results and resources: nationally and globally.

One of the recommendations of the Commission was the establishment of an independent Expert Review Group to hold stakeholders accountable for their commitments to the Global Strategy. The IERG reported annually on implementation from 2012 to 2015 (and the conclusion of the MDGs process).

With the transition from MDGs to SDGs, in September 2015, a revised global strategy was developed (this time including adolescents and scheduled for 2016-2030), again under the auspices of the UN SG and the Every Woman Every Child 'movement', and with the support of the PMNCH. The UN SG also appointed a High Level Advisory Group to guide the strategic direction of Every Woman Every Child and the implementation of the new strategy.

With the launch of the revised Global Strategy the UN SG appointed an Independent Accountability Panel (IAP) to be hosted and supported by the PMNCH. The IAP will produce an annual 'State of the World's Women's, Children's and Adolescents' Health' report and in so doing identify areas to increase progress and accelerate action.

As part of strengthening accountability relations WHO has developed the indicator and monitoring framework (described in EB140/34) and WHO and partners have adopted the Unified Accountability Framework.

As described in the UAF there are three pillars to the implementation plan for the Global Strategy: accountability (the Framework itself, the IAP, the indicators etc), technical support and financing.

Technical support is to be provided by the 'H6' (UNAIDS, UNFPA, UNICEF, UN Women, WHO, and the World Bank Group) and finance is centred on the Global Financing Facility (GFF) hosted by the World Bank.

Finance

As explained in A69/16 the bulk of the funding required for the implementation of the Global Strategy is expected to be raised domestically. However, financial assistance will be made available for 62 low and lower middle income countries through the new Global Financing Facility sponsored by the World Bank. According to A69/16 (para 19):

> *The newly established Global Financing Facility in support of Every Woman Every Child aims to accelerate efforts towards the implementation of the Global Strategy by coordinating and harmonizing external funding flows in support of national plans, assisting governments in identifying strategies to increase domestic resources for health progressively, and reducing inefficiency in health spending over time. The Facility will provide an opportunity for 62 low- and lower middle-income countries to access substantial new funding for women's, children's and adolescents' health,*

including through the World Bank's Global Financing Facility Trust Fund. Currently 12 countries have the option of support from the Global Financing Facility Trust Fund linked to International Development Association loans.

The GFF was launched in July 2015, out of the World Bank's Health Results Innovation Trust Fund and with funding from World Bank Group and governments of Canada, Norway, and the United States. According to its director, Mariam Claeson, the GFF was launched in 2015 as "the new approach to smart, scaled and sustained financing across reproductive, maternal, newborn, child and adolescent health". More on the GFF here.

Human rights approach

EB140/34 recalls the 2014 recommendation of the independent Expert Review Group for the establishment of a global commission, on the health and human rights of women and children, to propose ways to protect, augment and sustain their health and well-being. By way of following this up WHO and OHCHR have convened a High Level Working Group for the Health and Human Rights of Women, Children and Adolescents which will recommend ways in which human rights can be integrated into health programming.

The 'multi-stakeholder partnership' model

The fourth pillar of the Global Strategy is the 'multi-stakeholder partnership'. Both the Partnership for Maternal, Neonatal and Child Health and the Every Woman Every Child are multi-stakeholder partnerships. The PMNCH undertakes project work; the EWEC styles itself more as a movement. Likewise the H6 is a partnership within the UN system (plus the WB).

A69/16 explains (in para 15(d)) that the Global Strategy aims to "Harness the power of partnership, reinforce multisectoral and multistakeholder commitments and collaboration, and use governance mechanisms that have the ability to effectively facilitate cross-sector collaboration and action; recognize the importance of informed community engagement in planning, supporting and monitoring services so as to reach everyone."

PHM comment

The Global Strategy

The Global Strategy, as a document, is admirable. The action areas are sensible. The list of evidence based interventions is very useful and the descriptions of the enabling environments which will need to be created also make sense. The targets and the commitment to information and accountability are admirable.

However, the bureaucratic superstructure which has been erected around the implementation of the Strategy is bewildering in its complexity.

It seems that a number of considerations associated with this Global Strategy have combined in contributing to this complexity. These include:

- the legitimation imperative: the need to be seen to be doing something about needs which are widely seen as insufferable and which reflect poorly on the contemporary regime of global governance;
- the leadership imperative: the assumption that assembling as many political celebrities as possible will help to drive implementation;
- the multi-stakeholder partnership requirement: a paradigm of program design based on the assumption that the authority of inter-governmental organisations is insufficient to drive implementation without the blessing of various private sector entities, including the large philanthropies;
- the donor chokehold: the dependence of WHO, and the UN system generally, on voluntary and earmarked donations from philanthropies and rich member states;
- the outcomes measurement fetish: faith in the power of quantitative outcomes feedback on the political drive for implementation;
- the social movement imperative: a recognition that change requires social mobilisation and an assumption that a social movement can be constructed from the top, constrained within particular institutional boundaries and led by the global elite; and
- neglect of the inequities generated through the prevailing global economic regime: an assumption that the failures of MDGs 4 & 5 were due to a lack of political will on the part of governments rather than an unsustainable and inequitable global economy which reproduces poverty and marginalisation and crimps the public revenues needed for decent health care and the 'enabling environments' identified in the Strategy.

Financing

The Global Strategy states that expanding the funding flows to women's, children's and adolescents' health should draw largely on domestic financing but concludes that there will still be a huge need for development assistance financing in low and some middle income countries.

The design of the Global Financing Facility reflects in part a recognition that the funding structures established to support the MDGs contributed to health system fragmentation, administrative overload and internal brain drain. However, there is no guarantee that the new GFF will reduce the problems associated with multiple channels of donor assistance. The development of integrated comprehensive health systems is critical for women's, children's and adolescents' health but there is no guarantee under the GFF that funds which are earmarked for women's, children's and adolescents' health will not distort health system development in the same ways as the vertical funding of infectious disease programmes has done.

There are no indicators in the indicator and monitoring framework which would signal health system fragmentation consequent upon GFF disbursements. Indeed there are no indicators which might help to evaluate the targeting of GFF disbursements generally.

PHM notes the enthusiasm of the World Bank to promote the role of the private sector in reproductive, maternal, newborn, child and adolescent health:

> *The majority of resources mobilized from the private sector for RMNCAH will come from private sources at the country level. In addition, the GFF is developing innovative financing mechanisms to bring international sources of private capital to the effort to improve RMNCAH results* (page 19 of Business Plan).

This is quite worrying as it is clearly ideological (faith based) rather than evidence based.

Use of process indicators to follow implementation

There is a sharp focus on targets and indicators in the Global Strategy and the indicator and monitoring framework but this is largely restricted to 'outcome' indicators including those specified through the SDGs process.

In fact the Global Strategy is quite innovative in listing, in Annexes 2-4, a series of 'interventions' and a series of 'enabling environments' which are seen as preconditions for delivering those interventions. However, there are no references in either the Strategy or the indicator and monitoring framework to the monitoring of progress with respect to such interventions and enabling environments. Clearly the creation of quantitative indicators in these respects would be difficult but there would be scope for more qualitative methods of review, evaluation and adjustment.

Recognising the macroeconomic determinants of poverty, inequality and undernutrition

There are several references in the Global Strategy to the role of poverty, marginalisation and discrimination in contributing to death and disease. However, there are no references to the unsustainable and inequitable nature of the global economy which contributes to reproducing poverty, marginalisation and exclusion.

While the rich capitalist countries are rallying around this Strategy and promising contributions to the Global Financing Facility (GFF) they are at the same time implementing economic policies globally which reproduce the poverty and inequality in the heavy burden countries.

PHM affirms the importance of addressing the immediate health needs of women, newborns, children and adolescents, including through the interventions and enabling environments mentioned in the Global Strategy. However PHM calls for an approach to global health which also maintains a focus on the macroeconomic and geopolitical dynamics which contribute to reproducing those health needs.

PHM calls for stakeholders in the reproductive, women, newborn, child and adolescent health field to direct more attention to the macroeconomic and geopolitical dynamics which shape health outcomes in this field and to promoting policies which, while addressing the

immediate needs of women, children and adolescents, also lead toward a more equal, sustainable and inclusive global society.

Notes of discussion at EB140