Concept paper in relation to the development of the Global Business Plan to accelerate progress towards MDG 4 and 5

As part of an ongoing consultation process, this concept paper is being widely circulated to stakeholders in developing and developed countries. The concept paper is a reference paper on which the Global Business Plan will be based. Your feedback will help to shape its content. Responses must be received by email no later than 1 June 2007. All comments are welcomed, as are suggestions for text, figures and examples to include in the first draft, which will be circulated at the end of June. The Global Business Plan will be launched in New York at the end of September 2007. It will be a concise report aimed at global and country leaders. Please note that the section on implementing and evaluating the Global Business Plan has not been included in this concept paper because it has not yet been developed.

We look forward to hearing from you.

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Overview of the Global Business Plan

One child dies every three seconds and a woman in labour every minute – a staggering ten and a half million lives lost every year. It does not need to be like that. Many countries, among them low-income countries from around the world, demonstrate that with political leadership, good management, adequate health services and community commitment progress can be made even with modest means. We all have a moral imperative – as individuals, as societies and as elected leaders – to respect, protect and fulfil the rights of women, their newborns and children.

A plan is being developed on the initiative of the Prime Minister of Norway, together with other world leaders, for an intensified effort to reduce maternal, newborn and child deaths and to accelerate progress towards Millennium Development Goals 4 and 5. What is the Global Business Plan and how is it different?

Optimal use of currently available resources is an important platform for raising additional ones, both domestic as well as international. Output-based financing, combined with independent validation of reported results are powerful tools to demonstrate effective use of resources. Central governments around the world are increasingly using such tools in the management of public and private health services at the operational level.

Moreover, an output-based strategy provides a good balance of flexibility and accountability. It allows flexible inputs of resources at the local level where the needs are best understood and at the same time greater accountability in reporting from the operational level to the central government and beyond.

In the rapidly expanding field of global health, most of the billions of dollars available today are targeted for specific purposes: antiretroviral therapy for AIDS, vaccinating children, supplying bed nets, and so forth. As laudable as these efforts are, women, newborns and children need more: to stay alive, healthy and well they need to have access to essential health services in the communities where they live.

This is what the Global Business Plan aims to do. Through output-based financing it will promote the channelling of funds through existing mechanisms to support the delivery of essential health services, rather than earmark support for specific interventions. This will promote consolidation in the crowded global health arena. The Global Business Plan will propose that low-income countries rapidly move towards submitting one proposal, their national health plan, to a consolidated group of bilateral and multilateral funders for review, rather than submit separate proposals to each potential source of funding. The Global Business Plan will reinforce the core functions and comparative advantages of the multilateral agencies, reduce mission creep and minimise overlap as outlined in the UN reform agenda.

In order to be effective, the delivery of health services needs to be built on firm evidence. Instead of waiting until all the evidence is available, the Global Business Plan will take a “learning by doing” approach. Evaluation research will be supported in order to generate and share valuable knowledge about what works and what does not. Mutual accountability will be necessary to ensure long-term financial commitments.

Political momentum will be mobilised through the Network of Global Leaders, and an advocacy plan will be designed to raise funds, build political will, and create demand within countries for improved health services as outlined in national plans. Engaging with civil society and building local advocacy skills will be instrumental to accelerating progress towards MDG 4 and 5.

Part 1: Why is the Global Business Plan needed?

1.1 What is the problem?

Each year more than 500,000 women die from pregnancy-related causes, 3 million stillbirths occur, and 10 million children die before their fifth birthday – nearly 40% of them in the first month of life. But the reality is even worse than these unconscionably high death tolls reflect. For every woman who dies giving birth to a child, another 30 suffer severely debilitating injuries. For every child that dies from cerebral malaria, three who survive will be permanently brain damaged.

It is an unfair reality. Among all health statistics, those related to maternal, newborn and child health show the greatest disparity between developed and developing countries. More than 99% of maternal deaths and 98% of child deaths occur in poor countries; up to a third of all deaths in women of reproductive age in poor countries result from pregnancy-related complications. What these statistics mean is that most of these deaths could have been prevented.

Healthy citizens are the greatest asset any country can have. We all—as individuals and as societies—have a moral imperative to respect, protect and fulfil the rights of women and of their newborns and children. Most countries have ratified international human rights treaties and conventions, which protect the rights of women to special attention during their pregnancies and childbirth, and the rights of children to have a safe and healthy upbringing.

It is not surprising then that keeping mothers, newborns and children alive and well features prominently in the Millennium Development Goals (MDGs). The eight goals are part of a declaration adopted in 2000 by the United Nations General Assembly to promote development and eliminate poverty. Goals 4 and 5, which aim to significantly reduce maternal and child mortality by 2015, are a clear demonstration of political interest at the highest level. Unfortunately, the goals in and of themselves have not been enough to accord mothers and children the political and economic priority they need. Halfway to 2015, many countries are making progress, but very few are moving fast enough to be on track to meet either goal.

Unless efforts are stepped up radically, Goals 4 and 5 are destined to join “Health for All by 2000”, “3 by 5”, and all the other ambitious, time-bound global health targets that have not been met. This is not to say that world leaders were wrong to make a commitment to meet the two goals. On the contrary, although the challenge is daunting, remarkable results are within reach. Success is first and foremost conditional on improving access to existing interventions. As beneficial as a new vaccine or a novel treatment may be, success is not conditional on entirely new discoveries not available or in development today. There is no reason to wait – the time to act is now.

1.2 Why has progress toward MDG 4 and 5 been slow?

The many reasons why progress has been slow in reducing maternal, newborn and child mortality have been well-documented in recent years. Of particular note are the three series on maternal survival, newborn health, and child survival published by *The Lancet* between 2004 and 2006, the World Health Organization’s World Health Report 2005, and the UN Millennium Project’s Task Force on Child Health and Maternal Health report, published in 2005.

The reasons are complex in part because they involve political, social and economic issues as well as non-health sectors such as those responsible for water, sanitation, nutrition, education, power, communications, transport and infrastructure. That said, all analyses agree, the single most important factor standing in the way of a country achieving MDG 4 and 5 is the state of its health services.

For example, the Task Force's report is titled: "Who's got the power? Transforming health systems for women and children". Its first principal recommendation is:

> *Health systems, particularly at the district level, must be strengthened, with priority given to strategies for reaching the child health and maternal health goals.*
>
> - *Health systems are key to the sustainable and equitable delivery of technical interventions.*
> - *Health systems should be understood as core social institutions that are indispensable for reducing poverty and advancing democratic development and human rights.*
> - *To increase equity, policies should strengthen legitimacy of well governed states, prevent excessive segmentation of the health system, and enhance the power of the poor and marginalized to make claims for care.*

In countries where maternal, newborn and child mortality rates are high, health services are either struggling or they have completely collapsed. In contrast, the low-income countries most likely to meet MDG 4 and 5 have reasonably well-functioning health services with health workers providing essential medicines and interventions for free at the point of delivery.

In fact, all global health programmes and initiatives – not only those related to maternal and child health – have done as much as they can within existing health services. The limiting factor for achieving more now is the weakness of those health systems. But strengthening health systems is not their core competency, nor should it be. A situation where the major international agencies, bilateral donors and global health initiatives separately work out strategies to strengthen health systems and begin to implement them in low-income countries is to be avoided. A new approach is required, one that through a common approach and in a measurable way assists countries to improve health services.

A lot is known about what is required to ensure effective delivery of essential services: political commitment, allocation of resources for the most cost-effective interventions, providing commodities and finance in a timely fashion to the peripheral levels, enticements to staff for turning up for work, and community engagement.

In addition, adequate financing is necessary for scaling up essential health services including effective maternal, newborn and child health (MNCH) interventions in order to achieve MDG 4 and 5. In 2002, the Commission on Macroeconomics and Health concluded that a minimum requirement for delivering an essential package of interventions was US$ 34 per capita. Most health systems operate at a much lower level. Nevertheless, good progress is being made in many countries, especially those that provide steady incremental increases to the operational level. According to WHO, increases starting at US$ 0.5 per capita per year and increasing over time to US$ 3 per capita from domestic and international sources would meet the estimated gaps to make MNCH interventions accessible to 95% of the population.

1.3 Poised on the edge of moving forward

Even though progress in improving maternal health and reducing child mortality has been slow, there have been some positive developments:

- Most countries have national health sector development plans in place, which include plans to attain MDG 4 and 5. Regional frameworks are being finalised and adopted, evidence has been synthesised, and monitoring and evaluation efforts are being strengthened.
- Global health has a higher public profile, and financial commitments from donors and governments have almost doubled since 2000. New financing instruments (International Finance Facility for Immunisation, Advanced Market Commitments and UNITAID) are in place.
- The Paris Declaration on Aid Effectiveness signed by donors and recipients in 2005 commits their institutions and countries to continuing and increasing efforts in harmonisation and alignment (a box will be included in the Global Business Plan).
- Ongoing reform at the United Nations offers new opportunities, and UNICEF, WHO and UNFPA are in the process of working out ways of collaborating around MDG 4 and 5. The WHO and the World Bank have announced their commitment to work together to strengthen health systems in low-income countries. The Partnership for Maternal, Newborn and Child Health has been created to galvanise action to reduce maternal and child deaths.

Making progress in improving maternal, newborn and child health is a strong indication that a country is moving in the right direction in terms of building a robust and responsive health system. As Laurie Garrett writes in the January 2007 issue of Foreign Affairs:

> *"Maternal mortality data is a very sensitive surrogate for the overall status of health-care systems since pregnant women survive where safe, clean, round-the-clock surgical facilities are staffed with well-trained personnel and supplied with ample sterile equipment and antibiotics. If new mothers thrive, it means that the health-care system is working, and the opposite is also true. Life expectancy, meanwhile, is a good surrogate for child survival and essential public health services."*

In an increasingly interdependent and globalised world, the case can be made on many levels – from humanitarian reasons to protecting national self interest – that strengthening national health systems is an urgent global priority. It is the way to realise the basic human right to health and wellbeing, to spur economic growth and development, and to improve security. The question is how to do it?

Part 2: What is the solution?

2.1 Introducing the Global Business Plan

A plan, the Global Business Plan, is being developed for an intensified effort using current mechanisms to accelerate progress towards Millennium Development Goals 4 and 5. It will promote effective country-led action to achieve results at the national, district and community levels. Results are key to raising the necessary additional funding, not just for international aid but also for national health budgets.

Given that the global health arena is already very crowded with a large number of initiatives with overlapping missions and redundancies, the Global Business Plan will pursue its agenda through a different approach. The approach will be to address the health of women and children by improving health-care services rather than by targeting specific interventions related to the attainment of MDG 4 and 5. Advocacy will be at the heart of the agenda.

To convince low-income countries and international funders that it can make a real difference, the Global Business Plan has to have a significant impact in two broad areas:

1. make better use of existing resources: improve efficiency and effectiveness by being better organised at all levels (operational, national and global)
    - improve delivery of public and private health services at the local level
    - improve management of health services at central and district levels
    - encourage the consolidation of donor activities (so resources aimed at countries and districts reach those areas and people in need)
    - help to clarify the roles and responsibilities of the different players in the global health arena
2. increase funding for national health systems
    - long-term domestic and international commitments, consistent with delivering health services in a stable way over a long timeframe.
    - predictable and reliable, with low risk of failure to gain approval and, once approved, of interruptions for reasons beyond host country control.
    - flexible in use, especially to fit a variety of local conditions, with as few mandatory earmarks and restrictions as possible and with the ability to switch between instruments (e.g. sector vs. general budget support) in a way that has minimal impact on the delivery of services.

Box 1: The Global Business Plan's guiding principles

The Global Business Plan will include a set of guiding principles. Most of the principles that have been suggested to date reflect the aspirations of a well-functioning health system:

- *Build political will:* politicians see it as in their political interests to improve health system performance.
- *Start with communities:* a central authority should carry out only those tasks which cannot be carried out at a more local level. The national level only deals with what cannot be dealt with at the operational level and engagement happens at the inter-country or global level only for tasks that cannot be done at the country level.
- *Outcome/output-driven:* identify and address health system and demand-side barriers to accessing health services, monitor progress and use the results to improve system performance.
- *Pro-equity:* identify and reach marginalised populations to maximise chances of achieving universal coverage.
- *Empower women and households:* share knowledge about changes in behaviour and social norms that would lead to improved self care and care-seeking behaviour for women and children.
- *Engage with all providers of health services* including public sector, for-profit, not-for-profit, and the informal private sector.
- *Enhance ownership and accountability:* Encourage accountability for results as well as for inputs through a process of participation of all stakeholders, leading to eventual ownership.
- *Encourage capacity building at all levels:* Where possible, locally-based and sourced technical assistance should design and implement all aspects of the Global Business Plan. Where this is not possible, technical assistance should be sourced from development partners working in the country.

2.2 Making better use of resources: Output-based financing and independent review

The Global Business Plan will propose that low-income countries rapidly move towards submitting one proposal, their national health plan, to a consolidated group of bilateral and multilateral funders for review, rather than submit separate proposals to each potential source of funding. Once reviewed, the proposal can be funded through different mechanisms. The objective is to channel more funds to the district level in a way that achieves results, improves accountability, and allows for maximum flexibility on the one hand and for donor funds to be linked to specific outcomes on the other (see Box 2 for more details).

Part of the Global Business Plan has been adapted from the global health initiatives. As illustrated in Figure 1, an independent review mechanism and performance-based financing are the crux of the GAVI Alliance's scientific and rigorous approach. As illustrated in Figure 2, both these characteristics could be built into the national health systems. Performance-based funding (also called output-based financing) and the independent validation of reported results would serve at least two purposes. First, it would improve the central government's management of the overall health system and of public and private health services at the operational level. Second, it would give the global health initiatives and bilateral donors a way to fund MDG 4 and 5 and other specific areas through pooled funding for the strengthening of health services.

Figure 1. GAVI Alliance's scientific and rigorous approach

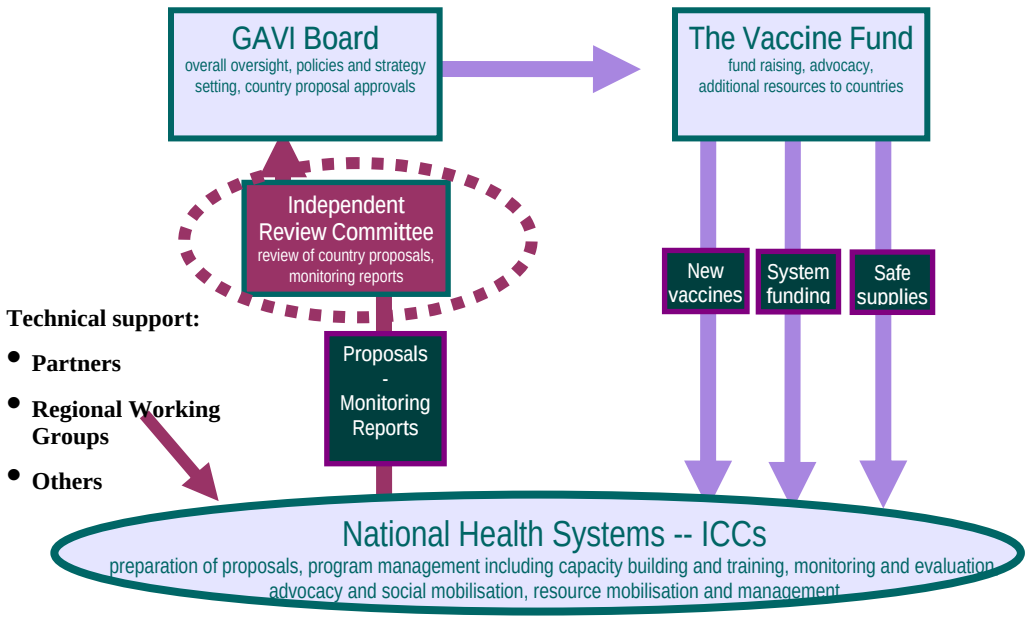
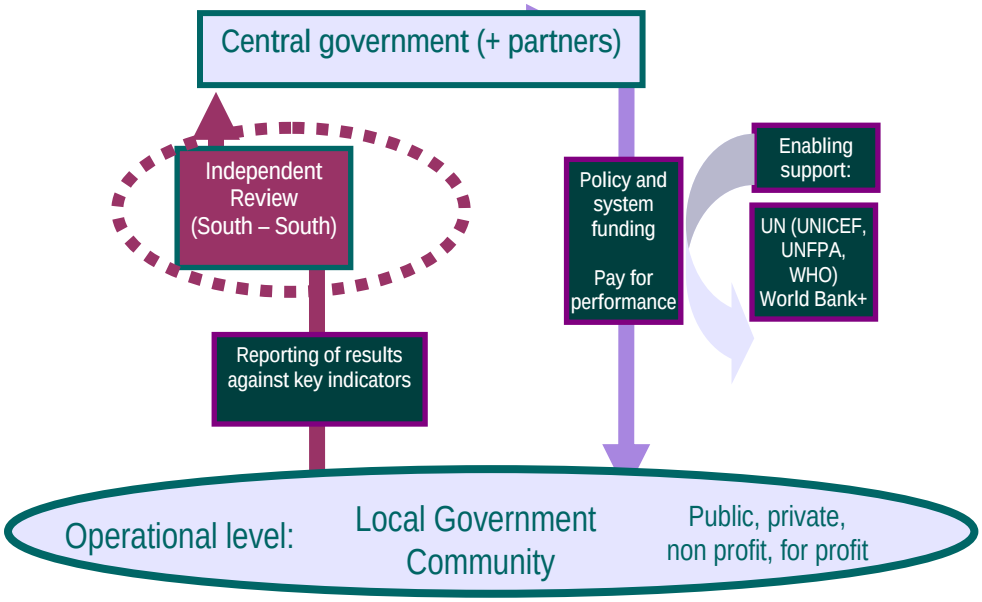


Figure 2. The Global Business Plan at the country level



Output-based financing is widely used throughout the world and can be defined as the "transfer of money or material goods to either demand or supply side conditional on taking a measurable action or achieving a predetermined target". Basically it helps change the health sector from payment for inputs to paying for results, putting emphasis on identifying strategies to strengthen existing systems that work or introducing new or innovative approaches. One of its biggest advantages is that it is not limited to health

services provided in the public sector; performance can be rewarded in the informal sector as well as the for-profit and not-for-profit private sector.

The theory is that the opportunity to earn more money if certain results are achieved will cause recipient parties to implement strategies and adopt practices that lead to success. Evidence suggests that financial incentives do matter (in addition to other intrinsic and extrinsic motivators) and that funding that holds recipients accountable for achieving health results has the potential to increase the effectiveness of assistance.

The Global Business Plan will ensure support for financial interventions on both the supply and demand side. While initial evidence on the impact of such interventions on health outputs seems promising, well-designed impact evaluations are required and novel approaches need to be pilot tested. Technical and financial investments will be made in evaluation research to build an evidence base for what works and in what contexts and to communicate the strengths and limitations of different approaches.

There are many examples illustrating how a “pay for output” system can be designed. A box will be included in the Global Business Plan.

Choosing “pay for output” indicators

In order to be manageable there can only be a few “pay for output” indicators. There needs to be more discussion about these indicators but whichever ones are selected will need to be sensitive and reliable with safeguards in place to minimise the risk of verticalisation.

Among the possible indicators that could be used in the Global Business Plan are:

1. Number of women receiving antenatal care
2. Number of births in facilities or with a skilled attendant providing post-natal care (by socio-economic status and geographic area).
3. Number of children aged 0-59 months with suspected pneumonia receiving appropriate antibiotics.

Additional indicators may be considered in areas where malaria and HIV/AIDS contribute to the high burden of mortality. It is suggested that one output indicator should be selected related to each, for example, the number of children sleeping under insecticide treated nets and the number of children born by HIV-positive mothers receiving antiretroviral treatment.

Independent review mechanism

Accountability will focus on results and not on how or on what the funds are spent. As such, countries will need to develop information systems to track and report on results. This requires a governance structure to evaluate results and decide on whether the performance payment should be made. An independent entity (analogous to an external auditor from outside the country) should be contracted to conduct random audits on the information submitted.

2.3 Demand-side financial interventions

Demand-side interventions attempt to overcome low utilisation of health care services, particularly by the poor. These programmes put additional purchasing power in the hands of household members for use in seeking pre-selected types of preventive and curative health-care services. Voucher schemes and community-based health insurance, as well as health insurance through micro-credit and other community self-help groups have been successful in low-income countries in changing health

behaviours and increasing utilisation of services. Conditional cash transfer programmes have had significant effects on utilisation rates for preventive services. Improvements in infant mortality, child height, and adult health also have been observed.

Given that the demand-side instruments are sensitive to culture and societal organisation, piloting of strategies is a preferred starting point. Political commitment is critical to success, particularly for conditional cash transfer programmes. Demand-side interventions require new ways of working across sectors and with a different range of stakeholders than previously addressed by ministries of health and their donor partners. The success of these strategies also depends on the availability of good quality primary health and nutrition services, particularly in low-income settings.

Possible examples of output-based financing and demand-side interventions to include in the Global Business Plan are the GAVI Alliance, Global Fund, GPOBA's Plan Nacer in Argentina, and Mexico's experience with Oportunidades.

Box 2: Example of country X

Under the Global Business Plan, a proportion, perhaps in the range of 5-10% of the total national budget for health (endogenous resources + international resources), would be linked to results. This means that these resources would be distributed on the basis of achievements against specific indicators. Resources would be disbursed in a flexible way to districts from one common national pool of funds.

Payments may be estimated on the basis of a combination of indicators against districts meeting its targets or they may be a specific indicator measuring progress. Paying US$10 per birth delivered in a facility (or additional over a baseline) is one example. The facility could be part of the public, private or not-for-profit sector. A direct subsidy to the family for delivery in a facility could also be part of the scheme. Details of the subsidy would be determined locally.

The results reported by local health services would need to be verified to release disbursements. Audits would be required, (i.e. an internal auditor as well as an external, independent auditor, reporting back to the central government and donors on verified outputs).

Rather than having to submit multiple proposals to different individual donors, the government would send one proposal, namely the national health plan, to a consolidated group of bilateral and multilateral funders for review. Once it has been reviewed, the single country proposal could then be funded through different mechanisms. Individual funders would in turn be able to link their support to specific indicators in the national plan. Which indicators to use could be determined in advance.

Once a year, the central government would report back to the consolidated group of donors independently verified results on a few selected output indicators. Participating donors would then be able to report specific results and progress to their constituencies and thereby raise further support.

Implementing such a scheme would require the strengthening of central government as well as the provincial governments, as both would have a key role to play in capacity building, monitoring and evaluation. The UN agencies and the World Bank would have a key facilatory role. The World Bank could also play an important part in facilitating coordination among different financing mechanisms.

Part 3 What difference will the Global Business Plan make?

3.1 Progress toward universal access to effective interventions

The importance of the health system to support universal access to key interventions is clear. Strengthening health systems requires attention to human resources, financing, equity, governance, supplies and infrastructure. It means a shift towards regarding the district as the unit of analysis rather than single interventions, and going beyond the medicalised view of the health system. Although health system development is a politically-driven process, evidence can and should be influential in guiding or informing decisions made by policy makers. The Global Business Plan will promote a rational, evidence-based approach to decision-making in this inherently political process.

One way to do this is to build the case for the continuum of care, which has two meanings. It refers to the continuum in space between the home (which is the primary health-producing unit), the community health centre and the district hospital. The other dimension of the continuum is the inextricable link between maternal, newborn and child health. This approach strongly advocates for the strengthening of health systems in order to deliver key interventions at scale and to be sustained in the long term. It also recognises the importance of defining the technical content. In other words, the delivery of interventions should not exist in isolation of a health system, and a health system should not operate in the absence of programme content. This approach does not advocate the delivery of all interventions at scale at the same time. Scaling-up is an incremental process, but if universal access is to be attained health system constraints must start to be addressed now.

There are a number of health-system challenges that have to be overcome:

- Addressing the critical shortage of health workers (doctors, nurses, community health workers and managers) and determining effective incentives to entice staff to show up for work (staff attendance is often low – in extreme cases as low as 20%).
- Allocating resources for the most cost-effective interventions and striking a balance between primary, secondary and tertiary care.
- Matching resources to disease burdens at the local level.
- Providing appropriate financing in a timely fashion (sometimes there are long delays with resources only coming in at the end of the fiscal year).
- Ensuring health facilities have a steady supply of good-quality essential drugs and other commodities.
- Developing an efficient referral system from the primary to the secondary level, especially for women and newborns.
- Delivering services at community level whenever possible, and ensuring that families know when and how to seek preventive and curative services and have the resources to do so.

The Global Business Plan will highlight examples from low-income countries showing the dramatic gains that can result when these challenges are overcome. Possible examples are Bangladesh, Cuba, Indonesia, Sri Lanka, and Tanzania.

In *The Lancet* series on maternal, newborn and child survival, more than 40 interventions are claimed to be effective and if implemented could save millions of women's and children's lives annually. Some of these are old success stories like most

of the vaccines, oral rehydration therapy for diarrhoea, better hygiene, and micronutrient supplementation. Coverage is uneven. For example, while some interventions reach less than 30% of the population in need in developing countries, others such as vaccines are reaching 80% of children worldwide and 75% of children in sub-Saharan Africa. This gives hope that newcomers like the pneumococcal and rotavirus vaccines will have a major impact on child mortality.

The following is a brief list of some of the most effective interventions a health worker could provide in a community setting (the list is not prioritised):

General
- Family planning services
- Insecticide-treated bed nets

Antenatal
- Teaching good practice and hygiene/nutrition
- Maternal iron supplementation
- Tetanus toxoid immunisation
- Intermittent presumptive treatment of malaria

Intrapartum
- Clean delivery practices
- Corticosteroids for suspected premature delivery
- Antibiotics for premature rupture of membranes
- Referral systems for suspected complicated deliveries

Postnatal
- Kangaroo mother care
- Prevention and management of hypothermia
- Exclusive breastfeeding for 6 months
- Oral rehydration treatment of diarrhoea
- Pneumonia case management
- Vitamin A supplementation
- Zinc supplementation
- Vaccines
- Antimalarials

3.2 Address concerns with the global health initiatives

The success of large health initiatives such as GFATM, GAVI and PEPFAR has paved the way for many other new health initiatives in recent years. Health aid has doubled since the year 2000 and almost all of the additional resources have stemmed from the new initiatives. Unfortunately this crowded playing field often results in a poor match for the integrated delivery of primary care requirements at the local level. So while these initiatives have considerable advantages in advocacy, research and fundraising they can cause confusion and fragmentation at the country level, particularly when they operate though projects. Perhaps the biggest problem is that funding from a single donor may be dispersed at the district or facility level through numerous implementing organisations (as many as 50) – mostly NGOs and development partners. Only a small percentage of funds gets channelled through central government or given directly to districts.

New initiatives will continue to be generated. Unless a common way forward is found, the global architecture is likely to grow in complexity. This will lead to increasingly ineffective and inefficient use of resources. Despite some positive improvements since the Paris Declaration on Aid Effectiveness several concerns remain. For instance, the

focus on HIV/AIDS, TB and malaria is creating distortions at the international level and integration problems at the country level. It is not that this focus is “too much”, rather that attention to maternal and child health and health systems strengthening in comparison is “too little”.

Rwanda is one example of a country plagued with difficulties caused by the profusion of disparate initiatives. It has a costed health plan and government systems in place that allow budget support. Yet only 15% of external funding from the 21 official donors goes through government channels. Aid funding does not follow the priorities identified in the plan: $18 million earmarked for malaria (the biggest cause of mortality and morbidity), $47 million for HIV/AIDS (grossly disproportionate in a country with a 3% infection rate), and just $1 million for the integrated management of childhood illness. As a result only 2 of 12 life-saving MNCH interventions reached more than half of potential users, with most achieving less than 20% coverage.

Many of the biggest funders of programmes that impact on basic health services are not represented at, or are not entirely accountable to, the in-country donor partnership. This is both an opportunity and a threat: without a really solid set of arrangements binding these agencies to country- and even locally-based programmes and endorsements, and without effective responses to non-compliance, a large part of the donor pool may not be substantially “aligned” to country needs, regardless of the best efforts of those present on the ground. The most radical solution, rarely tried, is for low-income countries themselves to reject donors on the grounds of insufficient alignment and harmonisation.

With its output-based system the Global Business Plan will facilitate the required consolidation at the national level by streamlining support for the national health system. The most significant implication for recipient countries is that they will only need to prepare one proposal to be reviewed internationally and will not be required to submit different proposals to each potential donor.

3.3 Clarify the roles and responsibilities of UN agencies, the Global Funds and the World Bank

A triangle of multilateral relationships has a very high potential to either enable, or disrupt, success in expanding basic services: that between (a) the UN agencies (notably WHO but also UNICEF, UNFPA and UNAIDS) (b) the Global Funds, especially GFATM and GAVI Alliance and (c) The World Bank.

The essence of the triangle is that the large global grant-making bodies in health—and indeed the rest of the donor community behind them—badly need two things from the Bank and the UN, especially WHO. First, they need them to provide much more support to countries in framing strategies that both make sense for their specific context and are sound financially, technically, and organisationally, according to best international practice. And second, they need them to support countries in building the necessary institutional capacity to deliver the programmes that the Global Funds finance.

When and where the Funds (and their client countries) operate successfully under such a “policy umbrella” and above such a “capacity safety net”, they should be able to finance a much higher share of flexible, bulk, sustainable programmes for basic service delivery with confidence—and the global funds’ resource base could increasingly reflect this role as their contributors see this happening.

This presupposes that the Bank is capable of offering its country analytical services well beyond the narrower range of its funding of health (directly or through broader-based budget support). As a largely loan-terms, demand-driven funder, it still will have an

important role in filling financing gaps that countries see as necessary, including for basic services. The Bank also has an important role in monitoring financial flows and disbursements to ensure that “additional” resources are indeed additional. It may also be needed, as has already been the case for some Global Fund operations, to provide large-scale institutional support to implementation where that is not available quickly from UN or bilateral sources. It also depends on whether the Funds are in fact able to offer more flexible and less conditional funding support, in addition to their more favourable grant terms.

It also presupposes that the Bank and WHO can jointly define their respective roles and responsibilities, especially in the area of setting policy standards, and quintessentially in health financing, where there is already an uncomfortable degree of overlap. The world community is not well served, for example, by having arguably inconsistent approaches to health risk coverage in low-income countries promoted by two or more global institutions. And in terms of fiscal space, staffing structures and workforce incentives, the Bank, the IMF, and the WHO need to deliver more coherent and more consistently high-quality guidance to countries trying to square their social service aspirations with their likely resource envelope. They also need to break down institutional and professional boundaries that limit communication and coherence.

Finally it presupposes that the WHO and other UN agencies (UNAIDS, UNICEF, UNFPA) will have adequate resources to fulfil their mandate to support countries wishing to develop policies and institutions and implement programmes financially sponsored by the Global Funds. As a minimum, however, WHO must be enabled to perform a set of core normative and advisory functions at the country level within its regular budget framework.

The Global Business Plan will reinforce the core functions and comparative advantages of the multilateral agencies, reduce mission creep and minimise overlap as outlined in the UN reform agenda.

3.4 Strengthen global monitoring systems

In order to accelerate progress there will need to be data and information on key impact indicators, focusing on levels and trends of maternal, newborn and child mortality in developing countries. Such information is required for raising awareness and funding, for mobilising interest, and for identifying priority countries for programme interventions. The Global Business Plan will work with key partners (e.g. Countdown to 2015, Health Metrics Network, WHO, UNICEF, etc) and support initiatives to assess unmet needs, track trends in effective coverage, and measure progress toward the attainment of MDG 4 and 5.

There are two primary problems with current monitoring and evaluation systems. First, data generated from surveys are often three to five years old. Second, the data collected are often not accessible and not used effectively to guide programme efforts at the district and national levels. Investment in innovative approaches that can generate up-to-date information for managerial purposes at local, national and global levels is therefore important, accompanied by mechanisms that support open access to these data sets. The Global Business Plan will support the development of systems, strategies and policies that will allow this to happen.

The Global Business Plan will promote a framework for the design and implementation of country-level effectiveness evaluations of its efforts to reduce maternal, neonatal and child mortality and build capacity for this work at the country level and among partners.

3.5 Build political commitment and create demand for action

Advocacy is foreseen to be a major component of the Global Business Plan. The goal of the advocacy plan is to raise funding for the financing mechanism, to build political will within countries (South and North) and globally for MDG 4 and 5, and to create demand for action at all levels. The Global Business Plan's success depends on many factors, including an enduring mobilising structure; strong leadership; competent professional strategic communication capability; and framing the overall agenda in a way that makes sense to (often inexpert) external audiences and unifies the internal players.

In the North, advocacy objectives are to increase awareness and action among key stakeholders, country leaders, news media and other opinion shapers—to ultimately generate global political support, remove maternal and child health barriers, formulate better policy, and mobilise resources for maternal and child health.

In low-income countries advocacy objectives are to build support and generate demand among country leaders, civil society, news media and other opinion leaders (including faith-based) for delivery of maternal and child health interventions—to ultimately generate political support, better policy and increased funding for maternal and child health.

Development is a political process. Getting priority to MDG 4 and 5 reflected in budget allocations and the ways of improving health system performance requires building domestic political alliances to shift public opinion from passive to active engagement on the issues. This is the job of political advocacy. The aim of the advocacy is long-term behaviour change to let social capital grow and institutionalise enduring change. The same core messages need to be presented to different audiences in ways that resonate (i.e. hit the "What is in it for me" button.)

The essence of advocacy is having the skill to present and frame issues in a way that brings about changes in opinions and behaviours. People with such skills – in practice, not just theory – are rare and need to be valued. The Global Business Plan may suggest that country level partners actively identify these "nodal points of excellence" and recruit and energise them to join the campaign for MDG 4 and 5.

The political, technical and professional leaders in the "South" who are trying to bring about change in health systems need access to professional and competent advocacy (also called "strategic communication") expertise. In many countries, this expertise needs to be developed.

Lessons on MDG 4 and 5 advocacy need to be shared within and between nations, professions and colleagues. The Global Business Plan will call for advocacy professionals to set up mechanisms – web sites, collegiate meetings and so forth – to ensure advocacy best practice is widely communicated.

A political advocacy-strategic communication "campaign" is being developed by the advocacy group. It will be in three distinct phases, with each phase building capacity for the next. It will be driven by answers to the core communication question: among the concerned stakeholders, who has to do what differently to get MDG 4 and 5 back on track?

Phase I will examine what is known about advocacy efforts to date on MDG 4 and 5 in Burkina Faso, India, Pakistan and Tanzania. This knowledge and understanding is the prerequisite for drafting the storyline to build a political case for the Global Business Plan.