Global Strategy for Women's, Children's and Adolescents' Health

Every Woman Every Child (EWEC) 2.0

Socioeconomic, political and environmental determinants

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Every Woman Every Child Determinants of Health Working Group[b]

[a] This paper is now open for public consultation on the PMNCH website.

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Abstract

The determinants of health are the conditions in which people are born, grow, live, work and age, and the distribution of power, money and resources which impact on these conditions. The determinants of health encompass social, economic, political, environmental and cultural dimensions, Determinants are crucial influences on the health of women, children and adolescents. For example, the goal of ending preventable deaths requires multi-sectoral action to address determinants of health, including within the health sector itself. No country has reduced mortality levels to the target levels through healthcare alone, or without transformations in social and economic development.

Yet strategies in the Millennium Development Goal (MDG) era to improve the health of women, children and adolescents have mostly concentrated on healthcare interventions delivered by the health sector. The current Global Strategy on Women's and Children's Health (Every Woman Every Child or EWEC)[2] does not substantively consider determinants of health and interventions beyond the health sector. Failing to sufficiently recognize the impact of determinants and other sectors undermines efforts to reach reproductive, maternal, newborn, child and adolescent health (RMNCAH) outcome targets, not only because it distracts from the importance of key polices across a range of sectors. It also undermines efforts to increase coverage of healthcare interventions, as the health sector is an important determinant of health itself. The updated Global Strategy on Women's, Children's and Adolescent's Health (EWEC 2.0) must address this omission to realize its vision of ending preventable maternal, newborn and child deaths within a generation, to reduce disparities, and to realize the right to health of women, children and adolescents.

In addressing determinants in the updated Global Strategy, we propose four key directions. First, to update the Strategy's conceptual framework and content to appropriately include a focus on determinants and multi-sectoral action, clarifying the different types of action required. Second, we propose a prioritized list of key Sustainable Development Targets for RMNCAH outcomes for joint tracking and action in the post-2015 era. Third, we identify a prioritized list of key determinants, interventions and policies, and indicators for multi-sectoral action, informed by the key SDG targets identified. Fourth, there is a need for attention to efforts to mobilize resources, improve governance, aid implementation and facilitate monitoring of multi-sectoral efforts. In concluding, we identify key tasks for multi-sectoral action in initial implementation of the updated Global Strategy, including calling for a new ***Commission on Implementation and Accountability of Multi-sectoral Action for Women's, Children's and Adolescents' Health***.

1. Background and introduction

The determinants of health are the conditions in which people are born, grow, live, work and age, and the distribution of power, money and resources which impact on these conditions.[1] The determinants of health encompass social, economic, political, environmental and cultural dimensions, and here we use the term "determinants" as shorthand to signify all of these complex factors ("social determinants of health"[1] or "underlying determinants"[3] are sometimes used in a similar way).

Determinants are crucial influences on the health of women, children and adolescents. Women, children and adolescents often suffer from discrimination and unequal access to resources and realization of their rights, resulting in exposure to adverse socio-economic, political and environmental conditions – the direct cause of inequities in health for women, children and adolescents within and between countries. Determinants affect access and coverage of essential health interventions, but also impact on health directly, including through shaping behaviours.

For example, gender (in)equality is a key determinant of health.[4] Manifestations of gender inequality (such as differential access to education and health services, forced and early child marriage, unequal labour market participation and remuneration, and violence against women and children) are major contributors to maternal and child mortality – while measures to address these factors can improve health outcomes for women, children and adolescents, and reduce disparities.

Determinants are not static, but instead interact with each other and change and are changed by the evolving context. Addressing determinants requires multi-sectoral action within various single sectors (such as health, education, water and sanitation, environment-related sectors, and nutrition) but also joint action across and between sectors (cross-sectoral and intersectoral action).

The current Global Strategy on Women's and Children's Health (Every Woman Every Child or EWEC)[2] does not substantively consider determinants of health and interventions beyond the health sector. The updated Global Strategy on Women's, Children's and Adolescent's Health (EWEC 2.0) must address this omission to realize its vision of ending preventable maternal, newborn and child deaths within a generation, to reduce disparities, and to realize the right to health of women, children and adolescents.

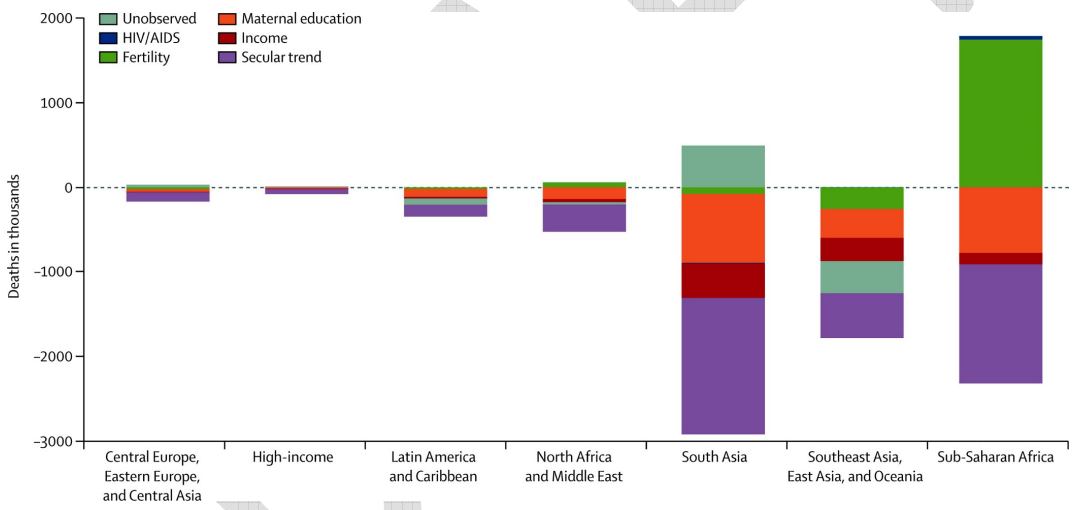
Ending preventable deaths requires multi-sectoral action to address determinants of health, including within the health sector itself. No country has reduced mortality levels to the target levels through healthcare alone, or without transformations in social and economic development. And addressing key health issues for adolescents such as road traffic injury, violence, suicide, drowning and obesity requires leadership beyond the health sector. In moving towards these goals, prioritizing action within and beyond the health sector corresponds with the identified need for both healthcare and interventions on the 'underlying' determinants in the health and human rights discourse.[3]

This working paper sets out key issues on multi-sectoral actions to address determinants to be included in the updated Global Strategy document currently in preparation, and to inform the Global Strategy's implementation strategy. The context of this work is the upcoming finalization of the Sustainable Development Goal agenda, which urges a more integrated and transformative view of development across social, economic and environmental pillars, with much greater cross-sectoral links. This paper is open for public consultation for inputs until April 15th, 2015.

2. Problem statement

It is well recognized that progress on reproductive, maternal, newborn, child and adolescent health (RMNCAH) can be accelerated by interventions beyond the health sector, particularly through efforts in education, nutrition, water and sanitation, and the environment. The contribution of non-health sectors is best understood for under-5 child mortality, with recent advances in distinguishing the comparative contributions of different sectors and interventions (see Figure 1).[5] Approximately half the decrease in child mortality in low- and middle-income countries since 1990 can be attributed to investments made in sectors outside health.[6] Estimates for the contribution of educational improvement by itself vary, but range as high as 51.2 per cent.[7] Malnutrition remains the underlying cause of 45 per cent of child deaths.[8] Diarrhoea, malaria and respiratory infections remain among the greatest single causes of under-5 child mortality, and environmental factors play a significant role in their aetiology, as they do for injuries and malnutrition.

Figure 1 Contribution to progress on child mortality 1990-2013: change in the number of child deaths due to income per person, maternal education, HIV child death rate, shift in secular trend, births, and unexplained factors for seven Global Burden of Disease super-regions (reproduced from [5])



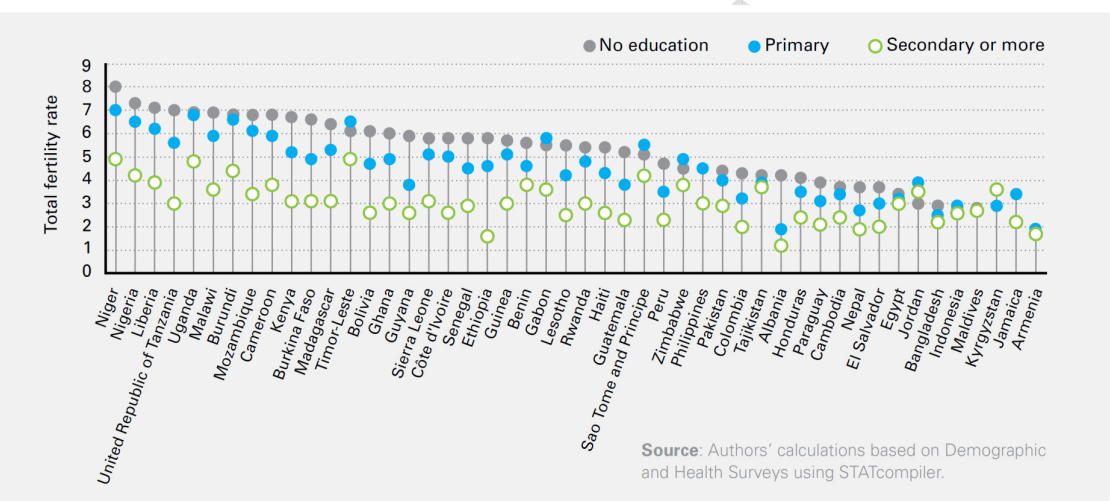
Outcomes involving non-health sectors, such as better education, reducing fertility rates, urbanization and infrastructural improvements (such as roads and electricity) also make important contributions to reductions in maternal mortality.[c] In general, the relative contributions of health and non-health sectors have been less well quantified for maternal mortality compared to child mortality. There are also important interactions between different determinants, for example, the impact of education on fertility rates (see Figure 2).[9]

Also recognized, but less well understood, is how structural factors in society, such as poverty, gender inequality and other forms of discrimination (such as racism) and inequality, have direct and mediated impacts on RMNCAH and generate inequities in the health of women, children and adolescents. Interventions to address these factors (such as reducing poverty, ending child marriage or tackling violence against women and children) make vital contributions to

[c] David Bishai et al, manuscript under review, details available on request.

improving women's, children's and adolescents' health, yet the evidence of mortality impact for specific interventions is not comprehensive. There is a definite correlation between economic growth and improvements in maternal and child mortality, yet this is complex. There are wide variations in performance between countries of similar wealth levels,[10] strongly influenced by differences in health systems and in the determinants of health. These differences underscore the importance of policy choices and attention to health and wealth disparities within countries, and of prioritizing new resources for marginalized communities who often lack political influence.

Figure 2 Total fertility rate of women in 48 low- and middle-income countries from 2008 to 2012, by level of education (reproduced from [9])



There is thus substantial evidence that multi-sectoral efforts to address determinants of health are extremely important for RMNCAH (including for reducing inequities and increasing coverage of health interventions). There is also increasing evidence on which policies and interventions are necessary – a recent compendium compiles multi-sectoral policies that influence RMNCAH service delivery and outcomes, drawing on the range of evidence and country experiences.[11]

Yet despite this evidence and policy guidance, strategies in the Millennium Development Goal (MDG) era to improve the health of women, children and adolescents have mostly concentrated on healthcare interventions delivered by the health sector (the MDGs did present eight goals as a joint agenda, which included key determinants such as poverty, education, nutrition and water and sanitation, but the different goals were not managed together in practice). The current Global Strategy is no exception. This is not to argue for lesser attention to essential health sector interventions for women, children and adolescents. Improvements in coverage of health services have been crucial to progress in MDGs 4, 5 and 6. Health sector interventions continue to represent a competitive and effective return on investment and can also drive change in other sectors.

But there have been insufficient efforts in tracking MDG progress to quantify the contribution of interventions beyond the health sector to the health-specific MDGs, with limited documentation of the benefits of multi-sectoral investment nor attention to high impact interventions beyond the health sector. Failing to sufficiently recognize the impact of determinants and other sectors

undermines efforts to reach RMNCAH outcome targets, not only because it distracts from the importance of key polices across a range of sectors. It also undermines efforts to increase coverage of healthcare interventions, as the health sector is an important determinant of health itself. Identifying and addressing why some groups have lower coverage of health services also requires a focus on, and measurement of, determinants such as discrimination, poverty and gender inequality, as well considering necessary interventions in other sectors such as roads and financing instruments.

A related challenge has been inadequate investment in institutions to advocate for or regulate multi-sectoral work. Working across sectors for health has proved challenging in all contexts and especially in high RMNCAH burden settings. The challenge in incorporating a determinants focus into RMNCAH efforts is not just to identify the key interventions in non-health sectors - rather it is to identify how to catalyse work with other sectors and how to contribute to policies and interventions that are other sectors' core concern. This requires addressing issues of governance, financing, implementation, and monitoring.

There has also been a lack of clear mechanisms for public and social accountability across sectors for RMNCAH outcomes. Despite the tremendous progress engendered by the Global Strategy in accountability within the health sector at both global and national levels (including through the Commission on Information and Accountability for Women's and Children's Health), little attention has been paid to increase the accountability of other sectors. This gap reflects how responsibility for the health of women's, children's and adolescents' health has been seen primarily as only the legitimate interest of the health sector.

3. Response and priority interventions

The updated Global Strategy, and its implementation strategy, can make a significant contribution to ensuring a focus on determinants in RMNCAH efforts, and catalysing greater multi-sectoral efforts. These opportunities can be summarised under the following key themes.

3.1 Update the current Global Strategy framework to appropriately include a focus on determinants and multi-sectoral action

The current Global Strategy focuses on interventions delivered by the health sector, including issues of workforce and access, and only makes passing reference to determinants. This omission has been recognized and needs to be remedied in the framework and content of the updated Global Strategy. The new Strategy should clarify the different types of action required:

1. Addressing structural forces and social and gender norms which impact across all of society, including those which drive disparities, and thus require broad ranging cross-sectoral policies driven by the executive of government.
2. Actions within single sectors which form their core business (such as ensuring children attend school and learn well for the education sector or access to safe water for the water and sanitation sector).
3. Actions within the health sector addressing its own status as a key determinant of health (such as addressing discrimination and abuse or the provision of differential quality of care to different groups) and its key role in primary prevention.
4. Actions requiring the collaboration of two or more sectors (intersectoral work) for joint or "co-benefits" and to maximize the health benefits (such as the use of cleaner stoves to reduce indoor air pollution, or sexuality education in schools).

While work on determinants often focuses on intersectoral work, it is important to understand that the greatest benefits for RMNCAH often lie in the first two types of action listed above – in addressing structural forces and social and gender norms (for example, reducing poverty or increasing gender equality) and in single sectors doing their own core business well. There is greater health impact, for example, from the education sector keeping adolescent girls in school and delivering them a quality education that enables their economic empowerment, than in collaborative activities to specifically increase health literacy or undertake school-based health clinics. While all of these activities can be beneficial, the health sector has all too often, when considering multi-sectoral action, focused on marginal collaborations at the expense of recognizing the impact of the core work of other sectors.

The Global Strategy should also recognize that determinants are also the context which influence all of its aspects, including global and national leadership, accountability and the actions of the health and other sectors. In conceptualizing determinants in the framework for the updated Global Strategy, the rich existing literature should be consulted, including the framework of the Commission on Social Determinants of Health[12] and recent adaptations, such as for child wellbeing.[13]

3.2 Identify key potential Sustainable Development Goal (SDG) targets for RMNCAH for joint tracking and action in the post-2015 era

In the MDG era, MDGs 4, 5 and 6 provided a strong underpinning for the Global Strategy. The context for EWEC 2.0 will be the Sustainable Development Goals (SDGs). The Open Working Group (OWG) targets that will form the basis of the SDGs provide an extended range of targets across many sectors related to RMNCAH, reflecting the vision for the SDGs to be a more comprehensive and universal set of goals and targets than the MDGs. Including a focus on determinants in the revised Global Strategy aligns with this expansion in scope, which provides an opportunity to learn from the fragmentation of sectors that accompanied the implementation of the MDGs, with goals often identified with single sectors.[14] At the same time, the expansive nature of the SDG agenda (the OWG has proposed 17 goals and 169 targets) also brings a risk that in trying to address such a broad range of issues, efforts will be diluted and there will be lack of focus on specific interventions.

Aiming to address determinants for RMNCAH faces a similar hazard. To mitigate this challenge, targets across different sectors in the SDG agenda for RMNCAH can be prioritized to help countries focus their efforts to improve women's, children's and adolescent's health. While the SDG agenda is still under negotiation by Member States, indications are that the OWG goals and targets will remain substantially intact. Under the health Goal 3, RMNCAH is well represented with updated MDG 4, 5 and 6 targets and new targets on noncommunicable diseases and injuries, and universal health coverage – all of which require multi-sectoral efforts.

Given the expansive scope of determinants, almost all of the proposed SDG targets could be seen as of some relevance to RMNCAH. As such, difficult choices need to be made about which targets are crucial, and moreover, which targets provide entry points for which the revised Global Strategy might credibly guide or contribute, keeping in mind the myriad other efforts at global and national levels that already exist or will be launched to realise the SDG agenda.

We propose in Table 1 an initial priority list of targets for the updated Global Strategy to concentrates its efforts, both for the Strategy itself and for implementation. This list is drawn from a longer list of potential RMNCAH targets in the OWG proposal available in Appendix 1, not

including the health goal outcome targets. The initial prioritization in Table 1 has been made according to the evidence of impact of available interventions, and informed by discussions and consultations undertaken in the development of this paper (including efforts by others to prioritize[15]) and will be further informed by the upcoming public consultation. The updated Global Strategy should endeavour to mobilize efforts across the final set of these targets and facilitate their joint monitoring, along with the health outcome targets, in RMNCAH accountability mechanisms at country and global level (for example, extending and expanding the current Countdown to 2015 platform).

Table 1 Initial priority potential SDG targets for RMNCAH (drawn from OWG proposal)

1.1 by 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than $1.25 a day

2.2 by 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons

3.9 by 2030 substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination

4.1 by 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes

4.2 by 2030 ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education

5.2 eliminate all forms of violence against all women and girls in public and private spheres, including trafficking and sexual and other types of exploitation

5.3 eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations

5.5 ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic, and public life

6.1 by 2030, achieve universal and equitable access to safe and affordable drinking water for all

6.2 by 2030, achieve access to adequate and equitable sanitation and hygiene for all, and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations

7.1 by 2030 ensure universal access to affordable, reliable, and modern energy services

13.2 integrate climate change measures into national policies, strategies, and planning

16.2 end abuse, exploitation, trafficking and all forms of violence and torture against children

16.9 by 2030 provide legal identity for all including birth registration

17.18 by 2020, enhance capacity building support to developing countries, including for LDCs and SIDS, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts

3.3 Identify key interventions and policies with indicators for multi-sectoral action on RMNCAH

The existing Global Strategy provides an overview of key health sector areas for focus in RMNCAH efforts. The updated Global Strategy should include a similar guide to multi-sectoral

action on RMNCAH determinants, highlighting a set of key policies and interventions, with indicators for joint monitoring against the SDG targets identified above. The process of identifying key actions will need further discussion through the remainder of the Global Strategy development process, including considering the outputs of other workstreams proposing non-health sector interventions, including adolescents, humanitarian settings, and the work on human rights (which provide a normative foundation for actions on determinants).

In Table 2, we present an initial proposal of key determinants, interventions and policies, indicators and corresponding SDG targets, to be prioritized as part of the updated Global Strategy and for subsequent implementation efforts. This will also be revised following the upcoming public consultation.

3.4 Contribute to governance, financing, implementation, monitoring and research of multi-sectoral RMNCAH actions to address determinants

Efforts to drive multi-sectoral action on determinants of health have often stalled at the phase of implementation, even when the rationale and conceptual framework is accepted by policy-makers. Governance, financing and joint monitoring of multi-sectoral action to achieve RMNCAH targets have proved difficult in practice. While addressing these issues in detail may be beyond the scope of the revised Global Strategy itself, they are fundamental for any implementation plan, and, moreover, country RMNCAH efforts.

The implementation strategy for EWEC 2.0 should highlight country experiences of success in addressing determinants and driving multi-sectoral efforts to improve RMNCAH (for examples, see Box 1). Specific guidance is required on the work and governance of different types of multi-sectoral action (single sector, intersectoral and cross-sectoral), including on how key policies for RMNCAH across sectors can be implemented and linked, even in low-income, high burden settings. There is much to learn in this regard from the HIV movement's response, and also from the work of the environmental and other sectors. Tools and methods for analysing health risks and benefits associated with policies implemented in other sectors (such as 'health in all policies' and health impact assessment) as well as to review specific determinants (such as gender assessments and audits and gender-responsive planning and budgeting) are also available and can be linked to.[16,17]

The Global Strategy should also aim to mobilize financial resources for RMNCAH actions beyond the health sector on determinants. Discussions on the Global Financing Facility have already identified key areas where non-health sector interventions are crucial for impact on RMNCAH outcomes. In all countries, resources are spent on determinants as part of the core work of other sectors. The question to consider is how the revised Global Strategy can catalyse accelerated investment in a set of key policies and interventions on determinants – which for most countries must be funded from domestic financing.

As noted above, a "quick win" that the revised Global Strategy could achieve is the inclusion of monitoring of key determinants and interventions beyond the health sector as part of its accountability work, building on what has been a clear strength of the existing Strategy. Disaggregating data for indicators for both health and non-health sector interventions would facilitate a greater equity and rights focus and also reinforce attention to determinants, given that the drivers of disparities mostly lie beyond the health sector. There is also a need to link

Table 2 Key RMNCAH determinants, interventions, indicators and corresponding SDG targets

Determinant	Policy and/ or Intervention	Indicators	SDG targets (see Table 1)
Income and social protection	Reduce poverty through the use of cash transfer programmes designed with health sector input, especially on use of conditionality	Proportion of population below $1.25 (PPP) per day disaggregated by sex and age group	1.1
Food security	Prioritize measures to enhance food security in communities with high mortality burden	Prevalence of undernourishment	2.1
Infant and young child nutrition	Implement Infant and Young Child Feeding (IYCF) guidelines	Prevalence of stunting in children under 5 years of age. Rate of exclusive breastfeeding among infants under 6 months of age	2.2
Education of adolescent girls	Prioritize support for adolescent girls to receive a quality education, including through mechanisms such as cash transfers	Completion rate (%) of upper secondary education by girls	4.1
Early child development	Implement a multi-sectoral approach to early child development for all children, using a progressive universalism approach to maximize gains for the worst off	Early Childhood Development Index	4.2
Ending child marriage	Enact legislation and provide social support services to end child marriage	Percentage of women aged 20-24 who were married or in a union before age 18 (i.e. child marriage)	5.3
Political participation of women	Implement minimum quotas for participation of women in political institutions e.g. parliaments	Proportion of seats held by women in local governments	5.5

Safe drinking water	Prioritize infrastructural investments to enable universal access to safe and affordable drinking water	% of population using safely managed drinking water services	6.1
Access to sanitation facilities	Community led total sanitation to end open defecation	% of population using safely managed sanitation services	6.2
Access to electricity	Prioritize new infrastructural development for energy access in high mortality burden communities	Percentage of population with electricity access (%)	7.1
Exposure to household air pollution	Increase use of clean home energy fuels and technologies (for cooking, heating, lighting)	Percentage of people using primarily clean fuels or technologies (for cooking, heating lighting), where "clean" is defined by WHO guidelines	7.1
		Child mortality and morbidity attributable to household air pollution	3.9
Hazardous child labour	Systematic detection and elimination of hazardous child labour	Percentage and number of children aged 5-17 years engaged in child labour, per sex and age group (disaggregated by the worst forms of child labour)	8.7
Lead	Eliminating non-essential uses of lead (such as in paint) and ensure the safe recycling of lead-containing waste	Number of countries that have regulated lead in paint	12.4
Climate change	Enhancement of climate resilience of environmental determinants of health (e.g. climate resilient WASH infrastructure and management practice).	Population coverage with climate-resilient infrastructure and management practices (e.g. climate resilient Water Safety Plans)	13.2
Birth registration	Build civil registration and vital statistics systems to achieve universal birth registration	Percentage of children under 5 whose births have been registered with civil authority	16.9

global reports on RMNCAH with corresponding efforts in other sectors, for example, nutrition, water and sanitation, and clean air, with the aim of delivering joint information and accountability to allow cross-sectoral analysis and prioritization for investment and implementation at country level.

While there is a large array of evidence on the contribution of non-health sectors to RMNCAH and the impact of determinants, specific evidence gaps remain to be filled, in particular by implementation research. For example, there is much less evidence on the health impacts of specific interventions within sectors, and on interventions and policies to address societal or structural forces. The existing evidence of multi-sectoral impact is scattered and often drawn from modelling exercises, which assess correlation but do not provide specific evidence on the mechanisms whereby interventions in non-health sectors directly lead to health improvement. Tools used in RMNCAH planning and budgeting (such as the Lives Saved Tool,[18,19] OneHealth and soon-to-be launched EQuIST) should be developed to encompass interventions beyond the health sector – but this will require improving and systematizing the evidence base.

A specific area for focus is the generation of cost-benefit and cost-effectiveness data for key interventions and policies beyond the health sector for RMNCAH. There is currently an inability to compare the health impacts and costs of policies and interventions in non-healthcare sectors with interventions within the health sector. The health sector itself has been reluctant to consider whether health outcomes might be more efficiently achieved through investment in policies and interventions on determinants than through spending on healthcare interventions. While for most countries, including those with the greatest RMNCAH burden, this is a false choice (with greater investment required in both essential health interventions **AND** interventions and policies on determinants), the inability to enter this debate with costing information has hampered the credibility of advocacy efforts for action on determinants.

Addressing the above challenges will need significant innovation – in governance mechanisms, planning tools, the use of technology in monitoring, and in social and policy innovation. The updated Global Strategy should therefore also build on the promising experiences in fostering innovation in the work of the existing Strategy since 2010, to build the available resources for countries for the implementation of multi-sectoral actions. In addition, the engagement of women, adolescent and children as agents and decision-makers with respect to their own health should be prioritized in the design of new governance structures, measurement tools, standards and policies.

4. Conclusion

The updating of the Global Strategy on Women's, Children's and Adolescents' Health is an unprecedented opportunity to "mainstream" a focus on multi-sectoral efforts on determinants of health in RMNCAH efforts at global, national and district levels – which are essential to end preventable maternal, newborn and child deaths and to realize the right to health of women, children and adolescents. This working paper has proposed key tasks for this process in terms of clarifying how multi-sectoral efforts on determinants fit into the updated Global Strategy; identifying key determinants, interventions and policies, indicators and SDG targets for focusing RMNCAH efforts; and building the governance, financing and monitoring required for implementation.

This is a demanding challenge for the Every Woman Every Child movement, which will require sustained efforts across the entire SDG period to 2030. The guiding principle for work on

determinants in EWEC 2.0 should not be to necessarily launch new efforts in other sectors for RMNCAH, but instead to analyse, support, scale and join up existing efforts that already contribute to better health that other sectors undertake as part of their core business. To begin, the following activities should be considered in initial implementation of the updated Global Strategy:

1. Joint monitoring at global and national levels of the interventions and targets proposed in Table 2, driven by the UN Secretary-General's office, building on existing monitoring efforts in health, education, nutrition, water and sanitation, and incorporating a gender-sensitive lens.
2. Specific efforts to synthesize and generate data on cost-effectiveness in terms of key RMNCAH outcomes of multi-sectoral interventions and policies to drive prioritization.
3. Specific efforts to synthesize and build knowledge of incentives for intersectoral action, including how to drive mutual additional benefits for RMNCAH and the core business of other sectors through joint efforts.
4. Mobilize the Every Woman Every Child movement, in particular governments and civil society, to invest in champions (such as parliamentarians) and institutions to steer multi-sectoral RMNCAH action on determinants.
5. Mobilize financing and incentivize multi-sectoral collaboration and action, through existing partnerships and the Global Financing Facility.
6. Consider how the Every Woman Every Child innovation pipeline can contribute further to multi-sectoral action.
7. Request the UN system to coordinate, as appropriate, the required work between sectors through its existing mechanisms, including setting an example for multi-sectoral action by coordinating itself better.

To facilitate the first three tasks, particularly the first one, we also propose a ***Commission on Implementation and Accountability of Multi-sectoral Action for Women's, Children's and Adolescents' Health***, to build on the model and work of the Commission on Information and Accountability for Women's and Children's Health. Such a Commission would be a clearly defined practical step to incorporating determinants into the Global Strategy, and more importantly, stimulating multi-sectoral RMNCAH efforts at global and national levels.

Box 1 Country examples of multi-sectoral efforts to address determinants of RMNCAH

PERU - A Good Start in Life (Reproduced from [20])
In 1999, a programme called A Good Start in Life ("Buen Inicio") was initiated in three regions of the Peruvian Andean highlands (Cusco, Cajamarca and Apurimac) and one region of the Amazon rainforest (Loreto). It was a collaboration between the government of Peru, USAID and UNICEF. The programme has focused on the prevention of stunting among children under the age of three, and on pregnant and lactating women. It uses community-based interventions such as: growth and development promotion; antenatal care; promotion of adequate food intake during pregnancy and lactation; exclusive breastfeeding and improved complementary feeding from six months; control of iron and vitamin A deficiency; improved early stimulation; promotion of iodized salt; and personal and family hygiene. The programme team, led by local governments, worked with local communities, staff of health facilities and local nongovernmental organizations. Emphasis was given to the strengthening of the capacities and skills of women counsellors and rural health promoters. In 2004, the programme covered about 75 000 children under the age of three, and 35 000 pregnant and lactating women living in 223 rural communities. A comparison between 2000 and 2004 showed

that, in the communities covered by the programme, the stunting rate among children under three years of age declined from 54.1% to 36.9%, while anaemia rates declined from 76% to 52.3%. Because of these results, Buen Inicio was made the basis for the national strategy CRECER (Creating Conditions for Economic Revitalization). This was launched in 2007 by President Garcia to combat chronic child malnutrition, and continues today through the strategy "Incluir para Crecer" (Inclusion for Growth) under President Humala's administration.

RWANDA - Good governance, gender equality and decentralization (Reproduced from [20])
Good governance is prioritized in Rwanda's national development policies, which include zero tolerance of corruption, a national gender policy and an annual Governance Scorecard. The MoH and development partners participate in bi-annual Joint Health Sector Reviews and Health Sector Working Groups (including a RMNCH working group). Rwanda has also instituted structures to empower women. The Rwanda Women Parliamentarian Forum advocates for policies that improve the welfare of women, and in 2006 introduced a bill to parliament on gender-based violence, which passed in 2008. Women currently hold an overall majority of seats in parliament (40% in the senate and 64% in the lower house – the highest in the world). The Women's Council, established in 1996, informs women about health and their basic rights, and includes organized structures from the grassroots to the national level. A programme of health-sector decentralization is implemented through the Social Affairs Cluster of Ministries and the District Council, which is the decision-making and coordinating body at district level. This is supported by a monthly Joint Action Development Forum for all partners, local and international. This level of coordination is repeated at local level, and has contributed to Rwanda's ability to scale up key interventions within and outside of the health sector.

ZIMBABWE - Keeping girls in school
Numerous studies show that increasing girls' educational attainment results in positive HIV and sexual and reproductive health outcomes, such as delaying the age of first sex, increased condom use, avoiding unwanted pregnancies, and reduction of age-disparate relationships with older men. Education played a critical role in HIV prevention in Zimbabwe, where HIV prevalence decreased from 29% in 1997 to 14% in 2007. In 2010, 75% of young women aged 15-24 in Zimbabwe had finished lower secondary school.

MALAWI - Cash transfers produce positive health outcomes
Cash transfers have proven to work in preventing HIV infections among women. A Randomized Control Trial in the Zomba district of Malawi, with more than 1200 never-married, in-school and out-of-school women aged 13-22 years, provided combined cash transfers ranging from US$1 to US$15 per month to young women, and their parents, in addition to payment of school fees. As a result of the program, teenage pregnancies and early marriage fell by 29% and 32%. The cash transfers also reduced HIV infections by 64% and HSV-2 prevalence by 76%.

UGANDA: Violence Prevention at community level
In sub-Saharan Africa, 58% of people living with HIV are women, and up to 71% of women experience violence from intimate partners. What does it take to prevent violence against women and HIV? This is the driving question behind the SASA! study. This study, a unique collaboration between Raising Voices, CEDOVIP, the London School of Hygiene and Tropical Medicine and Makerere University investigates the impact of the SASA! approach in communities in Kampala, Uganda. The SASA! study is a pair-matched cluster randomized controlled trial conducted in eight communities in Kampala. It is one of the few cluster randomized trials globally to assess the community wide impact of a violence prevention intervention. Outcomes evaluated include: reduction in the social acceptability of violence against women, reduction in women's experience of physical violence from an intimate partner, impact HIV risk behaviors and improve community response toward women experiencing violence.

In addition to the trial, the SASA! study includes extensive qualitative research to explore the nature and dynamics of social change and the diffusion of ideas and a costing study to assess the cost effectiveness of SASA! Results include:
- The level of physical partner violence against women was 52% lower in SASA! communities than in control communities.
- In SASA! communities 76% of women and men believe physical violence against a partner is not acceptable while only 26% of women and men in control communities believe the same.
- In SASA! communities 28% more women and men believe it is acceptable for a woman to refuse sex than women and men in control communities.
- Women exposed to SASA! were 3 times more likely to receive helpful support when reporting violence than women not exposed to SASA!
- In SASA! communities, 27% of men reported concurrent sexual partners whereas 45% of men in control communities reported multiple partners.

NIGER - Investing in Niger's Adolescent Girls: Knowledge for Dignity
An innovative programme aiming to reduce early marriage and lower the fertility rate by addressing socio-cultural factors is currently implemented in Niger. The initiative focuses on adolescents girls aged 10-19 years addressing key elements: Safe space where girls feel secure to receive non-formal education; mentorship from trained female mentors who train, assess and serve as role models to the adolescent girls; community involvement through dialogue organized by community facilitators; family engagement through home visits by mentors; holistic program that consists of health check-up for girls, basic literacy and numeracy training, building self-esteem, decision-making and public speaking skills, awareness raising on issues related to sexual and reproductive health, utilization of reproductive health services; and program monitoring. Positive findings after an initial one-year pilot include health related issues (e.g., about 89% of girls know at least three family planning methods); education (61% of adolescent girls can read the alphabet after the sessions compared to 21% before); marriage (93% of girls agree that it is their responsibility to choose their spouse); enhanced financial capacity (e.g., 97% have set up a savings plan compared to 28% before the program); positive attitude of girls' parents (e.g., parents have more open and frequent communication with their daughters); and engaged communities (e.g., sensitive issues and topics are discussed openly).

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Appendix 1. Open Working Group Post-2015 targets for determinants for RMNCAH

For reference, targets selected for Table 1 are emboldened

1.1 by 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than $1.25 a day

1.2 by 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions

1.5 by 2030 build the resilience of the poor and those in vulnerable situations, and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters

2.1 by 2030 end hunger and ensure access by all people, in particular the poor and people in vulnerable situations including infants, to safe, nutritious and sufficient food all year round

2.2 by 2030 end all forms of malnutrition, including achieving by 2025 the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons

3.9 by 2030 substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination

4.1 by 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes

4.2 by 2030 ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education

4.3 by 2030 ensure equal access for all women and men to affordable quality technical, vocational and tertiary education, including university

4.4 by 2030, increase by x% the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship

4.5 by 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples, and children in vulnerable situations

4.6 by 2030 ensure that all youth and at least x% of adults, both men and women, achieve literacy and numeracy

5.1 end all forms of discrimination against all women and girls everywhere

5.2 eliminate all forms of violence against all women and girls in public and private spheres, including trafficking and sexual and other types of exploitation

5.3 eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations

5.4 recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies, and the promotion of shared responsibility within the household and the family as nationally appropriate

5.5 ensure women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic, and public life

6.1 by 2030, achieve universal and equitable access to safe and affordable drinking water for all

6.2 by 2030, achieve access to adequate and equitable sanitation and hygiene for all, and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations

7.1 by 2030 ensure universal access to affordable, reliable, and modern energy services

10.1 by 2030 progressively achieve and sustain income growth of the bottom 40% of the population at a rate higher than the national average

10.2 by 2030 empower and promote the social, economic and political inclusion of all irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status

10.3 ensure equal opportunity and reduce inequalities of outcome, including through eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and actions in this regard

10.4 adopt policies especially fiscal, wage, and social protection policies and progressively achieve greater equality

10.7 facilitate orderly, safe, regular and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies

11.1 by 2030, ensure access for all to adequate, safe and affordable housing and basic services, and upgrade slums

12.4 by 2020 achieve environmentally sound management of chemicals and all wastes throughout their life cycle in accordance with agreed international frameworks and significantly reduce their release to air, water and soil to minimize their adverse impacts on human health and the environment

13.1 strengthen resilience and adaptive capacity to climate related hazards and natural disasters in all countries

13.2 integrate climate change measures into national policies, strategies, and planning

13.3 improve education, awareness raising and human and institutional capacity on climate change mitigation, adaptation, impact reduction, and early warning

16.1 significantly reduce all forms of violence and related death rates everywhere

16.2 end abuse, exploitation, trafficking and all forms of violence and torture against children

16.9 by 2030 provide legal identity for all including birth registration

17.2 developed countries to implement fully their ODA commitments, including to provide 0.7% of GNI in ODA to developing countries of which 0.15-0.20% to least-developed countries

17.14 enhance policy coherence for sustainable development

17.18 by 2020, enhance capacity building support to developing countries, including for LDCs and SIDS, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts

17.19 by 2030, build on existing initiatives to develop measurements of progress on sustainable development that complement GDP, and support statistical capacity building in developing countries