"Every Woman Every Child Every Adolescent Every Where"

Financing sexual reproductive, maternal, newborn, child and adolescent health in every setting

A contribution to the renewed
Global Strategy for Every Woman Every Child
Outcomes of Experts meeting held 22-23 June 2015, Washington, USA

Introduction

The data on critical trends in preventable mortality makes apparent that addressing the plight of those living in fragile and humanitarian contexts should be a top priority for the renewed Global Strategy for Every Woman Every Child (EWEC GS)

As the work on the renewed GS concludes, as the associated Global Financing Facility (GFF) is launched and as steps are taken to prepare GS implementation plans at country level, the focus must be squarely on extending services and support to better uphold health and wellbeing for every woman, every child, every adolescent everywhere. No one should be denied their right to health simply on the basis of their identity or where they live.

An experts meeting, held in February 2015 and hosted Supreme Council on Motherhood and Childhood of the United Arab Emirates, provided the technical foundations for this humanitarian strategic priority.[1] However, financing of measures to extend the GS' reach to underserved populations is key. In this context, the *World Bank Group* and the *United Arab Emirates* hosted an experts meeting in June to explore the financial dimensions of the "everywhere" agenda.

The meeting, convened by *HRH Princess Sarah Zeid*, who is leading the "humanitarian settings" work stream for the EWEC's next Global Strategy, and supported by *UNFPA*, brought together humanitarian and development academics and experts from more than 30 multi-lateral, private sector and civil society organizations[2].

Their recommendations, set out below, are directed towards 1) the EWEC Global Strategy process including those involved in developing country implementation plans 2) the GFF and its investors groups and 3) the broader international community of member states as they consider the future of financing for development.

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[1] The February meeting drafted the *Abu Dhabi Declaration* calling for a more strategic focus on RMNC&A health and wellbeing: 1) within a development and humanitarian contiguum, 2) over the life course and 3) in accordance with the exigencies of specific settings.
http://www.everywomaneverychild.org/images/The_Abu_Dhabi_Declaration_Feb_2015_7.pdf

[2] For the full list of participants see Appendix 1.

For EWEC and its GFF - "every-where" must be a core principle and a strategic priority

A majority of those most at risk of preventable maternal and child mortality, are living or, over the next 15 years, will be living in fragile or humanitarian settings. 60 per cent of preventable maternal deaths, 53 per cent of under-five deaths[3] and 45 per cent of neo natal deaths[4] take place in settings of conflict, displacement and natural disasters. Worldwide, women and children are up to 14 times more likely than men to die in a disaster.[5]

Crises may be slow or rapid in onset, short term or protracted, noting that the average time period of displacement has increased to 20 years[6] or five years longer than the period to be covered by the SDGs. Further, access to and acceptance of service delivery by non-state actors who, rather than the state, exercise control over many populations may be limited. This can only be addressed by complementary humanitarian action.

The EWEC GS will not be successful or sustainable if the human rights to health and wellbeing of these "hard to reach" populations are neglected or if anticipation of the realities of crises, outbreaks, conflict and disasters[7] is not embedded at the heart of its implementation plans.

The aim too of the EWEC Global Financing Facility's (GFF) to better leverage international financial flows (including multi-lateral and bi-lateral aid) for increased domestic financing will not deliver the intended outcomes if the exposure of its eligible countdown-countries to crises is not considered systematically.

Major points of focus to strengthen the effectiveness then of these global initiatives are:

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[3] These data are calculated for 50 fragile states based on the 2015 OECD report on States of Fragility. Data are not available for three countries namely Kosovo, Marshall Islands and Tuvalu. The maternal mortality data are based on: Trends in Maternal Mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division, 2014.

[4] Calculation of the proportions of under-five and neonatal deaths that occurred in 2013 in the fragile states listed in the OECD Report was done using the UN IGMe Report 2014 data, which can be found at http://www.who.int/maternal_child_adolescent/documents/levels_trends_child_mortality_2014/en/ and at www.childmortality.org

[5] Peterson, Kristina. "From the Field: Gender Issues in Disaster Response and Recovery." Natural Hazards Observer, Special Issue on Women and Disasters. Volume 21, Number 5 (1997) cited in: Plan International. Because I am a Girl: The State of the World's Girls 2013: In Double Jeopardy: Adolescent Girls and Disasters. (Surrey, UK: 2013)

[6] While the average duration of the 33 protracted refugee situations at the end of 2014 is estimated to about 25 years, most of the situations (24) have been lasting for more than 20 years," p.11, World at War, UNHCR Global Trends, Forced Displacement in 2014, UNHCR 2015.

[7] It is intended that this list, and the term "crises" when used in a more general way, be taken – unless otherwise stated to include epidemic disease at WHO level 2 or above, armed conflict, including conflicts waged exclusively by armed non state actors and major natural and technological disasters (including nuclear power plant accidents)

- ***Leave no one out to leave no one behind***

To be true to the *global* in its title, the renewed Every Woman Every Child *Global* Strategy (GS), its investors and its financing systems (i.e. the *Global* Financing Facility) – as a core principle – should commit to quality, essential services and support for every woman, child and adolescent everywhere – where ever they may be. This should include a commitment to address current gaps and fragmentation in programming, funding and priorities that leave millions of those residing in humanitarian and fragile contexts who are at risk of preventable mortality without the support to which, under universal human rights, they are entitled.

- ***Address gaps in service coverage***

In humanitarian response, there are frequently critical gaps in even minimal service provision, specifically related to sexual health (the "S"), including programmes, services and support programmes related to gender based violence, coercive and transactional sex, menstrual hygiene, contraception, post abortion care, comprehensive safe abortion services, and access to HIV services and antiretroviral therapy. To reduce preventable mortality and morbidities the "S" in sexual, reproductive, maternal, newborn, child and adolescent health (RMNCAH) must not be neglected or ignored.

- ***Include and fund humanitarian actors as implementing partners***

With so many women, adolescents and children living in areas beyond the reach of the state, in that the state is or will be absent, or unwilling or unable to reach them, humanitarian actors must be acknowledged and included as essential actors in universal health coverage including specifically for (S)RMNACH. In circumstances covered by such as international humanitarian law, they must be eligible for funding independent of government-led or -focused investment cases.

To help offset higher costs of expanding reach to those who are otherwise left out or left behind, the EWEC GFF must create net "additionality", meaning it must increase the absolute levels of funding to RMNAC health and increase the amount, as a total and a proportion, dedicated to reaching those who otherwise are not reached. This requires an acknowledgement that while the GFF – and its operating modalities - are designed to work with (fully functioning) governments and where domestic resources are available, the reality on the ground in a majority of countries where (S)RMNCAH is most a risk, is quite different.[8]

- ***Recognize that gender is a variable in humanitarian settings***

A disturbing but clearly discernible trend across disasters and other crises provides evidence that gender is a key variable in survival and recovery – driving significant gendered differences in exposures to hazards, in survival rates, in access to assets

[8] **Appendix One** provides a snap shot of the relevance of this to the GS by identifying the status of each of the EWEC Global Financing Facility's "eligible count down countries" across variables such as "disaster risk", "rates of armed conflict", "gender inequality", "rates of urbanization", "population movements" and "median age of population".

that support individual and community capability and in access to active participation in risk mitigation.

The EWEC Global Strategy and its financing instruments must engage these issues to better ensure that the human rights – including the right to health - of women and girls every where are better protected and respected.

- ***Promote "risk-sensitive" (S)RMNCAH planning***

To better address this, the EWEC GS2.0 should drive a fundamental shift from "risk-insensitive" RMNACH planning and programming towards a system-wide practice of integrating findings from crises and multi-hazard risk analyses, gender and conflict sensitivity and vulnerability assessments into strategic planning and programming.

- ***To expand reach, broaden the community of actors***

The community of effort to reach those most at risk of preventable mortality must be broadened. One of the most promising prospects for doing so is to be found in partnership with the private sector[9] and private individuals too. Not only are these immense sources of support, diverse in nature and scope and also influencing and directing financial flows, private sector actors are found in almost all settings with continuous access to most population groups. And, the private sector has a vested interest in risks averted, effective rapid response and rapid recovery, not the least because healthier more active people make for healthier active consumers.

Many private sector actors, including foundations, are already active and/or present in humanitarian and fragile settings but many are disconnected from the international community's and government's humanitarian efforts and goals. Further, the accountability of the private sector for its role in the larger humanitarian project must also be strengthened. The (S)RMNCAH community must extend its partnership with the private sector at local, provincial, national and international levels, deepening understanding of private sector expectations and broadening accountability processes to include their contributions and impacts. People-centered, rights based approaches, focusing on delivery of services for "every women every child" every-where must be a bottom line for, and the basis for the accountability of, public-private partnerships.

- ***Commit to strategic action***

In light of this, the following strategic priorities are recommended for consideration particularly by the drafters of the EWEC Global Strategy (GS) and its implementers, the GFF and its investors:

1. **<u>Define transparently and be accountable for whom we will and will not reach</u>**

   Transparently identify and specify those whom **<u>will be</u>** and **<u>will not be</u>** reached:

[9] As noted later in this document, the definition of "private sector actor" should be continuously updated to support segmentation for strategic focus on for example, large multi-nationals; informal private providers or enterprises, including faith based providers; individual business owners; major independent private donors and entrepreneurs; large and niche foundations; companies working in development etc.

- **Definitions** and **descriptors** of "target groups" should be inclusive in the first instance and only then – as a next step – appropriately segmented to identify those who will and will not be "reached" in the Strategy's implementation.
    - These descriptors (nomenclature) should clarify where the onus of responsibility for decisions to serve or not to serve lies. The bases for "not serving" or "not reaching" populations should be accounted for and be made publicly available.
    - In reporting on populations reached, the "tyranny of averages" must not obscure any inequities in *access* or *utilization* or *quality* whether those differences are based on geographic location, social status/stratification or, in conflict zones, for example, on areas that government controls, as compared to areas controlled by armed opposition groups.
        - Data on the populations that the GS "reaches" must be disaggregated by sex, age (starting at birth and then at 5 year intervals through until old age) and by all categories of detrimental discrimination prohibited under international law[10].
        - These data must make visible differential impacts – including age and gender related - on those whom we know to be "under-served" or about whom we know the least:
            - Communities affected by acute or protracted crises
            - People who are internally displaced or stateless, including those who are not resident in formal camps
            - Migrants – irregular and regular
            - Refugees
            - Those living in areas controlled by armed opposition groups
            - Those living on the social periphery – being subjected to systematic exclusion on the basis of, for example, ethnicity, caste, disability, culture or religion.

[10] The right to equality before the law and freedom from discrimination protected by Article 26 of the ICCPR which requires states to act against discrimination by private, as well as public agents in all fields. Not every unequal treatment of persons constitutes discrimination prohibited by human rights instruments. States, for example, may establish reasonable differences in view of different situations and categorise groups of individuals for a legitimate purpose. Only detrimental treatment (or effect) based on particular 'grounds' is prohibited. See for e.g. *Non-Discrimination in International Law, A Handbook for Practitioners*, Interights 2011 edition.

The prohibition of adverse distinction in the treatment of civilians and persons hors de combat is stated in common Article 3 of the Geneva Conventions, as well in the Third and Fourth Geneva Conventions. Adverse distinction in the application of international humanitarian law based on race, colour, sex, language, religion or belief, political or other opinion, national or social origin, wealth, birth or other status, or on any other similar criteria is prohibited.

        - There must be clear accountability for the resulting inequities between "the reached", the "not to be reached" and "those who were not reached".
        - Accountability requires that the associated duty bearers for "reach" be clearly and transparently identified.

- Measurement methods must be developed and adopted that better inform comprehensive and inclusive programmatic actions.
    - Current survey methods are often inadequate in their frequency, resolution (often at only the district level), and bias (systematically excluding the hardest to reach).
    - An essential step is expanding coverage of vital statistics and civil registration for comprehensive documentation of births, marriages and deaths by cause, as well as issuing to appropriate family members certificates of this documentation.
    - In addition, new methods are needed of assessing risk and assuring coverage that are more timely (at least annually), higher resolution (at the household level) and unbiased.
        - Such methods should give specific attention to those about whom we know the least – those who are hard to reach - and, an overlapping category, to those who live outside the administrative scope of these governments, many of whom have underfunded or greatly incomplete registry and ascertainment systems.
- Service delivery by civil society and the private sector that is complementary to, and extends service-reach beyond that achievable by governments or government-associated agencies (e.g. UN agencies), must be integrated in planning for (S)RMNCAH coverage, with the appropriate accommodations made in eligibility for funding also.
- The dimensions and focus of the GS's intended and achieved "reach" agenda should be clearly stated under each of its three pillars of "survive" (i.e. MISP – Minimum Initial Service Package of reproductive health in crises), "thrive" (human rights upheld everywhere) and "transform" (specific attention must be given to those living in protracted crises).
- The challenges of reaching, and the implications of not reaching, *every* woman, child and adolescent – including specifically the consequences for those "not-reached" - should be regularly highlighted and discussed at the highest levels of the EWEC governance structures.

2. **Expand reach by actively challenging and overcoming the bases for "exclusion"**

- The GS and its financing systems must engage and challenge those forces (e.g. practices, policies, attitudes, social norms) that constitute or otherwise create the barriers and exclusions that render certain categories of people underserved, "marginal" or entirely invisible, and, in implementation plans, must make the appropriate adjustments to operating modalities at national and sub national contexts to maximize reach.
  - This should include identified roles for humanitarian actors in service delivery in areas, and for populations that are out of reach of others.
  - Funding must not undermine the integrity and perception of humanitarian actors as independent, neutral and impartial.
- Confronting directly and transparently the limits to operating capability and the modalities in which implementing partners and investors are prepared to operate, the GS, the GFF and other funders should encourage and stimulate innovations for broadening reach and enhancing risk management: testing, evaluating and then up-scaling proven interventions and new implementing partners that expand reach, breach barriers and enhance timeliness of access; improving capability in risk assessment (see below).

3. **Expand "reach" to ensure coverage of the continuum of care across the life cycle - ensuring the comprehensiveness of "life saving" interventions and including the "S"**

In humanitarian response, there are frequently critical gaps, specifically related to sexual health (the "S"), including programmes, services and support programmes related to gender based violence, coercive and transactional sex, menstrual hygiene, contraception, post abortion care, comprehensive safe abortion services, and access to HIV services and antiretroviral therapy. To address this,

- Noting the criticality of working coherently across the sexual and (S)RMNCAH continuum-of-care over the life course (i.e. from birth, inclusively of the 10-15 yr. and the post 49 yr.), the GS and its investors must not leave out critical life-stage life-saving interventions for those it intends to reach:
  - Service provision strategies and modalities must ensure both coherence and comprehensiveness across the continuum of care for the life course, noting both the essential role of a Minimum Initial Services Package in crises and the importance of transition to comprehensive services when crises abate
  - Services' focus and priorities should be set in consultation with local communities – with women in particular – to ensure that these are shaped also by local demand

- The complete integrated health care package - defined as "life saving" – should be reviewed to ensure full relevance for those deemed "hard to reach" and to verify that it is up-to-date and comprehensive across the life-course

4. <u>Strengthen accountability for "risk appetites"</u>

- Ensure that all (S)RMNCAH plans integrate development and humanitarian interventions through a strong focus on risk management by including risk assessments, risk mitigation, disaster planning and contingency funding. This should include preparedness to release funds for the specific purpose of reaching hard-to-reach areas/populations.
    - Context/setting risk assessments should be based on population data (e.g. census data, MICS, DHS etc.), community inputs (including specifically from women and young people) and techniques for multi-hazard health sector risk analysis, including gender and conflict sensitivity analyses.
- GS implementing partners and funders should "own" their own risk appetites transparently and be held accountable for these:
    - Risk approaches should be stated clearly and publicly, including by explaining whom they will not reach, on what issues they will not work and under what circumstances.
    - The GS accountability system should focus on the implications of these risk-approaches, specifically for those populations who bear its negative consequences.
- For the purpose of achieving maximum possible coverage of both issues and of populations, the risk-appetites of the GS, the GFF, its investors and its implementing partners should be clearly stated, mapped, and clearly differentiated so that it is possible to identify who is willing to and capable of going **where** on **what issue** in order to reach **whom**:
    - Cross-border work, for example, is of particular importance – a critical option in tough circumstances and where issues know no borders (i.e. contagions, epidemics). Effective cross-border operating modalities should be prepared for through pre-negotiated agreements.
    - Differential risk appetites to provide services on "sensitive" issues across the continuum of care or for excluded populations should be identified and calibrated
    - Funding through national partners (whether government or national NGOs) should be designed to ensure long term sustainability of local systems and mechanisms
- GS implementing partners and funders must agree to support a comprehensive package of essential services, based on impartial assessment of population needs

  - Pressure must be exerted to reduce "cherry picking" in terms of populations reached and services offered.

- GS implementing partners and funders should establish clear mechanisms to seek out funding and support for gap areas, to avoid large gaps in services provided or populations not reached, such as a multi-donor coalitions dedicated to support such as comprehensive post abortion and safe abortion services.

5. **Ensure the GFF helps address major fragmentation and gaps in funding that undermine delivery for Every Woman Every Child Every Adolescent Everywhere**

Broadly, current financing practices for (S)RMNCAH are fragmented and uncoordinated, reinforcing, rather than bridging, a silo-ed approach to peace building, humanitarian, development and recovery efforts.

Development financing for fragile contexts and conflict-affected countries more often: i) does not promote synergies with humanitarian assistance; ii) is not positioned for aid coordination and alignment; and iii) leaves some key areas unaddressed.

The GFF must drive reach, equity and responsiveness to need across funding sources rather than worsen this current fragmentation.

6. **Include disaster risk reduction plans in GFF investment cases**

- A country's investment case should be based on multi-hazard risk assessment, and disaster risk reduction including emergency preparedness for (S)RMNCAH in partnership with national NGOs, communities themselves and the private sector.
- In the event of a crisis, countries should have the ability through the GFF/WBG to seek support of the WBG's private sector working group.
- Create a financing window within the GFF, or if WBG's rules so determine, in concert with and complementary to the GFF, capable of flowing financial support to and for crisis settings and for non-state actors as implementers where required to achieve maximum reach

7. **Strategically broaden engagement of the "private" sector**

With the "private sector" offering some of the greatest potential there is to expand the number and range of actors committed to and implementing the GS, and noting the opportunities for impact that come when public and private sectors work together, the GS should inspire work to enhance this relationship:

- The GS', and its investors', implementation approach should be based on a clear "segmentation" of the "not-public" sector as well, so that understanding and analysis of what is the "private sector" both expands and is more granular.

- The definition of "private sector actor" should be segmented and continuously updated to support strategic focus on, for example,
    - Large multi-nationals
    - Informal private providers or enterprises
    - Individual business owners and entrepreneurs
    - Large and niche foundations
    - For-profit-companies working in development
    - Private health care providers, including faith based providers
    - Major independent private donors
- The public sector role in assuring the quality of products (and services) in the private sector should be strengthened. This normative and regulatory function should be developed collaboratively and in a way that assures the quality of goods and services to those who are also hard to reach.
- In humanitarian and fragile contexts specifically, focus on and strategically engage a "total market approach"[11] without denying anyone in need access to essential services:
    - Financial flows from private individuals including specifically diaspora communities i.e. their remittances, charitable giving, local investments
    - Local and community based businesses and entrepreneurs
    - Cross-border business operators whose supply chains and delivery systems can offer models for innovation in reach
    - The technology sector including social media and other telecommunications innovators (Google, Face Book etc.) noting the high rates of take up of mobile technology and its potential to reach remote or otherwise hard to access areas.
    - The potential role of insurance including micro-insurance schemes
    - Innovation in full cost recovery models
    - Informal markets – including commodity distributers such as drug sellers
    - Social marketing and social franchising
- Attention to and innovations are required in the GS' accountability and governance frameworks to better quantify, make transparent and assess the contributions of the private sector to the meeting of the GS' aspirations.

[11] Such an approach means examining and shaping markets so that these also work for the poorest and those hardest to reach. This involves ensuring sustainable markets that delivering health impact and in an equitable manner.

8. Stick together where and when "the going gets tough"

For those issues in the life-course continuum of care, and with respect to certain services and populations that are otherwise deemed "controversial" or "sensitive", the GS will be more effectively implemented with:

- Local ownership, local voices and strong local engagement in respect to issues that otherwise are not "popular" with governments and/or donors
- Stronger inter-agency cooperation – within and beyond the UN system – to hold the normative line and convey to governments, donors and others that these gaps and fragmented approaches should not be tolerated.
- Concerted efforts to identify and influence donors and agencies to eliminate in a timely way key gaps in services and in populations reached.

Transformative implementation

Indicative practical steps that should be taken as part of the EWEC Global Strategy implementation plans include:

Goal 1. STRATEGICALLY INTEGRATE HUMANITARIAN AND DEVELOPMENT PLANNING & INTERVENTIONS

To better extend reach to otherwise excluded women, children and adolescents, integrate development assistance and humanitarian response programming and funding including by engaging, financing and utilizing local capacity, expertise and decision-making.

By 2030

- The affected community is in "the drivers seat" and actively engaged in identifying and determining:
    - Needs
    - Priorities for funding and services
    - Processes for access and delivery
    - Crisis response
- Risks (hazards) and at-risk communities and their associated assets and capabilities are mapped continuously and the results are made available publically. This includes mapping of:
    - Human resources for health
    - Health facilities and delivery points
    - Populations' access to delivery points – roads, rivers, pathways
    - Current (S)RMNCAH attitudes, messages, knowledge and services
    - Supplies, equipment and supply chains
    - Population and other key data baselines

    - International and local actors active in the context
    - Relevant government policies and practices

- To ensure timely deployment of appropriate skills, while recognizing that emergency and development needs increasingly overlap in time and geographic space, humanitarian experts are blended in with development and other host-country actors at all levels while retaining and positioning appropriately the distinctive contribution that humanitarian actors make to broadening reach by accessing populations and areas out of the reach to other actors.
- As an integrated part of (S)RMNCAH plans, 100% of countries are preparing, financing and fully implementing disaster risk reduction (DRR) including emergency preparedness plans (EPP) and are supported in doing so by their GS' implementing partners.
- There are proven operating modalities in place for services and financial flows to crisis-affected populations and, when crisis abates, for transition from MISP to comprehensive services.
- Proven capacity across international, national and sub-national systems for rapid, and otherwise more timely, funding and financial flows for (S)RMNCAH services matched to diverse populations' needs, their settings and circumstances including rapid, real-time cash transfers to crisis-affected populations in support of (S)RMNCAH outcomes.
- DRR including EPP are included from the outset of programming with a strategic focus on the importance of women and young people as first and early responders.

Critical strategic initiatives needed

- Investors/donors:
    i. Prioritize investments in approaches that build resilient service delivery from the community level up, including through technological innovations
    ii. Fund disaster risk reduction including emergency preparedness plans as an integral part of (S)RMNCAH plans
    iii. Implementing partners identify and support community champions to support community engagement in this.

Goal 2: EXPAND REACH AND INCLUSION

Expressly target in planning and financing those who are at risk of, or are, living in fragile and humanitarian contexts and who have limited access to services for (S)RMNCA health and well being.

By 2030

- Reach has broadened and exclusion eradicated so that those who are at risk of, or are, living in fragile and humanitarian settings are receiving (S)RMNCAH (with an S) services as evidenced by data on service access, utilization and quality
- Data on access, utilization, quality and outcomes is disaggregated by geography as well as sex, age (at five intervals) and by all forms of discrimination prohibited under international law.

Critical strategic initiatives needed

i. Data systems such as HDX (http://docs.hdx.rwlabs.org/), the humanitarian data facility currently in pilot stage, help provide macro level data mapping of populations on a continuous basis
ii. Systems to improve capture of the movements of "under-reached/hard to reach" populations and their proximities to hazards etc. are designed, supported and enable disaggregation (as per above)
iii. Working across stakeholders, identify data systems that are already working well and learn quickly from their experience
iv. Innovate use of "big data" to drive better multi hazard risk assessment for (S)RMNCAH and to enhance understanding of the risks for and specific needs of those who are rendered "hard to reach" either through exclusion, neglect or by other circumstance

Goal 3: ELIMINATE GAPS IN (S)RMNCAH PROGRAMMING FOCUS, FINANCING & IMPLEMENTATION

(S)RMNCAH plans, delivery, reporting and associated financial flows should be consistent with a life-course approach and coherent across the continuum of care. Gaps in funding, coverage and delivery must be filled and duplication or incoherence in effort reduced through commitment and coordination.

By 2030

- (S)RMNCAH funding allocations at national and subnational levels are based on the equity principle, rooted in a human rights based approach and reaching those with least or no access.
- National costed implementation plans for (S)RMNCAH are delivering:

- Coherence across the continuum of care (no service areas left out)
- Coverage across the life course (no one left behind)
- Inclusive reach (no one left out)
- Coordination of contribution (no gaps and no erroneous duplication)
- Resilience in local systems (systems bounce back from shocks more strongly)

- Independent in-country monitoring systems are reporting on progress
- 50% of humanitarian funding is delivered to and through accountable national and sub-national institutions by neutral and impartial organizations that are accepted and trusted by populations and, where applicable, armed non-state actors in areas or for populations outside of governmental control or reach
- Increased (S)RMNCAH funding to fragile settings both overall and as a proportion of the (higher) total, noting that extending reach in these circumstances may have a higher costs than for other settings

Critical strategic initiatives needed

i. National costed implementation plans for (S)RMNCAH, which are themselves part of national strategic plans for health overall, and that:
    - Are designed, monitored and "governed" with full participation of key stakeholders, especially crisis-affected community members and specifically women and young people, as well as the private sector
    - Include targets for the under-served and hardest to reach
    - Align and harmonise private sector investments including their contributions to public goods
    - Fully funded including as appropriate through mechanisms to optimally combine multiple donors to ensure comprehensive funding
    - Publically available
    - Supported by "one measurement" framework
    - Supported by diverse implementing partners including those who can directly access populations in restricted or remote areas including those held by armed opposition groups and those willing/able to provide specialty or sensitive services (e.g. ART, GBV, CAC)
    - Reduced vertical "stove pipes" in systems and services where these are inconsistent with the continuum of care or the collaborative action that is needed to delivery people-centered care

ii. Independent in-country systems monitoring implementation

iii. EWEC sponsored evidence based business-cases for coordinated long term investment in fragile settings across the development/humanitarian/peacebuilding contiguum[12]

[12] "*Contiguum* means… development and change, all hazards and their impacts, all "disasters" of whatever magnitude, and all stages of post-disaster response, are operating at the same time in overlapping

Goal – EXTEND THE GFF'S REACH WHERE THE STATE CAN NOT OR WILL NOT

Extend the relevance and reach of the GFF either directly, or through complementary financing mechanisms, given that so much of overall preventable RMNCA mortality occurs in settings that are beyond the reach of governments.

By 2030

- 50% of GFF funding and complementary instruments should be provided by the current non-DAC countries
- 100% of fragile states have received at least three years of predictable financing for (S)RMNCAH plans
- The GS and the GFF are helping deliver substantial and measurable improvements in countries' reach to populations that reside in humanitarian and fragile settings that governments cannot or are not willing to serve
- Multiple, diverse funding sources and mechanisms are aligned together to help reach "every-where" with responsive, comprehensive services inclusive of those actors whose capability means they are able to access "hard-to-reach" areas and populations.
- Increased funding to cover key gaps:
  - Areas under control of non state actors
  - Issues that are neglected or avoided
    - e.g. comprehensive abortion care, support for victims of gender based violence, access to contraception and access to anti-retroviral drug therapy
  - People excluded, invisible or left out by identity
  - Monitoring and reporting on expanded reach, noting that this may be more expensive

Critical strategic initiatives needed

i. Develop and advocate for incentives for investors/donors to assess and then address the barriers to comprehensive programming (e.g., inflexible policies or practices, safety risks for personnel, political constraints).

ii. Use the GFF *Front Runner* countries to demonstrate best DRR including EPP practices including for any areas that the Government cannot or will not reach.

iii. Bring donors and other investors (including implementing agencies) who have reach beyond the state into strategic alignment with the GFF.

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juxtaposition… 'Continuum' is about a selected event and its aftermath; 'contiguum' is about all events and non events as well." J. Lewis, "Continuum Or Contiguum"; Fifth ESA Conference 2001; found at http://www.dcscrn.org/cms/uploads/esa2001/lewies%20-%20continuum%20or%20contiguum.pdf

iv. Explore options for creating complementary (humanitarian) funding windows or instruments to allow needed flexibility in partners, operating modalities and in access (e.g. funding of local organizations).

Goal – PROMOTE & EXPAND HUMAN-RIGHTS BASED, PEOPLE-CENTERED PUBLIC/PRIVATE PARTNERSHIPS

*Across the development-humanitarian contiguum, establish **human-rights based, people-centered, public-private partnerships** at local, provincial, national and regional levels, to broaden reach to populations, fill service gaps and promote innovation in access to quality services.*

By 2030

- 100% of countries have business cases for private sector investment including specifically for humanitarian or fragile contexts.
- 30% of humanitarian funding is contributed by the private sector
- Private sector managers of critical (and big) data sets are contributing to continuous innovative mapping.

Critical strategic initiatives needed

i. Private sector participation in coordination and accountability mechanisms at global, regional and country levels, building on but extending beyond the PMNCAH private sector constituency group

ii. Collaborative structures, platforms, procedures, and best practices models are promoted with strong learning – provided these are associated with (S)RMNCAH outcomes - from initiatives such as:
   - CIV/MIL cooperation during the Ebola outbreak in Liberia
   - Conditional cash transfers and free time provided by telephone companies, private sector provided free laundry machines during the recovery from the earthquakes in Nepal
   - Diaspora funded dignity and reproductive health kits
   - Best practice examples such as GSK's commitment to reinvest 20% of profits back into improving the healthcare infrastructure in Least Developed Countries, and the SHOPS project which involves NGOs and for-profits on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector)

iii. Investments build capability in (S)RMNCAH public-private partnerships including specifically for emergency (S)RMNCAH preparedness and response:

- Build on private sector research and development capability and knowledge management capacities to accelerate innovation in access and reach.

iv. Explore and take advantage of corporate social responsibility commitments and obligations (e.g. tax incentives and opportunities such as introduced by the Government of India)

v. Return-on-investments evidence and analysis is developed to offer sound and persuasive arguments for the "business sense" of investing in (S)RMNCAH, including specifically in humanitarian and fragile contexts.

vi. Private contributions help to fill gaps in terms of funding, populations reached, timeframes in which response to crises are mounted and programming content.

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Appendix 1. List of participants in the Washington "Every Where" Meeting

Alfonso Rosales	Senior Policy Adviser, **World Vision International**
Anshu Banerjee	Deputy Exec. Director, **PMNCH**
Anushka Kalyanpur	Sexual and Reproductive Health Officer, **International Medical Corps**
Ashraf El Nour	The Permanent Observer of **IOM**
Beth Schlachter	Executive Director, **FP2020**
Blerta Aliko	Humanitarian and Gender Advisor **UN Women**
Carolyn Baer	Senior Technical Advisor, SRH for Emergencies, **CARE**
Christoph Kurowski	Sector Leader, **WBG**
Daniele Ligiero	Vice President, Girls and Women Strategy, the **United Nations Foundation**
Emmanual d'Harcourt	Senior Health Director, **International Rescue Committee**
Enrica Lerershe	Health specialist, **ICRC**
Erin Wheeler	RAISE Initiative, **Columbia University**
Hannah Tappis	Senior Monitoring, Evaluation and Research Advisor, **Jhpiego**
Jennifer Leaning	Director**, FXB Center for Health and Human Rights, Harvard**
Kathryn Alberti	Senior Programme Specialist, **UNICEF**
Klaus Simoni Pedersen	Chief, Resource Mobilization Branch, **UNFPA**
Kristonia Lockhart	Gender Coordinator, **Islamic Development Bank**
Laurie Noto Parker	Director, Special Projects, **Ipas**
Margareta Norris Harrit	Partners Specialist, **WBG,**
Mark Grabowsky	COO, **Office of the UN Special Envoy for Financing the Health MDGs & Malaria**
Michele Gragnolati	Human Development Sector Manager Latin America & Caribbean, **WBG**
Mina Barling	Senior manager, **Marie Stopes International**
Monique Vledder	Senior Health Specialist & Program Manager, Health Results Innovation Trust Fund, **WBG**
Nancy Harris	Vice President**, John Snow International**
Nazneen Damji	Gender Equality and HIV/AIDS Policy Advisor, **UN Women**
Njoki Rahab	Sr. Gender Adviser**, OCHA**
Nomi Fuchs-Montgomery	Deputy Director, Family Planning Program, **Bill and Melinda Gates Foundation**
Oscar Cordon	Director**, Chemonics International**
Rachel Moynihan	Advocacy & Communications Specialist, Washington office, **UNPA**
Rajat Khosla	Human Rights Adviser, **WHO**
Ribka Amsalu	Senior Advisor, Emergency Health, Depart.of Global Health, **Save the Children USA**
Rifat Hasan	Health Specialist, **WBG**
Salim Sohani	Senior Health Advisor**,** International Operations, **Canadian Red Cross**
Sameera Maziad Al Tuwaij	Lead Health Specialist, **WBG**
Sandra Krause	Reproductive Health Program Director, **Women's Refugee Commission**
Sara Casey	RAISE Initiative, **Columbia University**.
Sarah Craven	Chief, Washington office, **UNFPA**
Sarah Knaster	Coordinator, **Inter-Agency Working Group on Reproductive Health in Crises**
Seemen Saadat	Reproductive, Maternal and Child Health adviser, Health, Nutrition and Population practice, **WBG**
Tim Evans	Senior Director, Health Global practice, **WBG**
Tony German	Exec Director, **DevInt** (Development Initiatives)
Torris Jaeger	International Director, **Norwegian Red Cross**
Ugo Daniels	Chief of Humanitarian and Fragile Contexts Branch, **UNFPA**
Yannick Glemarec	ASG/DED Policy and Programme, **UN Women**
HRH Princess Sarah Zeid	Global Advocate, for **Every Woman, Every Child, Every Where**
Kate Gilmore	ASG/DED-programme, **UNFPA**

Appendix 2: *"Traffic lights" for "Everywhere"*

EWEC Global Financing Facility-Eligible - Low Income **"Countdown" Countries**

	2015 Global Peace Index ranking	2014 Deaths from Armed Conflict	2013 Risk of Disaster ranking	2015 IDPs	2011 to 2015 Urbanization rate	2014 Social Institutions & Gender Index	2010 Median Age compared to global median
Afghanistan				Also top refugee source			18
Bangladesh							23.5
Benin							17.3
Burkina Faso							16.8
Burundi							16.8
Cambodia							22.5
CAR				Also top refugee source			19.1
Chad				Also top refugee host			16.6
Comoros	NA	NA		NA		NA	18.9
DPR Korea	NA	NA	NA	NA	NA	NA	32.9
DRC			NA	Also top refugee source			16.5
Eritrea				Also top refugee source		NA	18.5
Ethiopia				Also top refugee host			16.8
Gambia							18
Guinea							18.5
Guinea Bissau							19.4
Haiti							20.5
Kenya				Also top refugee host			18.8
Liberia							18.4
Madagascar							18.1
Malawi							17.1
Mali							16.2
Mozambique							17.5
Myanmar				Also top refugee source			26.5
Nepal							21.2
Niger							19.1
Rwanda							18.6
Sierra Leone							19
Somalia			NA	Also top refugee source	NA		17.6
Tajikistan							22.2
Togo							18.9
Tanzania							17.3
Uganda				Also top refugee host			15
Zimbabwe							17.8

EWEC

EWEC Global Financing Facility-Eligible Lower-Middle **Income "Countdown" Countries**

"Traffic Lights" for "Everywhere"

	2015 Global Peace Index ranking	2014 Deaths from Armed Conflict	2013 Risk of Disaster ranking	2015 IDPs	2011 to 2015 Urbanizatio n rate	2014 Social Institutions & Gender Index	2010 Median Age
Bolivia							22.2
Cameroon							19.3
Côte d'Ivoire							19.4
Djibouti						NA	21.4
Egypt							24
Ghana							21.2
Guatemala							19.7
India							25.9
Indonesia							27.9
Kyrgyzstan							24.7
Laos							19.5
Lesotho							22.6
Mauritania							19.3
Morocco							26.5
Nigeria							19.1
Pakistan				Also top refugee host			21.2
Papua New Guinea						NA	21.6
Philippines							22.7
SaoTome & Principe	NA	NA				NA	17.5
Senegal							18.7
Solomon Islands	NA	NA				NA	20
South Sudan			NA	Also top refugee source		NA	NA
Sudan				Also top refugee source			19.3
Swaziland							20.1
Uzbekistan							25.2
Vietnam							27.4
Yemen							16.4
Zambia							17.2

Sources for EWEC "traffic lights"

The Global Peace Index measures peace according to 23 qualitative and quantitative indicators (Global peace index 2015.

Produced by the Institute of Economics and Peace (IEP), it ranks 162 countries covering 99.6% of the world's population. The Index gauges peace using three themes: the level of safety and security in society, the extent of domestic or international conflict, and the degree of militarization and it ranks countries according to 23 qualitative and quantitative indicators of peace. *The lower the score the more peaceful and stable the country.*

Key

Green = 1 – 1.89 GPI score
Yellow = 1.9 – 2.2 GPI score
Orange = 2.21 – 2.85 GPI score
Red = above 2.9 GPI score

The Uppsala Conflict Data Program (UCDP) (Deaths in armed conflicts) is a data collection project on organized violence housed at Uppsala University in Sweden. It gathers information on armed conflict and makes it publicly available online and in its annual report, "States in Armed Conflict."

Key

Green = 0 deaths in 2014
Yellow = 1 to 99 deaths in 2014
Orange = 100 to 999 death in 2014
Red = 1000 to 10,000 deaths in 2014
Purple = 10,000 or more deaths in 2014

The World Risk Index (Countries and disaster risk) calculated by the United Nations University for Environment and Human Security (UNU-EHS) - measures the risk of becoming a victim of a disaster as a result of vulnerability and natural hazards such as earthquakes, storms, floods, droughts and sea level rise for 173 countries worldwide, based on 28 indicators. Risk is at its highest where a high level of exposure to natural hazards coincides with very vulnerable societies. The higher "the score" the more at risk the country.

Key

Green = 0 – 3.61 disaster risk score
Yellow = 3.62 – 5.68 disaster risk score
Orange = 5.69 – 7.43 disaster risk score
Red = 7.44 – 10.37 disaster risk score
Purple = 10.38 – 36.43 disaster risk score

The World Factbook projects the average rate of change of the size of the urban population over 2010 to 2015 (Rate of Urbanization). It estimates that the world average annual rate of urbanization is 2% being the projected average rate of change of the size of the urban population.

Green = 2% or less pa (below average)
Yellow = 2.1% to 3% pa
Orange = 3.1% to 4% pa
Red = 4.1% or more

The figures on **Internally Displaced People** (IDP) (Global Internal Displacement Figures) are based on **Internal Displacement Monitoring Centre's** monitoring and analysis of information available from a range of sources on internal displacement caused by armed conflict, situations of generalised violence or violations of human rights. Top refugee "hosting" & "source" countries are in the top 10 according to UNHCR figures at end of 2014.

Green = 0
Yellow = 1- 30,000
Orange = 30,001 – 100,000
Red = 100,001 – 500,000
Purple = 500,001 – 3,100,000+

The **Social Institutions and Gender Index's** (SIGI) variables combine qualitative and quantitative data, taking into account both the de jure and de facto discrimination of social institutions, through information on laws, attitudes and practices. The variables track 160 countries and span all stages of a woman's life in order to show how discriminatory social institutions can interlock and bind them into cycles of poverty and disempowerment.

Green = Very Low
Yellow = Low
Orange = Medium
Red = High
Purple = Very High

Median age is the age that divides a population into two numerically equal groups - that is, half the people are younger than this age and half are older. It is a single index that summarizes the age distribution of a population (Median age). The median age ranges from a low of about 15 in Uganda to above 40 Austria, Italy, Canada and Japan, for example. World median age is 28.8.

Green = at world median or above
Yellow = up to 4 years below world median (24.8 – 28.7)
Orange = up to 8 years below world median (20.8 – 24.7)
Red = up to 10 years below world median (18.8 – 20.7)
Purple = Very High over 10 years below world median (18.7 and below)