

# PARTNERSHIP FOR MATERNAL, NEWBORN & CHILD HEALTH REPORT:

COMMITMENTS TO THE *EVERY WOMAN  
EVERY CHILD* GLOBAL STRATEGY FOR  
WOMEN'S CHILDREN'S AND ADOLESCENTS'  
HEALTH (2016-2030)



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# EXECUTIVE SUMMARY

This report tracks commitments to the "**Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)**" (EWEC *Global Strategy*) over the period of September 2015 to December 2017. It supplements a monitoring report on the EWEC *Global Strategy*, developed by the H6, which was presented alongside the World Health Assembly in May 2018.<sup>1</sup> The report tracks EWEC *Global Strategy* commitments through three main methods:

- First, it provides an update on pledges made to advance the EWEC *Global Strategy*, including their focus and alignment with the Strategy's objectives, key indicators, action areas, and guiding principles. Pledges were assessed based on a **content analysis**, which analyzed the content of commitment applications and text submitted by commitment-makers describing their actions and support of the EWEC *Global Strategy*.
- Second, a **financial analysis** was conducted. The amount of funding committed in support of the EWEC *Global Strategy* was calculated based on the available commitment information. Estimates were made of how much was spent against the committed amounts using data from two major databases and other sources.<sup>2</sup>

To contextualize the funding specifically pledged and spent in support of the EWEC *Global Strategy*, the report tracks overall trends in official development assistance (ODA) for reproductive, maternal, newborn, and child health using the Muskoka method.<sup>3</sup>

- Third, this report also analyzes progress in the implementation of commitments based on the results of an **online survey, which was sent to 176 non-governmental commitment-makers**. Of these 176 non-governmental commitment-makers, 60% (105 in total) responded to the survey. Survey responses were analyzed and appraised to calculate the amount of financial disbursements, the types of activities implemented, and the number of target populations reached through EWEC *Global Strategy* commitments.

Online self-report surveys are subject to limitations such as the potential for reporting bias and lack of representativeness of the data. In addition, governments were not asked to complete the survey to minimize reporting burden. This means that the survey results only refer to progress achieved by non-governmental commitment-makers who received and responded to the survey, thus resulting in underreporting of achievements. The Partnership for Maternal, Newborn & Child

Health (PMNCH) will be capacitating civil society to pilot both government and non-governmental commitment tracking in a number of sub-Saharan African countries. Preliminary results are expected later in 2018.

**Overall, the report shows encouraging trends but also points to important areas requiring additional focus. It has ten key messages:**

1

**The EWEC *Global Strategy* is more important and relevant than ever. In a difficult political and financial environment, it continues to attract impressive support for women's, children's, and adolescents' health.** From September 2015 to December 2017, a total of 302 commitments were made. In 2017 alone, there were 87 new commitments, an increase by 40% within just one year and 77% since September 2015. In 2017, the region that made the most commitments was sub-Saharan Africa.

2

**The Family Planning Summit in July 2017 was an important contributor for the mobilization of new commitments.** Eighty-three percent of all EWEC *Global Strategy* 2017 commitments were Family Planning 2020 (FP2020) commitments made at the Summit (72 in total) in support of EWEC. The aim of the Summit was to discuss efforts to reach FP 2020 goals and ensure that more women and girls around the world can plan their families and their futures. Over half (54%) of the commitments made via FP2020 in 2017 were made by stakeholders who had previously made a commitment to the updated EWEC *Global Strategy*. Through partnerships with initiatives such as FP2020, the EWEC *Global Strategy* has encouraged existing commitment-makers to expand upon the scope of their previous commitments.

3

**The EWEC *Global Strategy* successfully mobilized support from both governments and a diverse group of non-governmental stakeholders, reflecting the nature of the strategy itself—it is led by countries and is multi-sectoral, multi-stakeholder, and based on partnerships.** Multi-sectoral collaboration for action and results will be the main theme of the PMNCH Partners' Forum taking place in New Delhi on December 12–13, 2018.

## 4

**Financial commitments to the EWEC *Global Strategy* (2016–2030) have now reached over US\$35 billion.** Of this amount, an estimated US\$13.6 billion (39%) is additional funding for the health of women, children and adolescents.<sup>4</sup> Much of the additional funding was committed by low-income and lower-middle-income countries.

## 5

**Commitment-makers are on their way to disbursing the US\$35 billion pledged to the EWEC *Global Strategy*. However, the stagnation of health ODA has been mirrored by a similar plateauing of donor funding for the health of women, children, and adolescents.** Efforts to mobilize funding for the health of women, children, and adolescents from global and domestic resources need to be continued and must remain high on the political agenda. Many low- and middle-income countries are projected to experience significant economic growth, which will create greater domestic fiscal space for health financing. Development partners should support domestic resource mobilization through technical support. In addition, the role of political advocacy and mutual learning on best practices will become increasingly important.

## 6

**Non-governmental commitment-makers that responded to this year's online survey on progress in implementing the EWEC *Global Strategy* reported that they reached 146 million people through service delivery activities across the six focus areas of the EWEC Partners' Framework since the launch of the *Global Strategy* in September 2015.<sup>5</sup>** Three-quarters (74%) of the 146 million people estimated by the non-governmental commitment-makers who responded to the survey were reached with early childhood development services, the EWEC focus area highlighted by the 2018 H6 monitoring report. In addition, 13% of people reached were through services related to sexual and reproductive health and rights, 9% through services related to adolescent and young adult health and well-being, and 3% through services related to advancing quality, equity, and dignity in services. Commitment-makers reported reaching fewer people through services dedicated to empowerment of women, girls, and communities, and to humanitarian and fragile settings. In addition to the 146 million people reached with services, 377 million women, children, and adolescents were reached through EWEC commitments that used digital platforms, such as e-learning and mobile health platforms, that include reaching populations indirectly rather than through direct service provision.



## 7

**The content analysis of the commitment text and application forms among commitment makers shows strong support for the EWEC *Global Strategy's* "survive" and "thrive" objectives.** Overall, 89% of the 302 commitments across all sectors support at least one of the 16 key indicators of the "thrive" objective and 77% to at least one indicator of the "survive" objective. Only 27% of commitments support any of the key indicators measured under the "transform" objective. This may be due to the need to review and potentially revise the indicators under the "transform" objective. The 2017 progress report on EWEC commitments also reported fewer commitments in support of this objective.

## 8

**In 2017, attention towards adolescent health has significantly improved compared to 2015 and 2016.** Thirty percent of commitments focused on adolescent mortality rate and 22% on adolescent birth rate during the first two years of the updated EWEC *Global Strategy* (2015–2016). In contrast, in 2017, 79% of commitments explicitly supported improvements in adolescent mortality and 76% supported reducing the adolescent birth rate. This focus was largely driven by FP2020 commitments, many of which specifically targeted adolescent birth rate and mortality. Investing in adolescent health will be a critical driver of development in the Sustainable Development Goal (SDGs) era and will pay an enormous demographic dividend.

## 9

**Health system resilience is the action area that received the most attention, referenced by 71% of commitment-makers.** Results from the content analysis highlight the importance of EWEC as a platform to drive the global health agenda in a shifting health landscape towards universal health coverage (UHC). This may also suggest that commitment makers are recognizing the importance of cross-sectoral and structural action.

## 10

**Only 27% of commitments were made in support of improving women's, children's, and adolescents' health in humanitarian and fragile settings.** This is a low proportion given that 535 million children were living in countries affected by emergencies in 2017.<sup>6</sup> The content analysis also found that newborn health, stillbirths, and sexual and reproductive health and rights (SRHR) laws and regulations were only targeted by a limited number of commitments and require more attention.

The background features several overlapping circles in various shades of red and blue. A large, light red circle is the most prominent, with a darker red circle overlapping its bottom right. A blue circle is visible in the top right corner, and another darker red circle is partially visible at the bottom right. The overall composition is abstract and modern.

**1.**

# **INTRODUCTION**



In September 2010, during the United Nations (UN) Millennium Development Goals (MDGs) Summit, **Every Woman Every Child** (EWEC) was launched. The launch of this global movement was aimed at mobilizing international and national action across all sectors “to address the major health challenges facing women, children, and adolescents around the world” and to accelerate progress on the health MDGs.<sup>7</sup> It was guided by the **2010–2015 Global Strategy for Women’s and Children’s Health**.

A new **EWEC Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030** (EWEC *Global Strategy*), which updated and intensified the first strategy, is built on three key pillars: (i) survive (end preventable deaths); (ii) thrive (ensure health and well-being); and (iii) transform (expand enabling environments).<sup>8</sup> These objectives are accompanied by 17 targets, nine action areas, 11 guiding principles, 60 indicators with 16 key indicators to ensure alignment of the *Global Strategy* with the M&E framework of the **SDGs**.<sup>9</sup> The new strategy for the period 2016–2030 was needed to “complete the unfinished work of the MDGs, to address inequities within and between countries and to help countries begin implementing the 2030 Agenda for Sustainable Development without delay.”<sup>2</sup> The updated strategy provides a new vision (Box 1), takes a life course approach, highlights the importance of humanitarian and fragile settings, and, for the first time, puts

adolescents alongside women and children “at the heart of the *Global Strategy*.”

The EWEC *Global Strategy* has also been associated with several landmark activities in support of the health of women, children, and adolescents. Major initiatives, which fall under the umbrella of the EWEC *Global Strategy*, include the **Global Financing Facility in support of Every Woman Every Child** (GFF), **Every Newborn Action Plan, Ending Preventable Maternal Mortality**, and **Family Planning 2020** (FP2020).<sup>10</sup>

In April 2017, the **EWEC High-Level Steering Group** (HLSG) welcomed the **UN Secretary-General, António Guterres**, as its Senior Chair. The HLSG also endorsed the **EWEC 2020 Partners’ Framework** to facilitate collective advocacy and action for results against the 2030 targets of the EWEC *Global Strategy*. The framework is underpinned by **principles of human rights, equity, equality, and universality**. It places particular focus on six areas: 1) early childhood development; 2) adolescent health and well-being; 3) quality, equity and dignity in services; 4) sexual and reproductive health and rights (SRHR); 5) empowerment of women, girls and communities; 6) and humanitarian and fragile settings. It also serves to ensure greater alignment across the robust EWEC architecture by identifying a set of common deliverables to bring partners together for collective action in support of country-level implementation.

## Box 1.

### The Vision of the EWEC *Global Strategy*

"By 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies."

## About this report

The Partnership for Maternal, Newborn & Child Health (PMNCH) has played a critical role in fostering accountability for the EWEC *Global Strategy*, including publishing five annual reports from 2011 to 2015 on tracking commitments to the first strategy. It also conducted the first assessment of commitments to the updated EWEC *Global Strategy* in 2016, which informed two key accountability reports: (i) the World Health Organization (WHO) report *Monitoring Priorities for the Global Strategy for Women's, Children's and Adolescent's Health (2016- 2030)*,<sup>12</sup> and (ii) the first report of the Independent Accountability Panel (IAP).<sup>13</sup> In 2017, the first progress report for the updated EWEC *Global Strategy*, called *Progress in Partnership: 2017 Progress Report on the Every Woman Every Child Global Strategy for Women's, Children's and Adolescent Health*, was released and included a chapter on EWEC *Global Strategy* commitments and progress in implementation.<sup>14</sup>

This new report, commissioned by PMNCH, gives a further **update on commitments to the EWEC *Global Strategy* 2016–2030**, covering a longer time frame, from September 2015 to December 2017. As such, it captures commitments during an era in which there have been several trends and challenges that could potentially be acting against the interests of women's, children's, and adolescents' health worldwide, threatening the EWEC *Global Strategy's* vision. These include:

- **The stagnation of development assistance for health (DAH).**<sup>15</sup> The Institute for Health Metrics and Evaluation estimates that if the rapid growth rate in donor funding for health over the period 2000–2010 had continued through to 2016, instead of stagnating from 2010–2016, "an additional \$82 billion of DAH would have been disbursed for health in low- and middle-income countries from 2010 to 2016."<sup>16</sup>

- **The reinstatement and expansion of the Mexico City policy (the “global gag rule”).** Previous versions of the Trump Administration's policy restricted US funding to overseas non-governmental organizations (NGOs) that counsel, refer, or provide voluntary abortion services—even if those services do not use US funds directly for abortions. The expanded version that has been enacted goes much further, restricting US funding “not only to foreign NGOs but to all other recipients that enable the provision of safe abortion services; this could include governments as well as the United Nations system.”<sup>17</sup> This ruling could end up curtailing access to reproductive, maternal, newborn, adolescent, and child health services worldwide.<sup>9</sup> It has also been shown empirically that the previous “global gag rule” was associated with a fall in the use of effective contraception and a rise in the induced abortion rate, particularly in areas where women experience higher rates of morbidity or mortality related to unsafe abortion.<sup>18</sup>

Nevertheless, the international community has responded to these potential threats. For example, the reinstatement of the Mexico City Policy gave rise to *SheDecides*, an international initiative to raise financial and political support for sexual and reproductive health worldwide.<sup>19</sup> Initiated by the Dutch Minister of Foreign Trade and International Development, Lilianne Ploumen, *SheDecides* directs funding to organizations that became ineligible for US government funding because

they provide information about and access to safe abortion.<sup>20</sup> In 2017, US\$200 million were raised at the *SheDecides* Conference.<sup>21</sup>

Despite the difficult funding and political environment, this report shows that the EWEC *Global Strategy* is continuing to mobilize impressive commitments. The momentum to drive progress on women's, children's, and adolescents' health remains strong.

## Methodology

Tracking commitments to the EWEC *Global Strategy* requires the collection, analysis, and triangulation of a range of data from various sources.<sup>22</sup> This year's report builds on four interconnected analyses:

- **Commitment overview:** The report first provides an overview of commitments that were made to implement the updated EWEC *Global Strategy* (2016–2030). EWEC *Global Strategy* commitments undergo a formal approval process, which is led by the Executive Office of the UN Secretary General (EOSG). This analysis includes all EWEC *Global Strategy* commitments that were approved by the EOSG<sup>23</sup> from September 2015 to December 2017, including FP2020 commitments (the approval process differs between governments and non-governmental commitment-makers; see Limitations section below).<sup>24</sup> These commitments are available on the EWEC website.<sup>25</sup>

- **Content analysis:** Commitments were analyzed based on the commitment text and commitment forms filled out by commitment-makers and submitted to the EOSG.<sup>26</sup> The commitment text and forms were assessed for their level of alignment with the objectives, targets, key indicators, action areas, and guiding principles of the EWEC *Global Strategy*. As such, the content analysis indicates the focus of commitments across the strategy's dimensions.
- **Online survey:** To support the IAP's 2017 report recommendations to strengthen the EWEC commitments process overall, PMNCH, in partnership with the EOSG and FP2020, updated the online survey for non-governmental commitment-makers to report on their progress. FP2020 non-governmental commitment-makers were also included in the EWEC progress survey this year. This is a useful contribution to ensure coherence of reporting on the EWEC *Global Strategy* and increases alignment and efficiency. This update also improved survey user friendliness and aligned survey elements with the EWEC Partners' Framework's six focus areas and the targets and indicators for the EWEC *Global Strategy*. The survey was sent to 176 non-governmental commitment-makers. Sixty percent of these commitment-makers (105 in total) responded to the survey and provided valuable data on implementation progress, including on target populations reached and services provided.
- **Financial analysis:** The financial analysis involved three interconnected assessments:
  - The amount of financing commitment-makers pledged in support of the EWEC *Global Strategy* was calculated based on the available commitment information (commitment text, commitment forms, and survey data). As part of this analysis, the amount of committed funding that was subject to double-counting was estimated along with the amount of additional financing that was pledged above baseline levels (see Appendix 1 for methodological details).
  - The ultimate measure of progress in terms of financing is whether committed funds were spent. To assess donor disbursements against committed funding, we used data from the International Development Statistics (IDS) online databases.<sup>27</sup> These databases are owned by the Development Assistance Committee of the Organisation for Economic Cooperation and Development (OECD DAC). Data from the Global Health Expenditure Database (GHED) were used to estimate expenditures of low- and middle-income countries.<sup>28</sup> In addition, a document search was conducted to identify additional financial data from country documents. Finally, the online survey provided data on the extent to which the committed funding has been disbursed by non-governmental actors.

- To contextualize the funding specifically pledged and disbursed in support of the EWEC *Global Strategy*, the report tracks overall trends in ODA for reproductive, maternal, newborn and child health (RMNCH) using the Muskoka method, a method for estimating the share of health ODA benefitting RMNCH.<sup>29</sup>

In addition, two **deep dives on EWEC *Global Strategy* commitments in support of humanitarian and fragile settings and adolescent health** were developed. These deep dives build on the analysis in this report and are available as separate publications.

## Limitations

Tracking commitments to the EWEC *Global Strategy* and progress in implementation can be difficult depending on how some commitments are defined when they are made and due to problems with the quality and timeliness of data. This report thus has several limitations:

- **Ambiguity of commitments:** Commitments can be vague at times, laying out a broad vision and goals rather than specific activities and explicit financial amounts.<sup>30</sup> Imprecise language can sometimes be coupled with missing baselines, targets, or indicators. This can make it difficult to estimate the overall value of commitments or the additionality of commitments. In addition, to date commitment-makers have not been asked to align commitments with national health strategies (where appropriate) or national

health targets in support of women's, children's, and adolescents' health. There is also limited information on the countries and regions their pledges target; as such, this report cannot provide an overview on countries and regions targeted by the commitments.

- **Difference in commitment-making process:** Governments do not undergo the same commitment-making process as non-state commitment-makers through the EOSG.<sup>31</sup> Only non-governmental commitment makers complete commitment-forms and are required to describe their commitment using SMART objectives (i.e., specific, measurable, achievable, realistic, and time-bound), whereas governments are required to submit a letter from its Head of State or Government or Minister to the UN Secretary-General, outlining their commitment to implement the EWEC *Global Strategy*. Governments report on the EWEC *Global Strategy's* indicators to the custodial UN agencies, and these data are available on the *Global Strategy* data portal of the WHO Global Health Observatory and are summarized as part of WHO reporting to the World Health Assembly every May.<sup>32,33</sup>
- **Survey limitations:** A limitation of the online survey is that it is based on self-reported data, which can be subject to over or under-reporting, the misinterpretation of survey questions, and lack of representativeness. Governments were not asked to complete a survey and therefore the results can only be used to ascertain progress among non-



governmental commitment-makers who submitted the survey. Overall, the lack of survey data from governments likely results in an underreporting of achievements.

- **Financial data:** As part of their financial commitments to the EWEC *Global Strategy*, low- and middle-income countries often commit to increase their health expenditures (e.g., African countries commit to meet the Abuja target<sup>34</sup>). The GHED, which is administered by the WHO, is the best source of data for domestic health spending.<sup>35</sup> However, one challenge is that the GHED only includes country expenditures up until 2015 – the baseline year for the updated *Global Strategy*. At this time, it includes only a few data points for 2016. While a document search was conducted to unearth additional data from country documents, data are only available for a small number of low- and middle-income countries. And while the OECD DAC database includes 2016 health ODA disbursements, 2017 disbursements will only be made available in December 2018. As such, progress in terms of financial spending is incomplete and so the spending estimates in this report are likely to be an under-estimate of actual spending.

Importantly, this report does not reflect the full scope of commitments to the health of women, children, and adolescents. The report is focused on EOSG approved commitments to the updated EWEC *Global Strategy*. There are additional commitments made by the global community that are linked to the EWEC *Global Strategy* but that had not completed the formal commitment-making process at the time this report was written. For example, a few commitments made to FP2020 in 2017 have not yet fully completed the administrative process, and, as such, fall outside the scope of this report.

## Structure of the report


The report is organized as follows: Section 2 provides an updated overview of commitments to the EWEC *Global Strategy*. Section 3 presents the results of the content analysis and discusses the focus of commitments and their level of alignment with the different dimensions of the strategy. Section 4 provides the findings of the financial analysis. Section 5 summarizes the findings of the online survey. Section 6 provides conclusions.



**2.**

**WHO ARE THE  
COMMITMENT  
MAKERS TO THE EWEC  
*GLOBAL STRATEGY?***





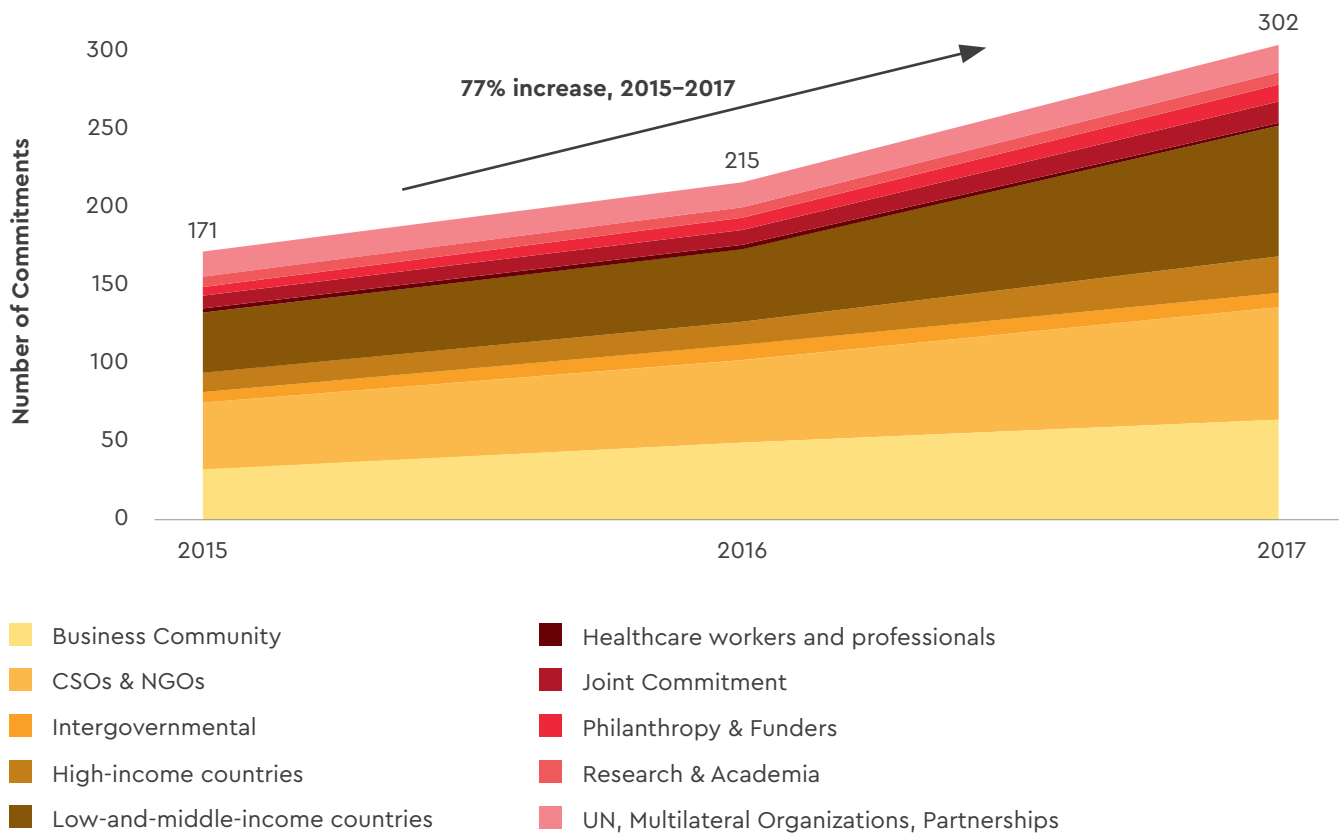
***The EWEC Global Strategy continues to attract impressive support for women's, children's, and adolescents' health. From September 2015 to December 2017, a total of 302 commitments were made. In 2017 alone, there were 87 new commitments.***

The September 2015 launch of the EWEC *Global Strategy* catalyzed ground-breaking support for women's, children's and adolescents' health. A total of **302 commitments were made between the launch and December 2017**. In 2015, there were 171 commitments, which increased to 215 in 2016. In 2017, 87 additional commitments were made, an increase by 40% within just one year and 77% since September 2015 (Figure 1).

An important moment for the mobilization of new EWEC commitments in 2017 was the **Family**

**Planning Summit for Safer, Healthier and Empowered Futures**, convened in London on July 11, 2017 to advance FP2020 goals. Seventy-two of the 2017 EWEC commitments were made through FP2020, accounting for over 80% of commitments received in the past year (Box 2).<sup>36</sup> Of these 72 commitments, **39 were from stakeholders who had previously made commitments to the updated *Global Strategy*** and made further pledges to accelerate progress towards the vision and goals of the EWEC *Global Strategy*.

**Figure 1.** Substantial increase in EWEC *Global Strategy* commitments since the launch in 2015



## Box 2.

### FP2020 advances access to family planning

FP2020 is a global partnership of governments, civil society, multilateral organizations, donors, the private sector, and researchers that work to **"enable 120 million more women and girls to use contraceptives by 2020."**<sup>37</sup> Founded following the 2012 London Summit on Family Planning, FP2020 is in support of the EWEC *Global Strategy*.

In July 2017, the UK government, the United Nations Population Fund, and the Bill & Melinda Gates Foundation co-hosted the **2017 Family Planning Summit for Safer, Healthier, and Empowered Futures**. Ministers of health, finance, and international cooperation gathered with civil society, youth advocates, and development partners to accelerate universal access to family planning. The summit highlighted progress from FP2020 countries and called attention to adolescents and youth as well as women and girls in humanitarian settings.<sup>38</sup> The **summit mobilized substantial financial, service delivery, and political commitments**, increasing the number of FP2020 commitment makers to over 120. As of September 2017, FP2020 reported 74 new and renewed commitments from the summit.<sup>39</sup> Additional pledges continued to be made following the event.<sup>40</sup>

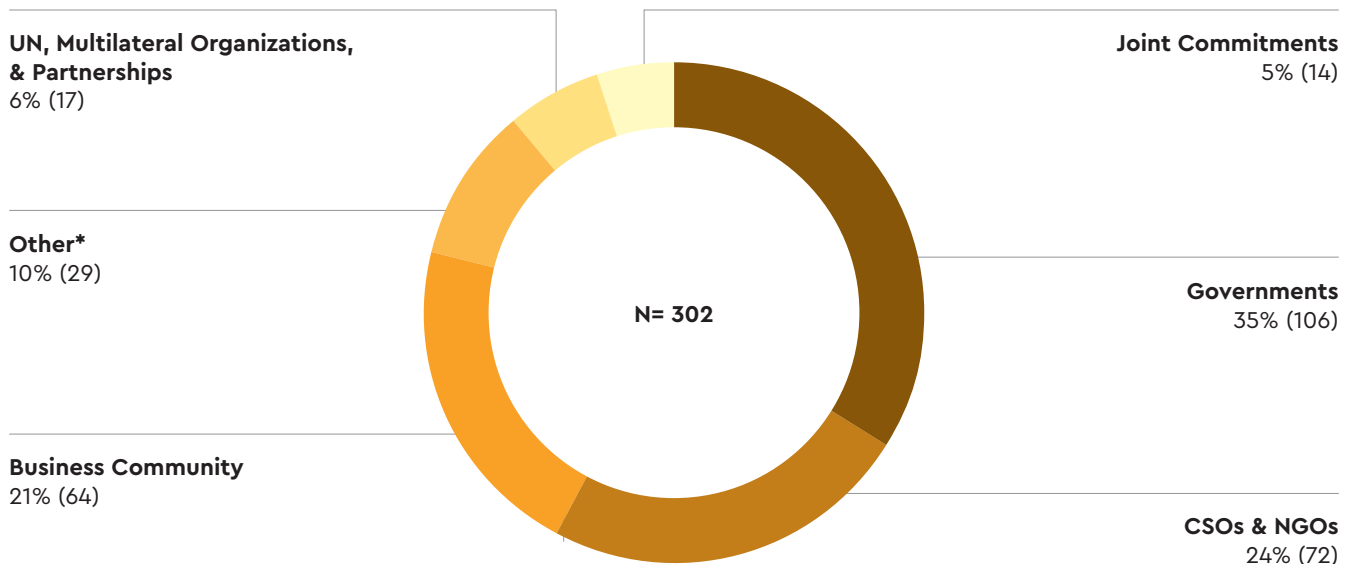
As shown in Figure 2, over the commitment period **September 2015 to December 2017**, the EWEC *Global Strategy* successfully mobilized support from both governments and a diverse group of non-governmental stakeholders, reflecting the nature of the strategy itself—it is led by countries and is multi-sectoral, multi-stakeholder, and based on partnerships.<sup>41</sup>

The largest number of commitments to date has been from **governments, which made 106 commitments**, or just over one third (35%) of all commitments. The 106 commitments include three subnational commitments made in 2017, the first subnational commitments to the EWEC *Global Strategy*.<sup>42</sup> Low-income countries (LICs) accounted for 14% of all commitments, followed

by lower-middle-income countries (LMICs) at 10%, high-income countries (HICs) at 8%, and upper-middle-income countries (UMICs) at 4%.<sup>43</sup> **These 106 commitments were made by 68 country governments.**<sup>44</sup>

The second largest number of commitments (24% of all commitments) came from **civil society organizations (CSOs) and NGOs**, followed closely by the **business community** (21% of all commitments). The remaining commitments were made by the UN, multilateral organizations, and global partnerships (6%); joint partnerships from multiple actors (5%); intergovernmental bodies (3%); philanthropists and foundations (3%); academic, research, and training institutes (3%); and healthcare professional organizations (1%).

**Figure 2.** Commitments to the EWEC *Global Strategy* by commitment-maker group, September 2015 – December 2017

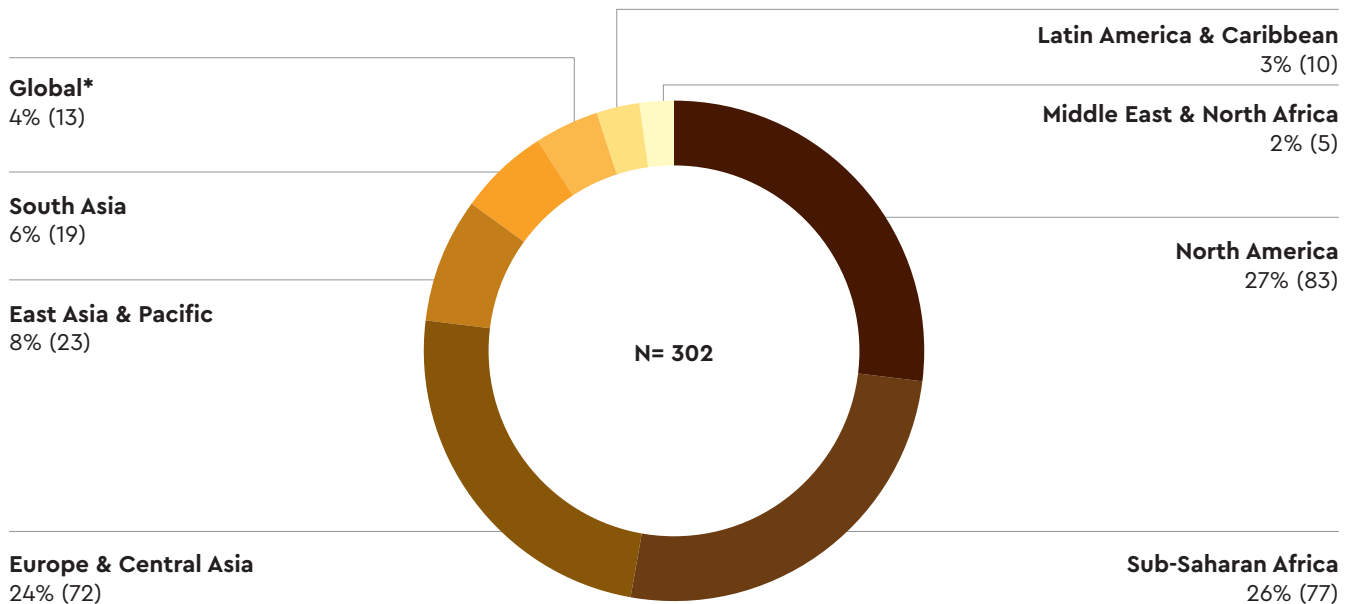


\* Other refers to Philanthropy & Funders: 3% (10); Intergovernmental: 3% (9); Research & Academia: 3% (8); Healthcare Professional 1% (2). Percentages do not add up to 100% due to rounding.

A total of 26 commitments were made by 16 government commitment-makers from fragile states.<sup>45</sup> In 2015, 11 fragile states made commitments, followed by three more in 2016. In 2017, nearly all of these countries (12) made a second commitment towards the EWEC *Global Strategy* through FP2020. The **Family Planning Summit** highlighted the sexual and reproductive health needs of women and girls in humanitarian settings and announced global goods to support the provision of modern contraception, including updates to the Minimum Initial Service Package<sup>47</sup>, which is the international standard for reproductive health care in crisis settings, and a Global Roadmap for Improving Data, Monitoring, and Accountability for Family Planning and Sexual and Reproductive Health in Crises.<sup>48</sup>

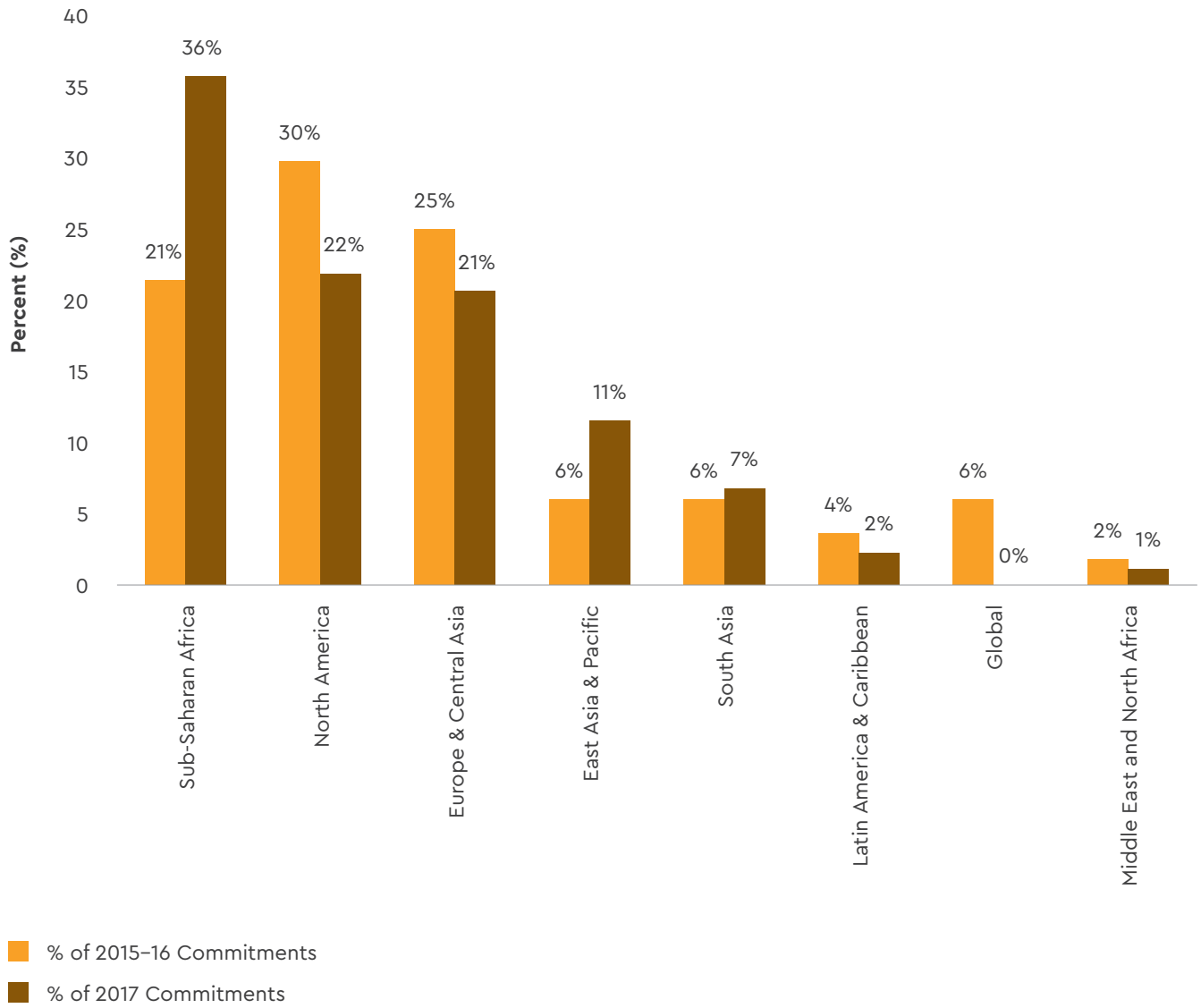
EWEC *Global Strategy* commitment-makers are based all over the world (Figure 3). A geographic analysis shows that the largest number of commitments come from commitment-makers with headquarters in North America (27%), followed by those headquartered in sub-Saharan Africa (26%) and in Europe & Central Asia (24%).<sup>49</sup> In 2017, **sub-Saharan Africa had the greatest regional contribution of commitments**, demonstrating a marked increase in terms of the share of annual commitments (Figure 4). The majority of the 2017 commitments from sub-Saharan Africa were made by governments (see Figure 4A in Appendix 1). Commitments from East Asia and the Pacific also increased as a percentage of annual commitments in 2017.

**Figure 3.** Commitments to the EWEC *Global Strategy* by geographic origin, September 2015 – December 2017



\* Global commitments are commitments made by global coalitions involving a range of actors from varied geographic origins.

**Figure 4.** Commitments to the EWEC *Global Strategy* by geographic origin, comparing 2015–16 to 2017





**3.**

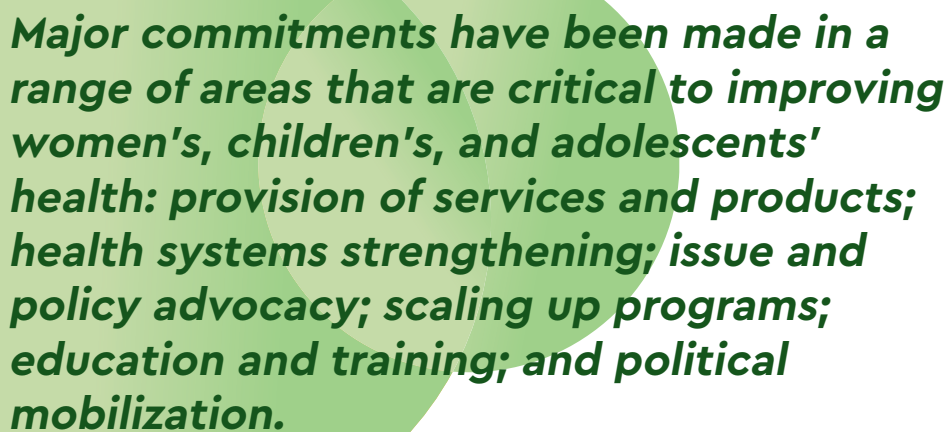
**WHAT IS THE FOCUS  
OF COMMITMENTS  
AND WHERE ARE  
OPPORTUNITIES  
TO ACCELERATE  
PROGRESS?**



This section presents the results of the content analysis of the text of commitments pledged to the EWEC *Global Strategy* and commitment applications filled out by non-governmental commitment-makers.

When making a new commitment to the EWEC *Global Strategy*, commitment-makers are asked to identify the "type of commitment" they are making. There are 12 "types" in the **commitment form**, including financial, research, monitoring and evaluation, scaling up programming, issue and policy advocacy, and technical assistance.<sup>50</sup> As commitment-makers can select as many types that apply, most commitments covered multiple "types". These are captured in Figure 5.

The most common commitment type chosen by supporters was **direct provision of services and/or products** (52%; 157 in absolute terms). In addition, commitment-makers chose **health systems strengthening** (50%; 150), **issue and policy advocacy** (47%; 143), **scaling up programming** (47%; 142); (42%), and **education and training** (45%; 135). These commitments focus more on committing value through in-kind delivery of services, products, training, or innovation, rather than direct financing. The three commitment types receiving the least attention were technical assistance (25%; 75), research (23%; 69), and cross-sectoral commitments (22%; 67).



***Major commitments have been made in a range of areas that are critical to improving women's, children's, and adolescents' health: provision of services and products; health systems strengthening; issue and policy advocacy; scaling up programs; education and training; and political mobilization.***

**Figure 5.** Commitment types referenced by commitment-makers, September 2015 – December 2017

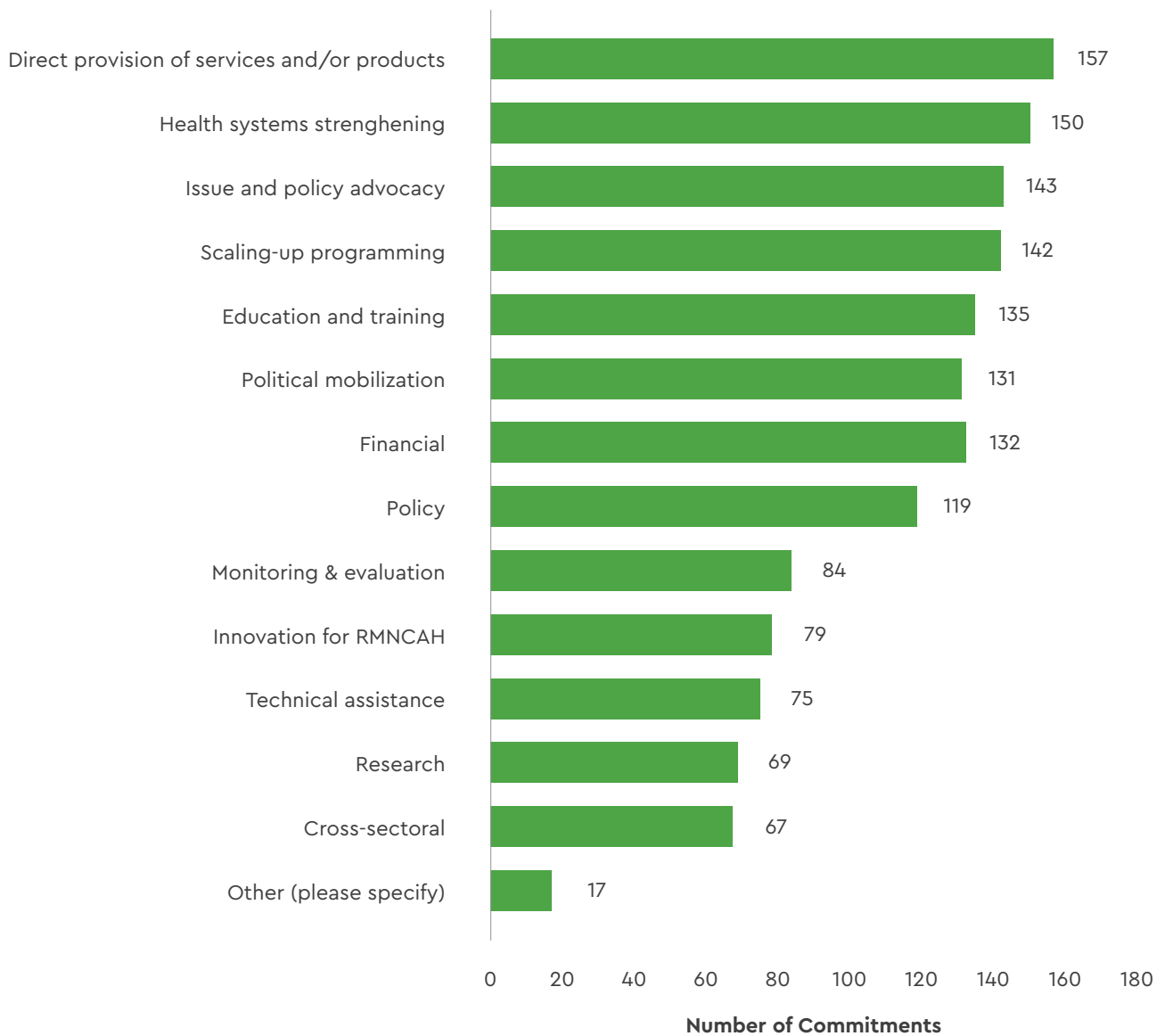


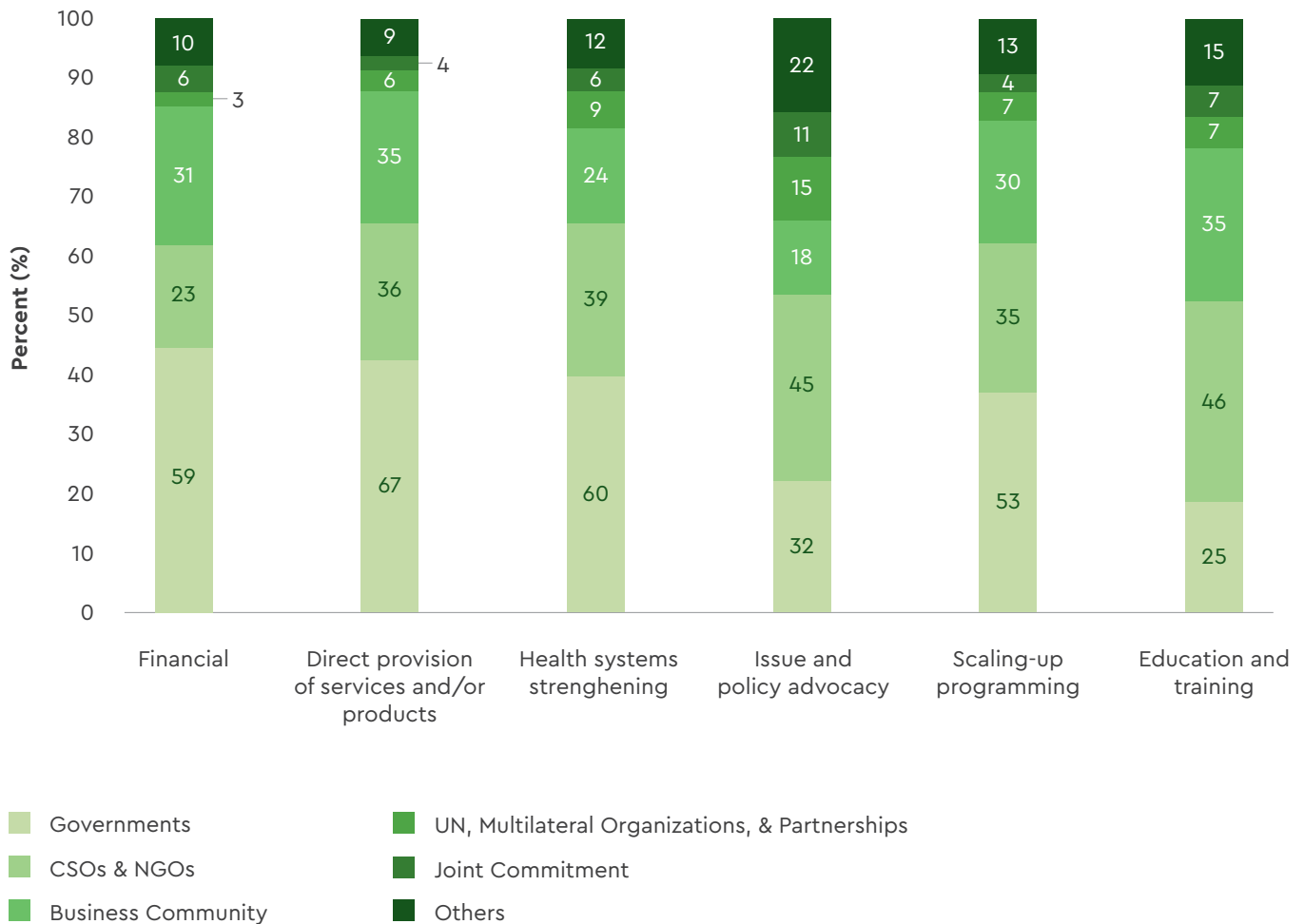
Figure 6 shows the distribution of commitment types across the six major commitment-makers groups: governments; CSOs and NGOs; the business community; the UN, multilaterals and global partnerships; joint partnerships; and all other groups of commitment-makers. Support for different types of commitments varies

across the six groups, showing the variety of ways that the EWEC *Global Strategy* can be advanced. For example, **governments** are the largest contributor to the direct provision of services and/or products and health systems strengthening. **CSOs & NGOs** focus on issue and policy advocacy and education and training.

The value of the different non-financial commitments to the EWEC *Global Strategy* is substantial (for an overview of financial commitments, see Section 4). A total of 22 commitment-makers from varying sectors provided information on the value of their non-financial commitments through the online survey. At the end of 2017, the reported value of these commitments was **US\$15.1 billion**. Of this amount, 47% came from the business community and 39% was provided by CSOs. UN, multilateral organizations and

partnerships accounted for 14% of the total reported value. Because this estimate is derived only from the 22 commitment-makers that provided information the 2017 survey, the true value of these commitments is much higher than US\$15.1 billion. Commitment-makers, including from the business community, may not be able **to publicly disclose the value of their commitments**, although many of them may have made highly substantial commitments in support of the strategy.

**Figure 6.** Distribution of selected commitment types by commitment-maker group, September 2015 – December 2017



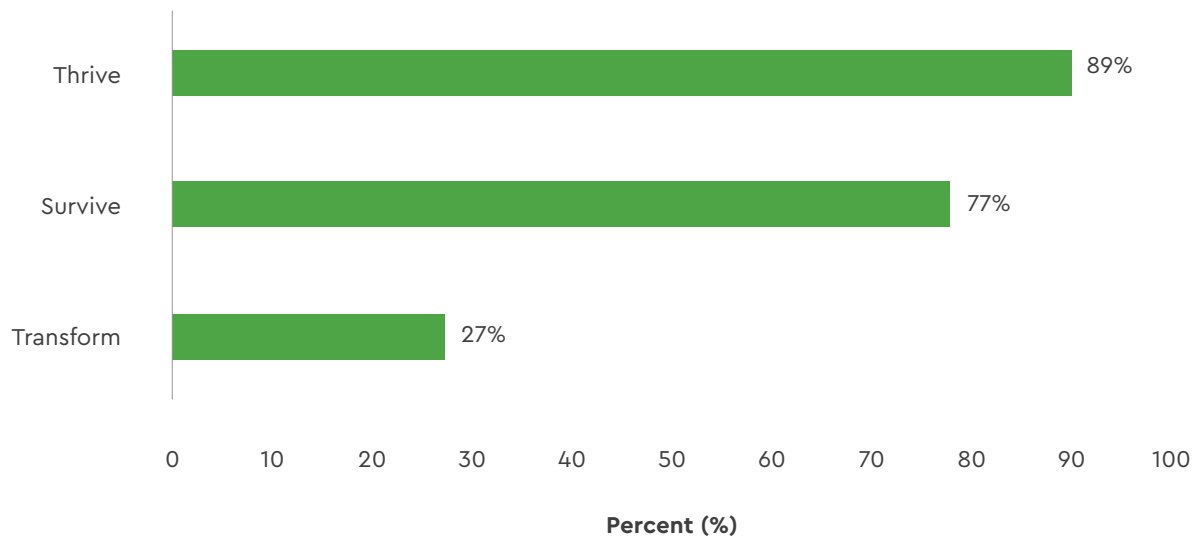
The **content analysis** shows that there is **very strong support for the "survive" and "thrive" objectives of the EWEC Global Strategy, but poor support for the "transform" objective**. From September 2015 to December 2017, almost nine out of ten commitments (89%) were in support of at least one of the 16 of the *Global Strategy* key indicators within the "thrive" objective. More than three quarters (77%) supported at least one of the 16 of the *Global Strategy* key indicators within the "survive" objective. However, in sharp contrast, only one quarter (27%) supported any of the key indicators measured under the "transform" objective (Figure 7).<sup>51</sup>

The "transform" indicators focus on issues, such as lack of civil registration of children

at birth, poverty, gender inequality, lack of education, lack of adequate water, sanitation and hygiene, air pollution, gender-based violence, and discrimination. These issues have a substantial negative impact health and well-being. However, as mentioned, only 27% of commitments in support of any of the key indicators measured under the "transform" objective. Clearly, there persists the need to attract more commitments, including from stakeholders working outside of the health sector, to focus their efforts on the structural factors important to the health of women, children, and adolescents (please refer to Figure 7A in Appendix 1 for an additional breakdown by objective and commitment-maker group).

***There is very strong support for the "survive" and "thrive" objectives of the EWEC Global Strategy. However, there is much less support for the "transform" objective, which relates to social determinants of health and cross-sector collaboration—it will be important to engage supporters if the "transform" objective is to be achieved.***

**Figure 7.** Commitments in support of at least one of the 16 EWEC *Global Strategy* key indicators within the "survive," "thrive," and "transform" objectives, September 2015 – December 2017



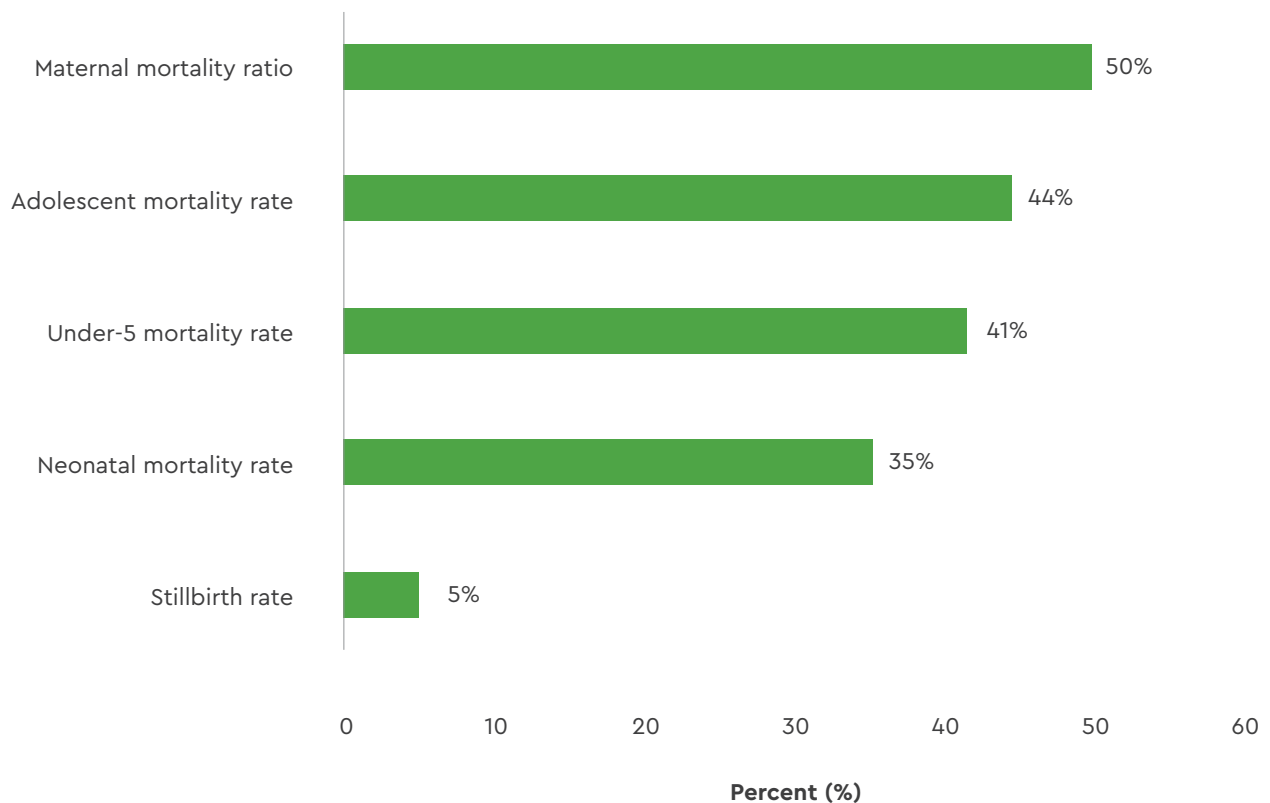
***Examining key indicators under the "survive" objective, maternal mortality was the most commonly referenced indicator (50% of commitments), followed by adolescent mortality (44%), and under-five mortality (41%).***

Further analysis of the commitments under the **"survive" objective** provides additional insights on their focus. A breakdown of commitments to key indicators show that there were **three "tiers" of support**. Maternal mortality and adolescent mortality are in the top tier; they were referenced by 50% and 44% of commitment-makers, respectively. In the middle tier are two indicators: under-five mortality (41%) and neonatal mortality (35%).<sup>52</sup> Going forward, a stronger focus on newborn health is required; neonatal mortality is not declining globally as quickly as under-5 mortality. Particular attention is needed in sub-Saharan Africa and Central and South Asia, where

the neonatal mortality rates are the highest globally at 28 and 27 per 1000 deaths respectively.

In the bottom tier is stillbirth—only 5% of commitments referenced this indicator (Figure 8). These results are concerning, because they suggest that supporters of the *Global Strategy* are paying insufficient attention to stillbirths. Progress in reducing stillbirths is slower than in reducing maternal or under-five mortality.<sup>53</sup> About 2.6 million stillbirths were estimated to have occurred in 2015.<sup>54</sup> A significant scale-up of resources and attention is urgently needed to reduce this burden.

**Figure 8.** Commitments in support of the EWEC *Global Strategy* key indicators under the "survive" objective, September 2015 – December 2017

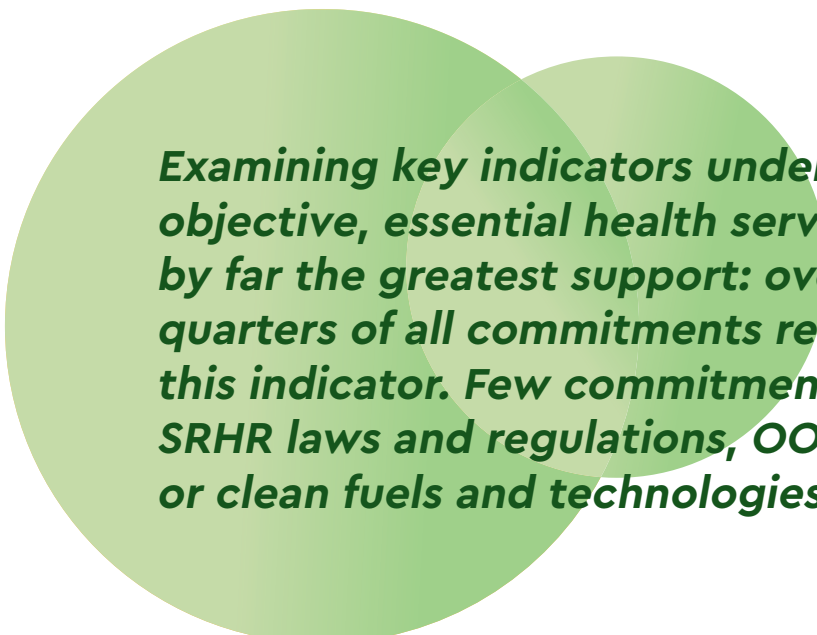




A breakdown of the commitments under the **“thrive” objective** shows that the coverage of **essential health services** received by far the strongest support, with 80% of all commitments making a reference to these services (Figure 9). The essential health services category contains efforts towards improving health services, including for sexual, reproductive, maternal, newborn, child and adolescent health at community and facility level (e.g., skilled birth attendance, family planning). The proportion of commitments that referenced essential health services was more than double the proportion that referenced any other indicator. A substantial proportion of commitments (38%) referred to the **adolescent birth rate**.

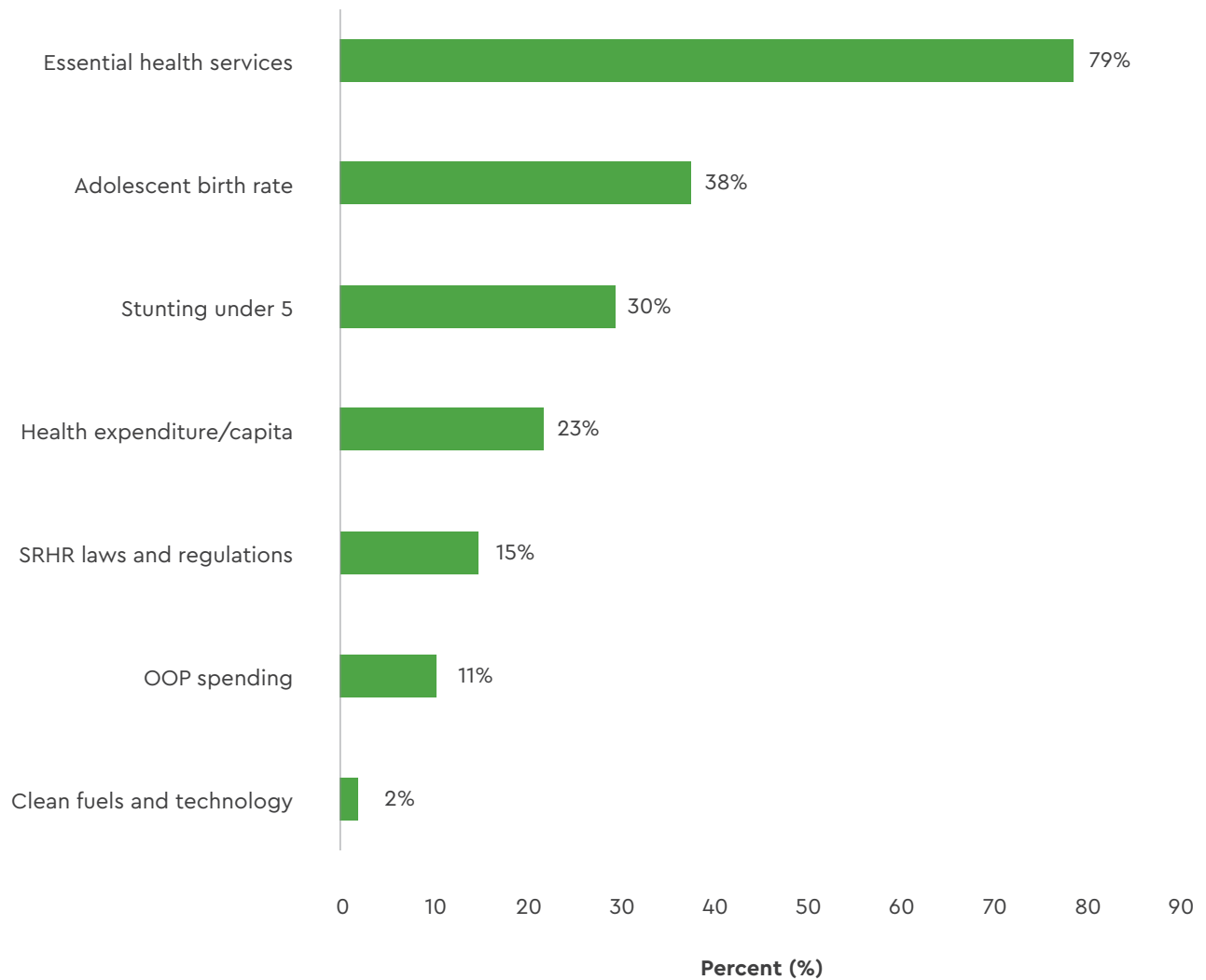
Only 30% of commitments refer to **stunting**. This low proportion is concerning given that globally,

in 2016, nearly one in four children under the age of 5 years (23%) was stunted due to poor nutrition. The rate of stunting was even higher in South Asia (36%) and sub-Saharan Africa (34%).<sup>4</sup> **Only 15% of commitments refer to the establishment of effective SRHR laws and regulations**, which are critical to ensure that women aged 15–49 years have access to sexual and reproductive health care, information, and education. Only 11% all of commitments referenced reductions in out-of-pocket (OOP) expenditures. In addition, only 2% of commitments focus on **clean fuels and technologies**, even though 3.3 million people died in 2016 from indoor air pollution caused by burning solid fuels for cooking.<sup>56</sup> Women and children, especially girls, are heavily affected by biomass use due to their central role in food preparation.<sup>57</sup> This lack of attention to clean fuels was already identified in the 2017 monitoring report.<sup>58</sup>



***Examining key indicators under the “thrive” objective, essential health services received by far the greatest support: over three-quarters of all commitments referenced this indicator. Few commitments addressed SRHR laws and regulations, OOP expenses, or clean fuels and technologies.***

**Figure 9.** Commitments in support of the EWEC *Global Strategy* key indicators under the “thrive” objective, September 2015 – December 2017



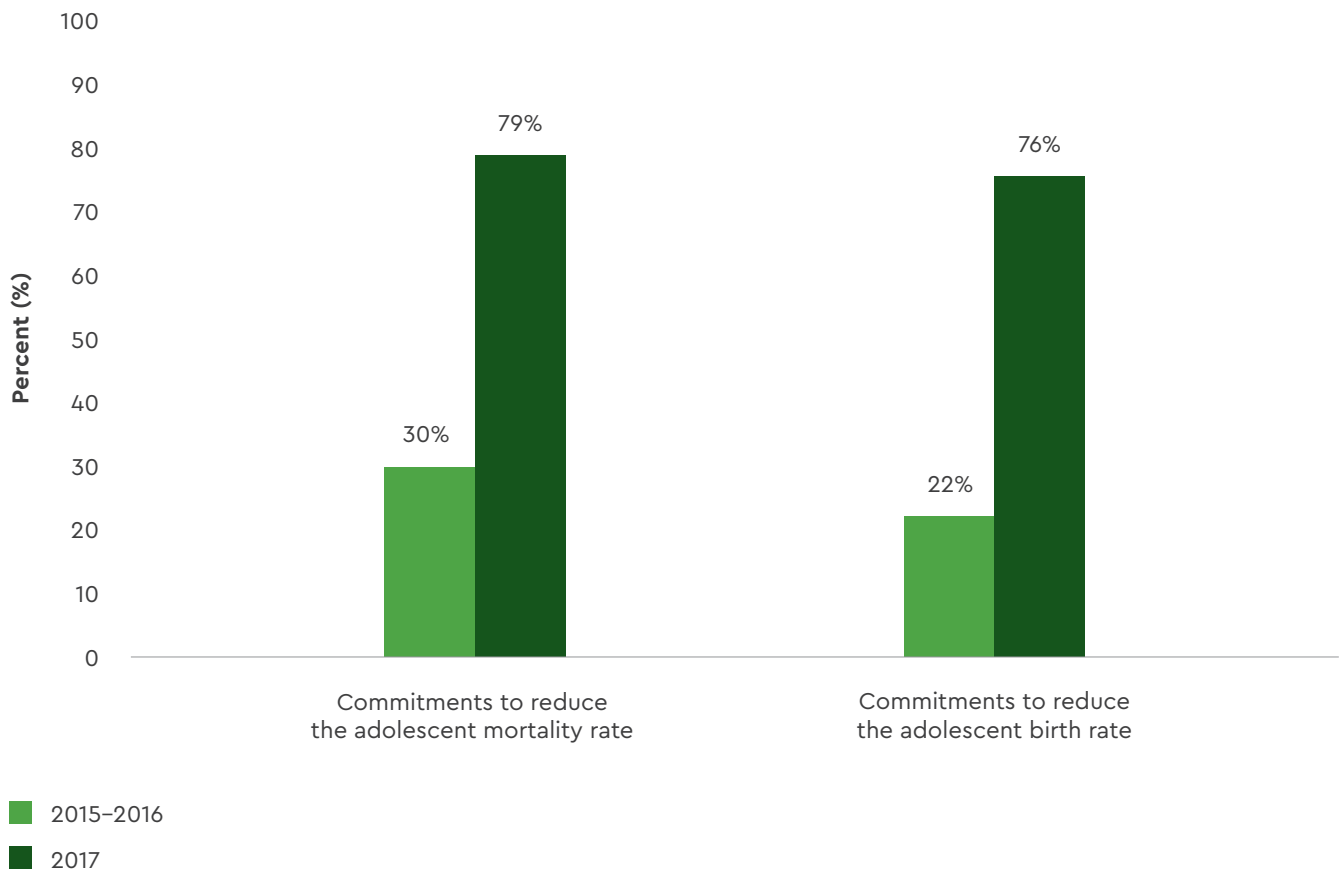
In 2017, the attention towards adolescents has significantly improved compared to 2015 and 2016. During the first two years of the EWEC *Global Strategy* (2015–2016), only 30% of commitments focused on reducing adolescent mortality (adolescent mortality rate) and 22% on reducing teenage pregnancies (adolescent birth rate). In contrast, in 2017, 79% of commitments explicitly supported interventions to reduce

adolescent mortality and 76% supported interventions to reduce the adolescent birth rate (Figure 10). This focus was largely driven by FP2020 commitments, which accounted for 88% of adolescent mortality commitments and 92% of adolescent birth rate commitments in 2017.<sup>59</sup> About 60% of the 2017 commitments towards adolescent health were made by governments (see Figure 10A in Appendix 1).

This new focus of commitment-makers is critical given that adolescents in low- and middle-income countries continue to face major health challenges: in 2012, 1.3 million died from preventable causes (the top five causes were road injuries, HIV, suicide, lower respiratory infections, and interpersonal violence). In girls aged 15–19 years, the complications of pregnancy and childbirth, and suicide are the two top global causes of deaths, with wide

disparities by and within regions.<sup>60</sup> Investing in adolescent health will be a critical driver of development in the SDGs era and will pay an enormous demographic dividend. As the EWEC *Global Strategy* says: "By investing in the right policies and programmes for adolescents to realize their potential and their human rights to health, education and full participation in society, we can unleash the vast human potential of this "SDG Generation" to transform our world."

**Figure 10.** A new focus on adolescent health in 2017 – *Global Strategy* commitments to adolescent health, 2015–16 vs. 2017

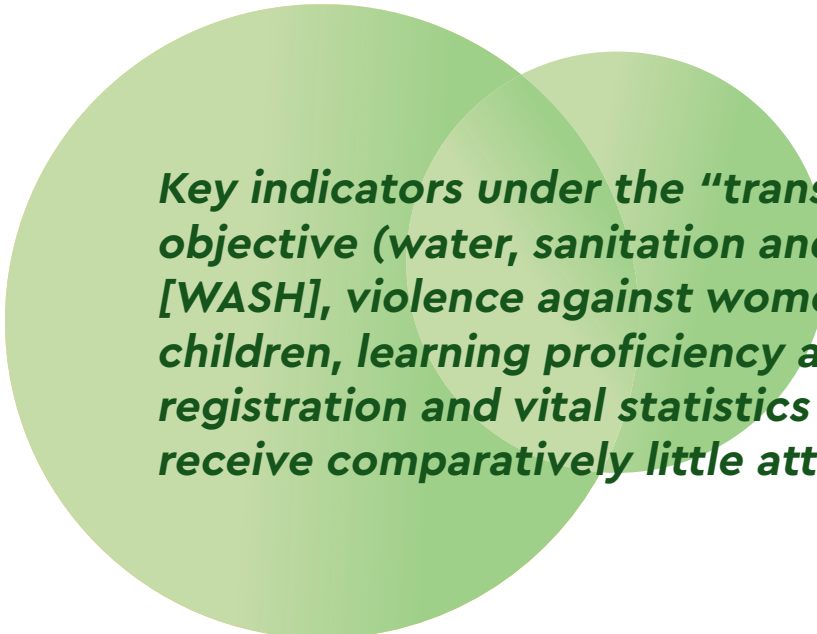


Compared with support for the "survive" and "thrive" indicators, all indicators under the **"transform" objective** receive very little attention and need further engagement (Figure 11). Only 12% of commitments referenced WASH and 12% referenced actions to reduce violence against women, children, and adolescents. Even though education is a major determinant of health, just 4% of commitments referenced learning proficiency.<sup>61</sup> Only 2% of commitments explicitly mentioned civil registration and vital statistics (CRVS) functions, a cornerstone of public health planning and well-functioning national health systems. Investments in CRVS are critical to ensure that all births and deaths are registered.<sup>62</sup>

All key indicators of the "transform" objective receive less attention, so there is need for

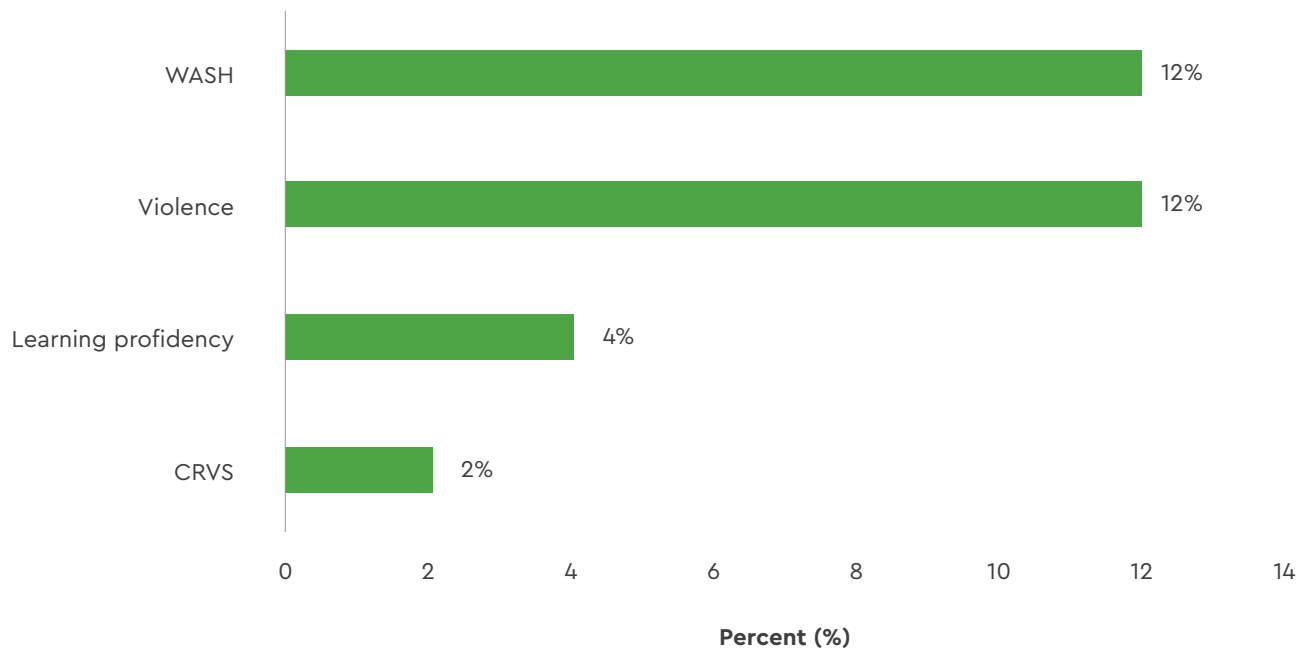
stronger engagement. Progress requires action across all the interlinked "survive, thrive and transform" objectives. For example, malnutrition underpins around half of all causes of child mortality; and girls' education is associated with better women's health outcomes.<sup>63</sup> Multi-sectoral approaches are thus important to address the social determinants of health and inequalities. The SDGs are based on the need for global partnership and reflect the importance of multi-sectoral action to achieve the 2030 Agenda.

Multi-sectoral collaboration for action and results will be a key topic of the PMNCH Partners' Forum taking place in New Delhi on December 12–13, 2018. It will be a major opportunity for mutual learning on best practices for multi-sectoral action.



***Key indicators under the "transform" objective (water, sanitation and hygiene [WASH], violence against women and children, learning proficiency and civil registration and vital statistics [CRVS]) receive comparatively little attention.***

**Figure 11.** Commitments in support of the EWEC *Global Strategy* key indicators under the "transform" objective, September 2015 –December 2017



***Of the nine action areas identified as key to achieving the EWEC Global Strategy, health system resilience is the area that received the most attention, while humanitarian and fragile settings received the least.***

**Health system resilience** is the action area that received by far the most attention, referenced by 71% of commitment-makers (Figure 12). Results from the content analysis thus highlight the importance of EWEC as a platform to drive the global health agenda in a shifting health landscape towards universal health coverage (UHC).

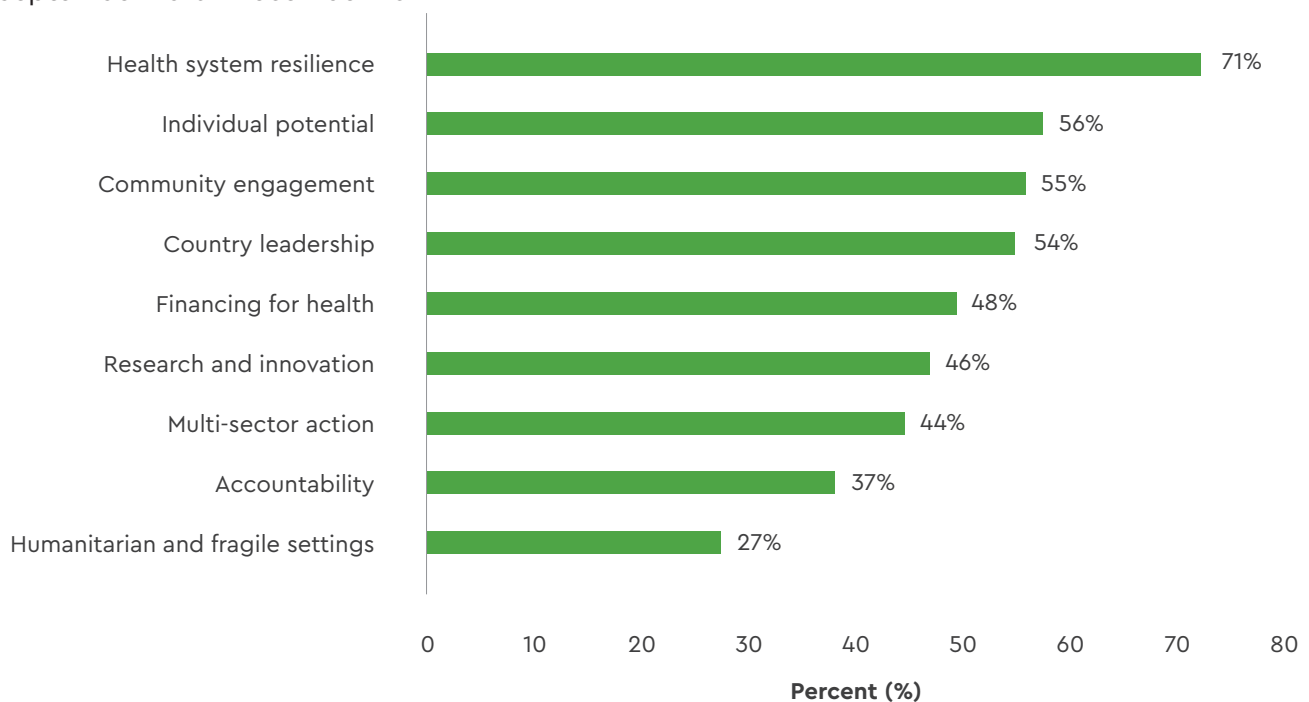
Two other action areas that were mentioned by over half of all commitment-makers were **individual potential** (56%), **community engagement** (55%), and **country leadership** (54%). These are all factors that have been associated with accelerated reductions in maternal and child deaths, and so the attention by commitment-makers to these action areas could pay valuable dividends.

It is also encouraging to see robust support for **community engagement**, as this action area

has a critical role to play in reaching UHC and the health-related SDGs. There is emerging evidence showing the association between community engagement, improved health outcomes, and reduced health inequalities, including for women's and children's health.<sup>64</sup> Community engagement can improve uptake of health services and promote sustainability and ownership of health programs.<sup>65</sup>

A stark finding is that only 27% (83) of commitments were made in support of **humanitarian and fragile settings**. This includes the 26 commitments from governments of fragile states as well as 56 commitments from other commitment-makers. This is a low number given that 535 million children were living in countries affected by emergencies in 2017.<sup>66</sup>

**Figure 12.** Commitments in support of the 9 EWEC *Global Strategy* action areas, September 2015 –December 2017





**4.**

**FINANCIAL  
COMMITMENTS  
TO THE EWEC  
*GLOBAL STRATEGY***





Substantial financial commitments have been made to the EWEC *Global Strategy*: from September 2015 to December 2017, commitment-makers pledged a total of **US\$35.1 billion** in financial commitments (Figure 13).<sup>67</sup> Of this amount, HICs pledged US\$14.9 billion (42% of all financial commitments), followed closely by LICs and LMICs, which together pledged a total of US\$12.9 billion (37%).<sup>68</sup> The remainder was pledged by CSOs and NGOs (US\$4.7 billion, 13%), philanthropy and foundations (US\$1.5 billion, 4%), the business community (US\$1.0 billion, 3%), and other sources (US\$0.2 billion, <1%).<sup>69</sup>

In 2017, committed funding increased by US\$5.8 billion, up from US\$29.3 billion, which

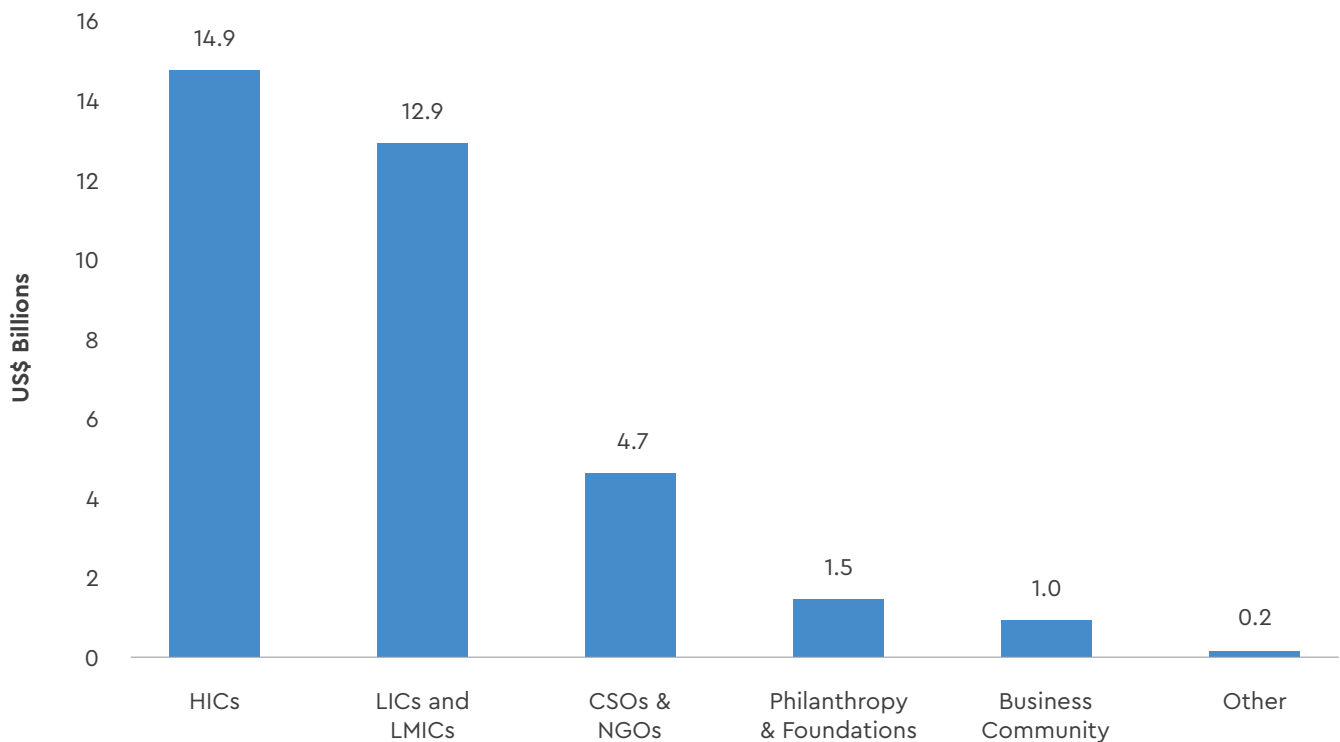
was pledged between September 2015 and December 2016.<sup>70</sup> The large majority of the funding committed in 2017 was pledged at the FP2020 summit to improve access to family planning services.<sup>71</sup>

This analysis also estimated the amount of additional funding – the amount of pledged funding that is beyond previous baseline spending: US\$13.6 billion of the US\$35.1 billion in financial commitments to the *Global Strategy* is expected to be additional.<sup>72</sup> This is a conservative estimate, which considers that any calculation of additionality is inherently difficult, unless commitment-makers clearly lay out their additional contributions during the commitment-making process.



***Between September 2015 and December 2017, commitment-makers pledged a total of US\$35.1 billion in financial commitments.***

**Figure 13.** Financial commitments to the EWEC *Global Strategy* by commitment-maker group



Note: Due to rounding, the component parts add up to US\$35.0 billion.

Much of the additional funding was committed by low- and middle-income countries:

- US\$11.2 billion of the \$12.9 billion in committed funding pledged by LICs and LMICs is additional financing through increased domestic resource mobilization.
- US\$2 billion of the \$15.3 billion committed by HICs is estimated to be additional. This includes funding pledged by Norway, Sweden, the United Kingdom, and the United States.
- There is only limited information on the additionality of funding from non-governmental commitment-makers. An estimated US\$447 million of the total amount committed by these commitment-makers is additional.

Commitment-makers are making progress with their commitment-related disbursements and expenditures.<sup>73</sup> An estimated US\$9.4 billion was disbursed by December 2017. Donor governments disbursed an estimated US\$7.8 billion.<sup>74</sup> Non-governmental commitment-makers disbursed a reported US\$1.2 billion. Only limited information is available on the progress of LICs and LMICs. Expenditure data for six countries with commitments to the EWEC *Global Strategy* indicates that these countries spent an incremental US\$297 million against their *Global Strategy* commitment since the launch of the updated strategy in September 2015.<sup>75</sup>

Going forward, efforts to mobilize additional resources from domestic and international sources for women's, children's, and adolescents' health need to be continued. An analysis of trends in donor funding for sexual, reproductive, maternal, newborn, and child health (SRMNCH) in the 62 GFF countries indicates that the stagnation of development assistance for health has been mirrored by a similar plateauing of donor funding for SRMNCH (Figure 14).

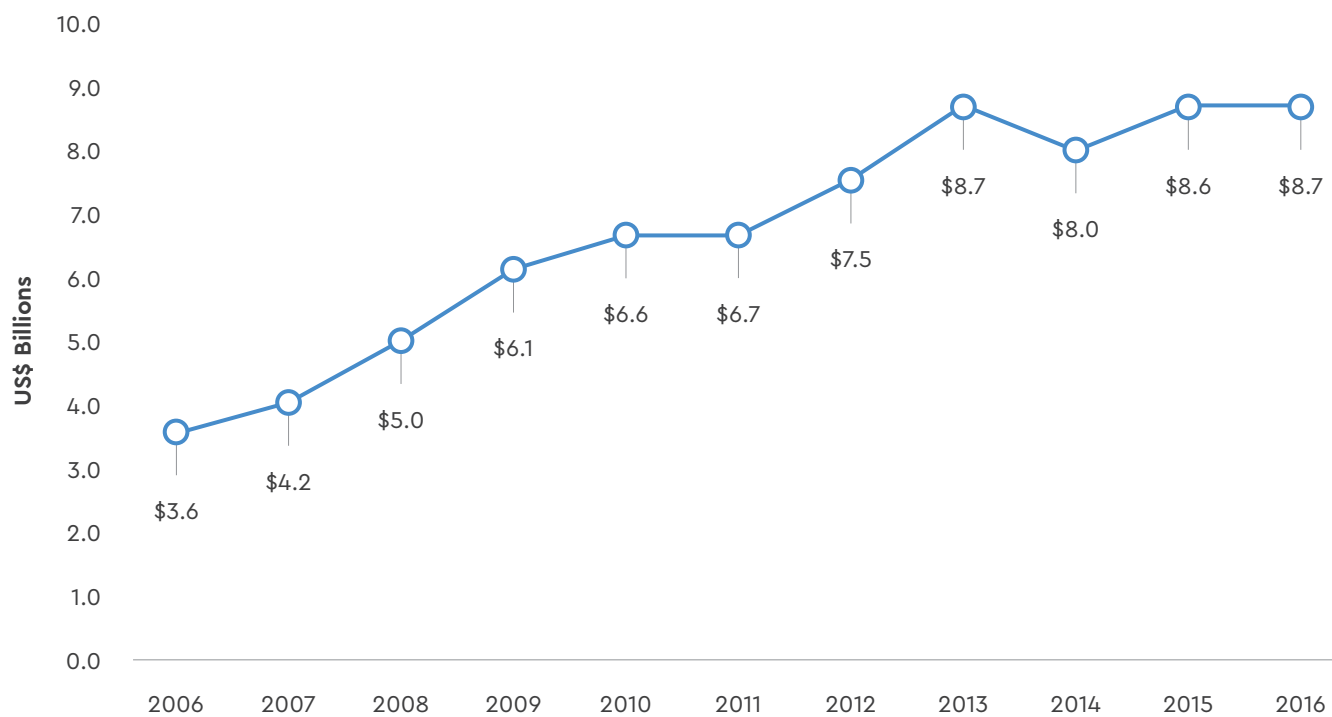
In 2015, the GFF estimated that an additional annual amount of US\$33.3 billion would be required for the countries that are eligible for financing through the GFF Trust Fund.<sup>76</sup> Comparing this estimate with a key finding of this report – that commitment-makers have pledged US\$13.6 billion in additional financing to the EWEC *Global Strategy* in total – suggests that much more funding is needed on top of current commitments.

Low- and middle-income countries need to further strengthen efforts to self-finance their RMNCH needs. Domestic financing is the most important source of funding to close this gap. Many LICs and LMICs are on course to experience significant economic growth, which will create greater domestic fiscal space

for health financing.<sup>77</sup> The role of technical support and political advocacy will become increasingly important in the expansion of countries' fiscal space and revenues for health.

Going forward, more action is also required to improve and align the tracking of global and domestic financing for women's, children's, and adolescents' health. Accurate and comprehensive tracking is important to maximize the use of existing funds and to mobilize additional funding. In May 2018, Countdown to 2030 and PMNCH organized a consultation on the tracking of ODA and domestic financing for women's, children's, and adolescents' health (WCAH). This meeting brought together representatives from major tracking initiatives, donor governments, multilateral agencies, and partnerships to lay the foundation for greater alignment and coordination, agree on essential elements of a key tracking method, and integrate health ODA and domestic health financing tracking approaches. The group agreed to form a **Joint Countdown to 2030 and PMNCH Technical Working Group for the Tracking of ODA and Domestic Financing for WCAH** to continue to coordinate actions and help bring to fruition a tracking method based on the foundational principles agreed upon at the meeting.

**Figure 14.** ODA disbursements for SRMNCH to the GFF countries, 2006–2016<sup>78</sup>



Note: Disbursements in US\$ Billions – Constant 2016 prices.

Source: OECD CRS (Yrs 2006–2016)

The background features a vibrant red color with several large, overlapping, curved shapes in a lighter shade of red and a bright yellow. The shapes are organic and fluid, creating a dynamic and modern aesthetic.

**5.**

**COMMITMENTS BY  
NON-GOVERNMENTAL  
ACTORS: PROGRESS  
ON IMPLEMENTATION**



A total of 176 non-governmental commitment-makers were invited to participate in an online survey to report on progress in the implementation of their EWEC *Global Strategy* commitments. Of these 176 commitment-makers, 105 (60%) completed the survey between February 28, 2018 and April 26, 2018. The self-reported survey information was assessed, appraised and, where feasible, aggregated.

The results show that commitment-makers made significant progress, implementing a range of activities to improve the lives of millions of

newborns, children, adolescents, and women. **The following results represent the progress of 60% of non-governmental commitment-makers, not the entire universe of commitments to the EWEC *Global Strategy*.** As government commitment-makers did not participate in the survey, and only 60% of non-governmental commitment-makers completed the survey, the actual number of people reached as part of the commitment implementation process is much higher. Further, the survey results do not fully align with the content analysis results given that only a subset of commitment-makers participated in the survey.

### Box 3.

#### About the Progress Reporting Questionnaire

The progress reporting questionnaire serves as the annual reporting mechanism for non-governmental commitment makers to the EWEC *Global Strategy*. It includes:

- **Commitment progress summary:** Commitment-makers describe their progress on commitment activities, including key achievements and how commitments have improved women's, children's, and adolescents' health.
- **Financial commitment progress:** Commitment-makers report any changes to their overall financial support, the amount of funding disbursed/spent-to-date, the funding source, and the estimated value of non-financial commitments.
- **Thematic commitment progress:** Commitment-makers describe how their commitment-related activities contribute to the updated EWEC *Global Strategy* objectives and indicators, which EWEC focus areas are relevant, the activities implemented, and results achieved, and the number of people reached by target population.

Appendix 4 provides more details on the survey.

## Activities implemented across EWEC focus areas

Commitment-makers reported through the online survey on activities, results, and number of people reached through commitment-related activities across **six focus areas from the 2020 EWEC Partners' Framework**.<sup>79</sup> These areas are: early childhood development; adolescent and young adult health and well-being; SRHR; quality, equity, and dignity in services; empowerment of women, girls, and communities; and humanitarian and fragile settings. These areas are cross-cutting in the sense that, for example, SRHR services may also target adolescents.

There was robust activity reported across each of these focus areas (Figure 15). Survey respondents provided a brief description of the activities they implemented and results achieved. About half of survey respondents reported activities related to SRHR (52%), adolescent and young adult health and well-being (46%), and quality, equity, and dignity in services (46%). Around one-third of respondents reported activity related to early childhood development (32%), empowerment of women, girls, and communities (33%), and humanitarian and fragile states (27%).

Forty-one percent of commitment-makers that completed the survey also included estimates of the number of people reached by those activities (Figure 16).<sup>80</sup> These commitment-makers reported that they **reached 146 million people through service delivery activities** – defined as “activities that include education, training, and the direct provision of products and services that tangibly reach people.”<sup>81</sup> This captures only direct beneficiaries; indirect beneficiaries are reported separately at the end of this section in the analysis of digital platforms, which includes e-learning platforms and digital health systems that may reach target populations indirectly.

Although commitment-makers were active across all six EWEC focus areas, certain areas reached more people than others (see Appendix 3 for more details). Early childhood development accounted for almost three-quarters of all people reached (74%) by those non-governmental commitment-makers who completed the survey (Figure 16). Early childhood development includes physical, language, socio-emotional and motor development of children from conception to eight years of age, and critically impacts health and well-being throughout life.<sup>82</sup>



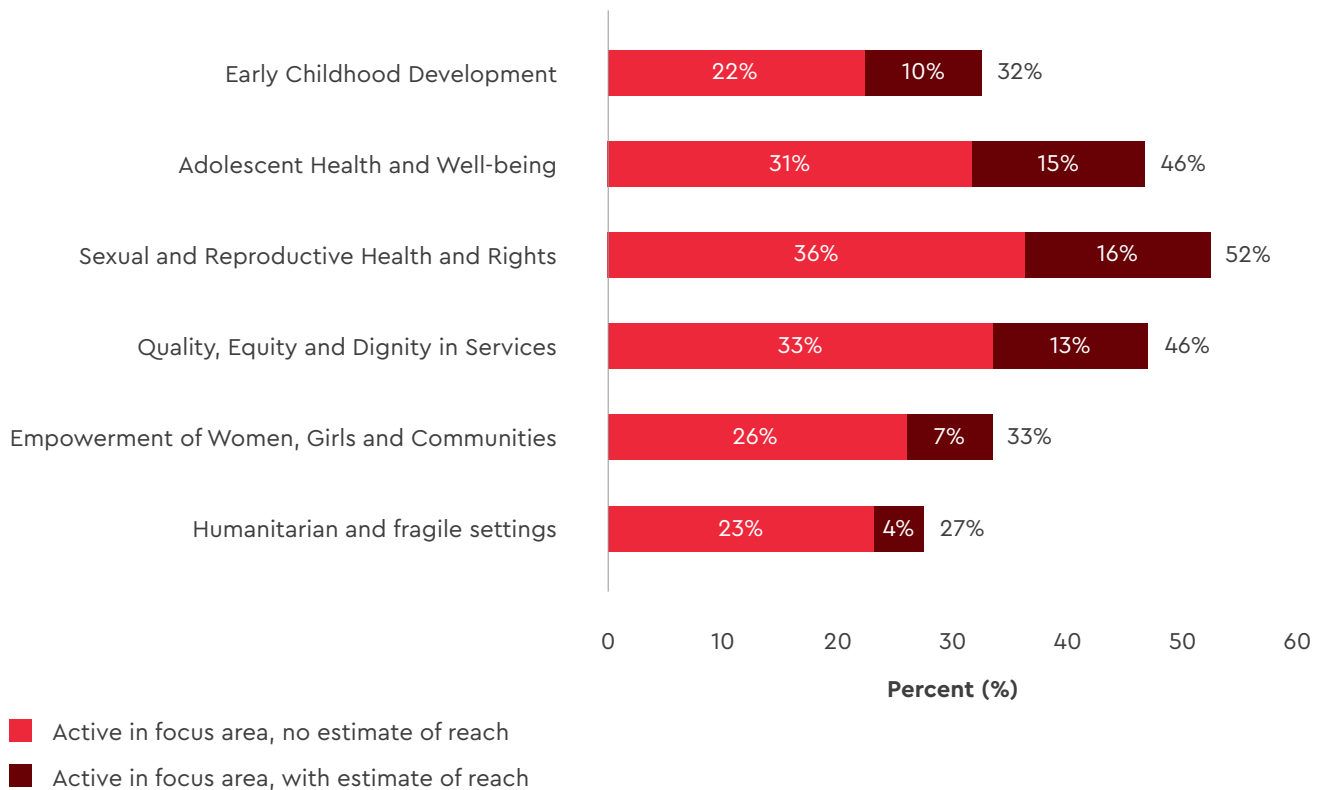
Although 52% of survey respondents (56) reported implementing activities related to SRHR, only 16% (17) also provided quantitative estimates of the number of people reached. These respondents report reaching 19 million people through SRHR services (13% of all reached).

An additional 14 million people were reached through adolescent health and well-being services (9% of all reached). Adolescents have unique physical, cognitive, social, and emotional development needs, and investing in their health and well-being has implications for their futures and larger society. As the number of commitments targeting adolescent health substantially increased in 2017 (see Section

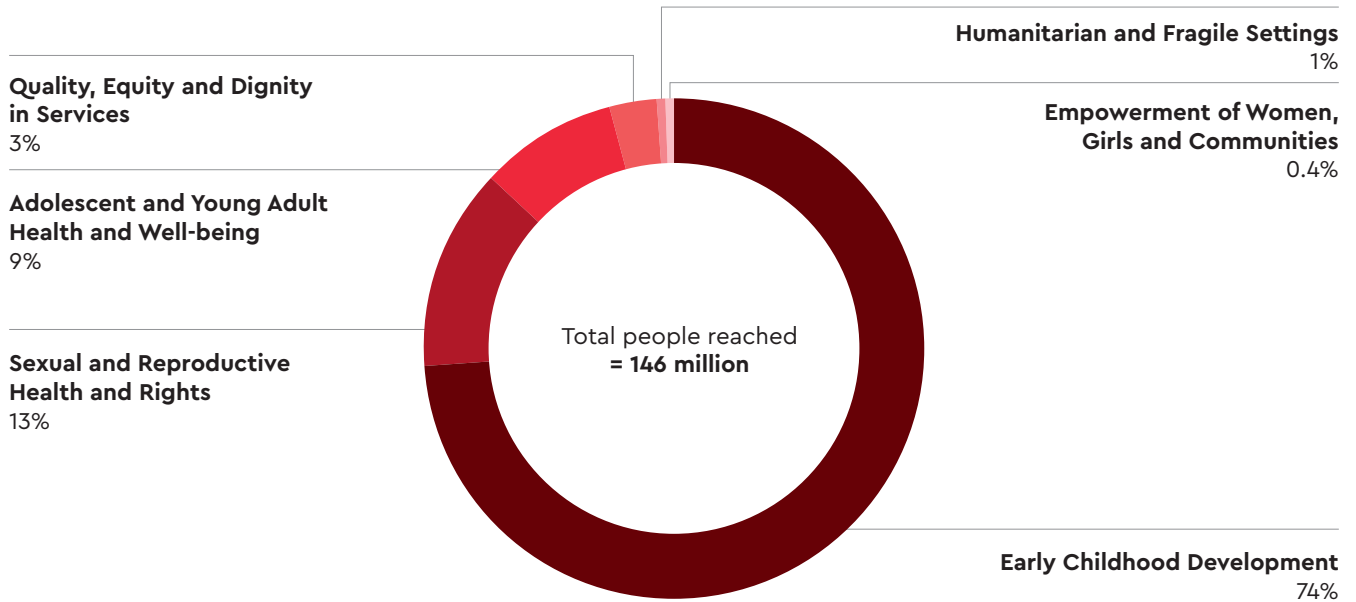
3), the 2019 online survey on implementation progress may find a much larger number of adolescent health services provided.

The other three focus areas accounted for a total of 5.5 million people reported reached through direct services. Women, children, and adolescents are particularly vulnerable in humanitarian and fragile settings, but only 1% of people were reached through this focus area. Services to empower women, girls, and their communities reached less than 1% of people. While there is a significant focus on strengthening SRHR services, commitment-makers reported reaching less people through efforts to improve gender norms and reduce discrimination.

**Figure 15.** The proportion of survey respondents that report activity in each EWEC focus area



**Figure 16.** People reached with service delivery activities, by EWEC focus area

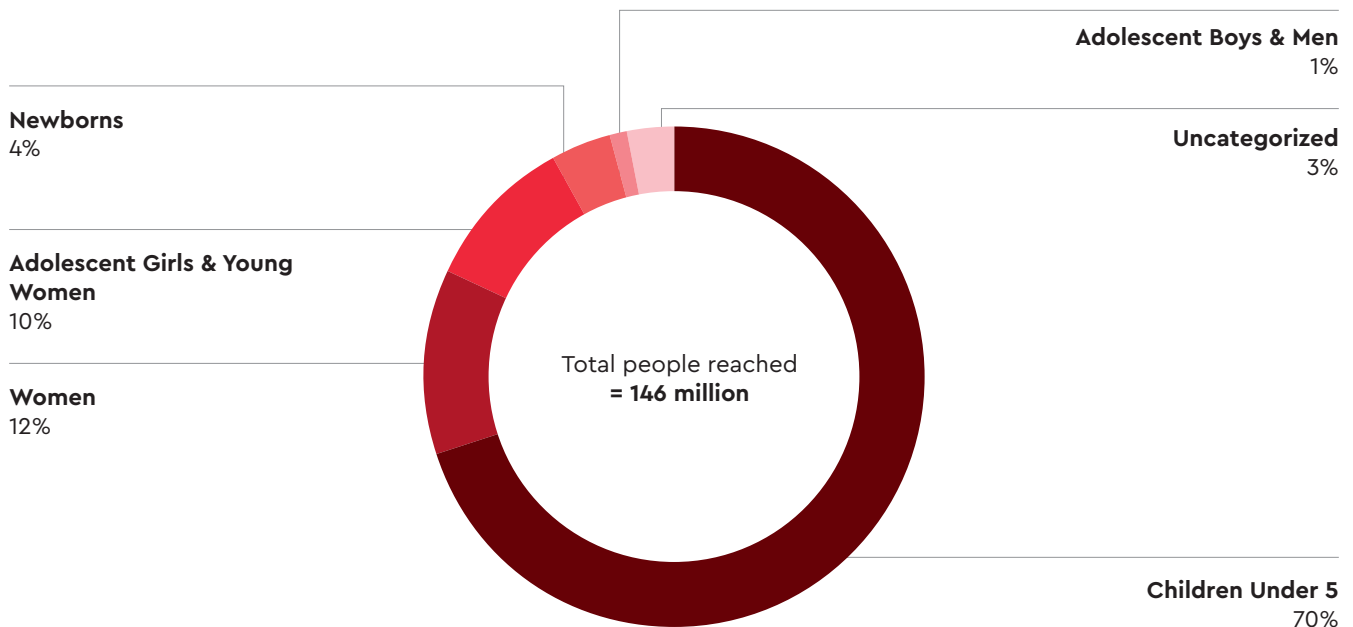


## Populations reached through service delivery activities

Commitment-makers also provided information on who was reached by these services, i.e. the number of people within **target populations**, which include newborns, children under five years of age, early adolescent girls (aged 10–14), early adolescent boys (10–14), adolescent girls and young women (15–24), adolescent boys and young men (14–24), women (25–49), and men (25–49). Commitment-makers could also select “other” and define a key population (see also Appendix 4).

Most people reached through service delivery activities were children under five years (70%), with 12 commitment-makers reporting that they reached over 102 million children (Figure 17). Many commitment-makers also reported progress in reaching women as well as adolescent girls and young women: 26 reported reaching women (aged 25–49), and 23 commitment-makers reported reaching adolescent girls and young women (aged 10–24). Of all people reached, 12% were women and 10% were adolescent girls and young women. Newborns accounted for 4% of all people reached; only seven commitment-makers reported reaching newborns. Men and boys aged 10–24 years comprised just 1% of people reached, reported by 11 commitment-makers.<sup>83</sup>

**Figure 17.** People reached with service delivery activities, by target population

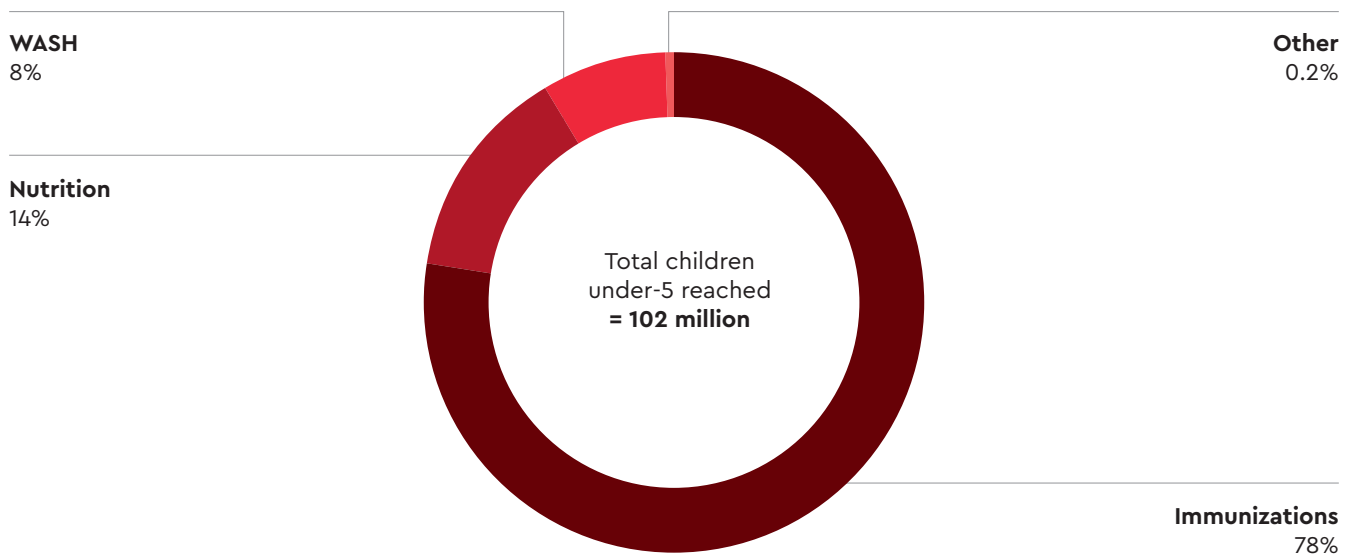


## Services reaching children under five years

EWEC commitment-makers reached 102 million children in 2016–2017. Most children (78%) were reached through large-scale immunization campaigns by Gavi, the Vaccine Alliance and other supporters, together serving nearly 80 million children worldwide with life-saving immunizations. Nutrition programs also

reached many children, reaching over 14 million children (14% of children reached) with services that included micronutrient supplements, nutrition education, and food assistance. WASH programs reached 8 million children (8% of children reached), for example with educational programming on handwashing. Other activities included supporting parents and caregivers to provide essential early childhood development services at home, implemented by mothers2mothers (Figure 18).

**Figure 18.** Services reaching children under five years



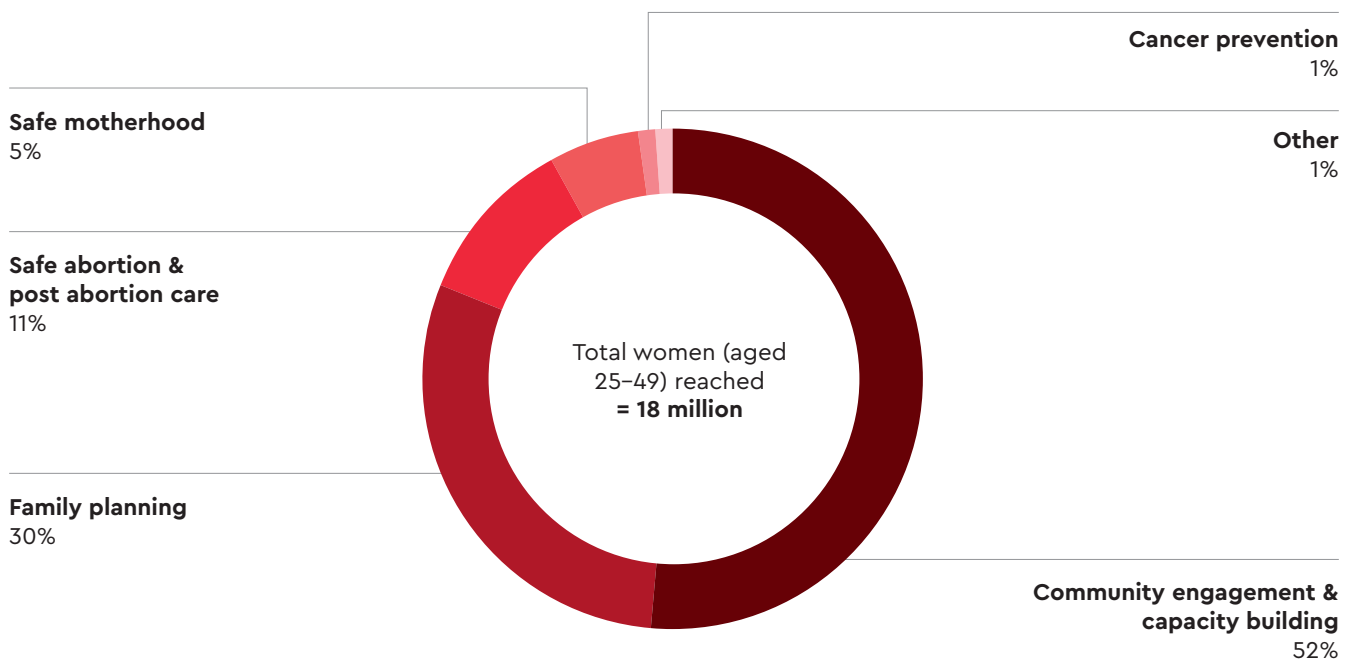
## Services reaching women aged 25–49

A total of 18 million women aged 25–49 were reached by EWEC commitment-makers in 2016–2017 (Figure 19). Just over half of women reached (52%) were engaged through community and capacity building programming reported by five commitment-makers. These educational and awareness raising interventions had an SRHR focus and cut across several topics such as family planning, safe abortion, gender-based violence, and nutrition.

Following these cross-cutting programs, the next largest numbers of women were reached

through dedicated SRHR services – 30% through family planning, and 11% through safe abortion and post-abortion care. Commitment-makers included Merck for Mothers, the Aman Foundation, and Marie Stopes International. Safe motherhood interventions also reached sizeable numbers of women and included gestational diabetes testing, improved midwifery services, emergency transport for pregnancy-related emergencies, and antenatal and postnatal care. Smaller numbers of women were reached through a collection of other women's health services. For instance, 1% of women were reached through cancer screening and education services. Other interventions focused on water, sanitation, and hygiene (WASH) services and nutrition.

**Figure 19.** Services reaching women aged 25–49



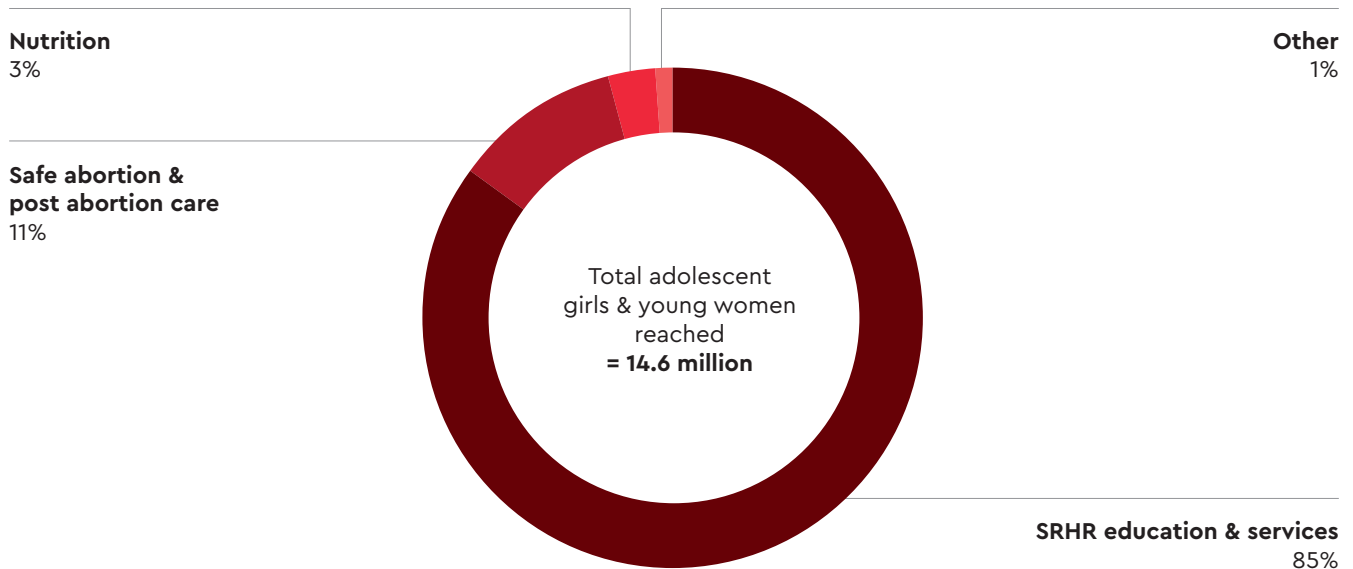
## Services reaching adolescent girls and young women

A total of 14.6 million adolescent girls and young women were reached through EWEC commitment-makers in 2016–2017 (Figure 20). Over 12 million (85% of population reached) were reached through SRHR educational programming and services, as reported by eight commitment-makers. These interventions described providing SRHR services broadly, or a combination of SRHR services such as family planning, safe abortion where legal, reproductive health education, and addressing social determinants of SRHR for adolescents. For

example, Médecins du Monde/Doctors of the World USA worked with community leaders in the Democratic Republic of Congo, a humanitarian and fragile setting, to improve access to sexual and reproductive health services for adolescents, reaching over 11,000 youth.

An additional 1.6 million adolescent girls and young women (11%) were reached through safe abortion and post-abortion care services. Half a million (3%) were reached through school-based nutrition programming. Additional adolescent girls and young women were reached through WASH services, youth development programs, job training, secondary school education, leadership and advocacy programs, and violence prevention efforts.

**Figure 20.** Services reaching adolescent girls and young women



## Services reaching newborns

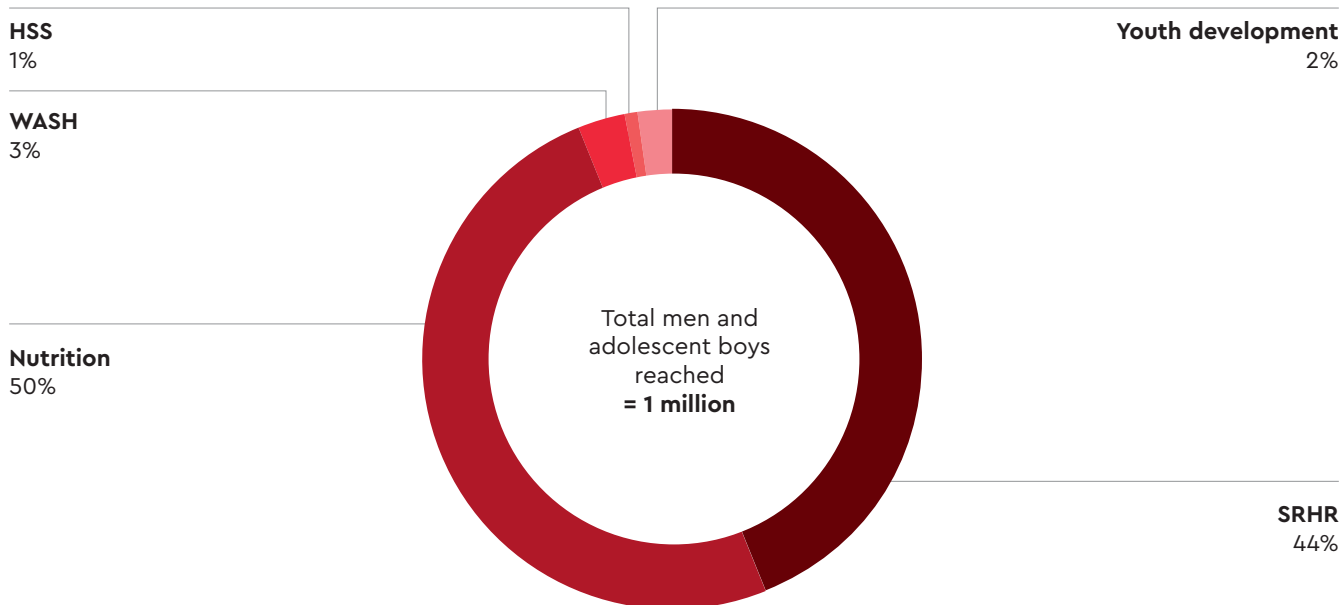
The EWEC commitment-makers that provided estimates of people reached through the questionnaire reported reaching 5.4 million newborns in 2016–2017. The actual number of newborns reached is likely much higher, as only seven commitment-makers provided estimates for newborns but there are over 100 commitments focusing on neonatal health, as shown in the content analysis. Among the seven, nearly all the newborns were reportedly reached (99%) by one commitment-maker, Johnson & Johnson. Johnson & Johnson reported a number of interventions to improve newborn health and increase newborn survival, including strengthening kangaroo care (skin-to-skin contact), implementing community-based pregnancy testing and family planning services, and increasing community awareness of the gender dimensions of maternal and newborn health.

The remaining 1% of newborns were reached through services for critical care newborns (e.g., breastfeeding for critical care infants, emergency newborn care, improving neonatal intensive care unit services), postnatal care, and improved midwifery services. However, despite the importance of newborn care, and its priority in the EWEC *Global Strategy*, the progress survey captured results from only a few commitment-makers reaching newborns.

## Services reaching men and boys

In total, one million adolescent boys, young men, and adult men were reached by EWEC commitment-makers, primarily through nutrition and SRHR services. For example, Advance Family Planning reported reaching adolescent boys in its work to expand access to contraceptives and to support young people as advocates (Figure 21).

**Figure 21.** Services reaching men and boys



## Populations reached through digital platforms

An estimated **377 million people** were reached through EWEC commitments that used digital platforms. Digital platforms were separated from other service delivery activities because these strategies have a far reach across a wide population, sometimes reaching people through indirect means (e.g., e-learning platforms) rather than the direct interaction found in most clinical services or community-based programs.

In 2016–2017, there were three commitment-makers (Royal Philips, Women's Health and Education Center, and Cycle Technologies) that reported reaching people through digital platforms. These efforts included:

- Investing in medical devices in low-income settings to improve primary health care;
- Developing information technology solutions

to digitize healthcare in low resource settings to improve data, monitoring, and population health management;

- Supporting health systems in adopting new technologies to improve systems and quality;
- E-learning platforms with evidence-based guidelines on maternal and child health, available in multiple languages and designed for healthcare providers and the general public;
- Mobile platform that provides women with free, direct access to information about their fertility and reproductive health.

Most people estimated to be reached through digital platforms were undefined (77%), perhaps due to the population-wide expected reach of these interventions (i.e., entire communities benefit from the digitization of healthcare, not only target populations). The remaining people reached included women age 25–49 (12%), children under five years (6%), and adolescent girls and young women (5%).



The background features several overlapping, curved shapes in various shades of green and red. A large, light green shape dominates the upper left and center. A darker green shape is on the right. A red shape is in the top right corner. A white shape is at the bottom left. The text is positioned on the left side, overlapping the light green and darker green areas.

# **6.** **CONCLUDING REMARKS**



This report analyzed the current situation in relation to commitments made to advance the EWEC *Global Strategy*. It included all commitments made between September 2015 and December 2017. Overall, the report showed significant progress but also points to important areas requiring additional focus.

The EWEC *Global Strategy* continues to catalyze unprecedented support for the health of women, children, and adolescents. A total of 87 commitments were mobilized in 2017 alone. Commitment-makers are delivering on their financial commitments and are on their way to disbursing the US\$35 billion pledged to the EWEC *Global Strategy*. The online survey also shows that commitment-makers are implementing very significant service delivery commitments.

However, the report also pointed to areas that require increased action and commitments, such as newborn health and stillbirths. More cross-sectoral action is needed to address the social determinants of health, such as poverty and lack of education, as these play a critical role for the health and well-being of women, children, and adolescents.

The report highlights that substantial additional funding is needed to achieve the health-related SDG-targets. At the same time, the stagnation of development assistance for health has been mirrored by a similar plateauing of SRMNCH donor funding. Going forward, the role of technical support and political advocacy will become increasingly important to support domestic resource mobilization.

# ACKNOWLEDGEMENTS

The Partnership for Maternal, Newborn & Child Health would like to extend its gratitude to all those who provided information through the online questionnaire and who contributed to the development of this report.

## **Partners**

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## **Other**

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Most importantly, we thank the *Every Woman Every Child* commitment-makers for their efforts to advance the health of women, children and adolescents around the world.

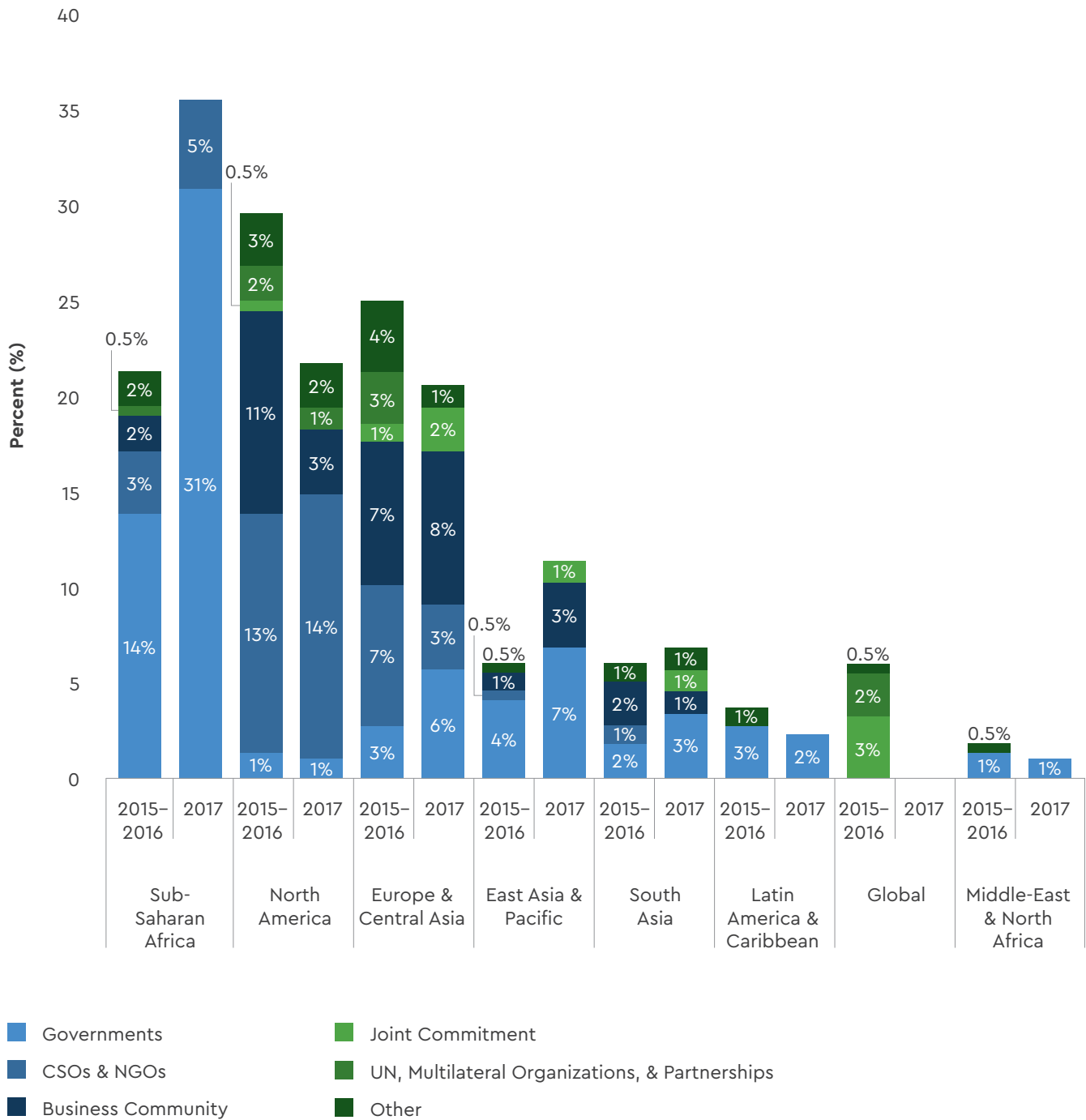
# APPENDIX

The background features a large, dark blue circle on the left side. To its right, there is a large, light green circle. Below these, there are several overlapping shapes in various shades of blue, creating a layered, abstract composition. The overall aesthetic is clean and modern.

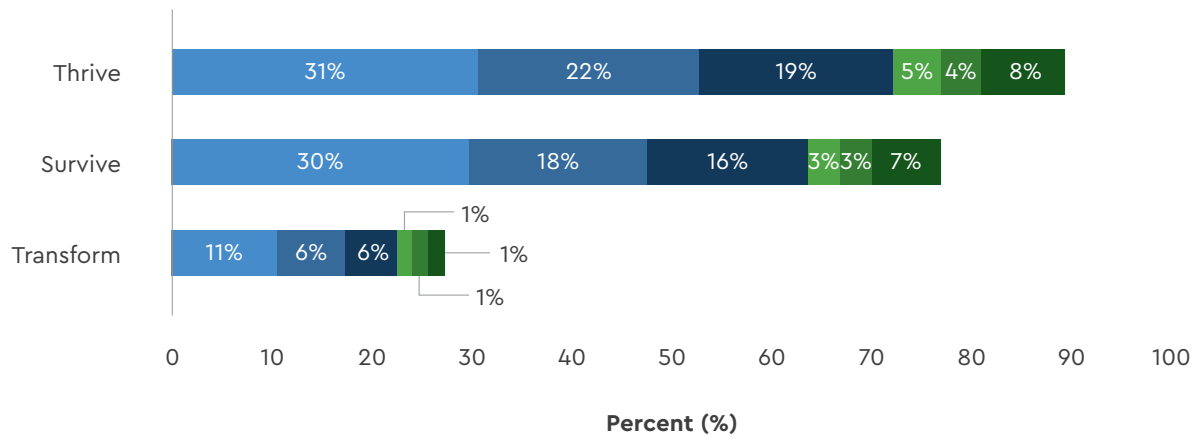


# Appendix 1: Additional graphics

**Figure 4A.** Commitments by origin of commitment-maker, and commitment-maker group  
September 2015 – December 2017

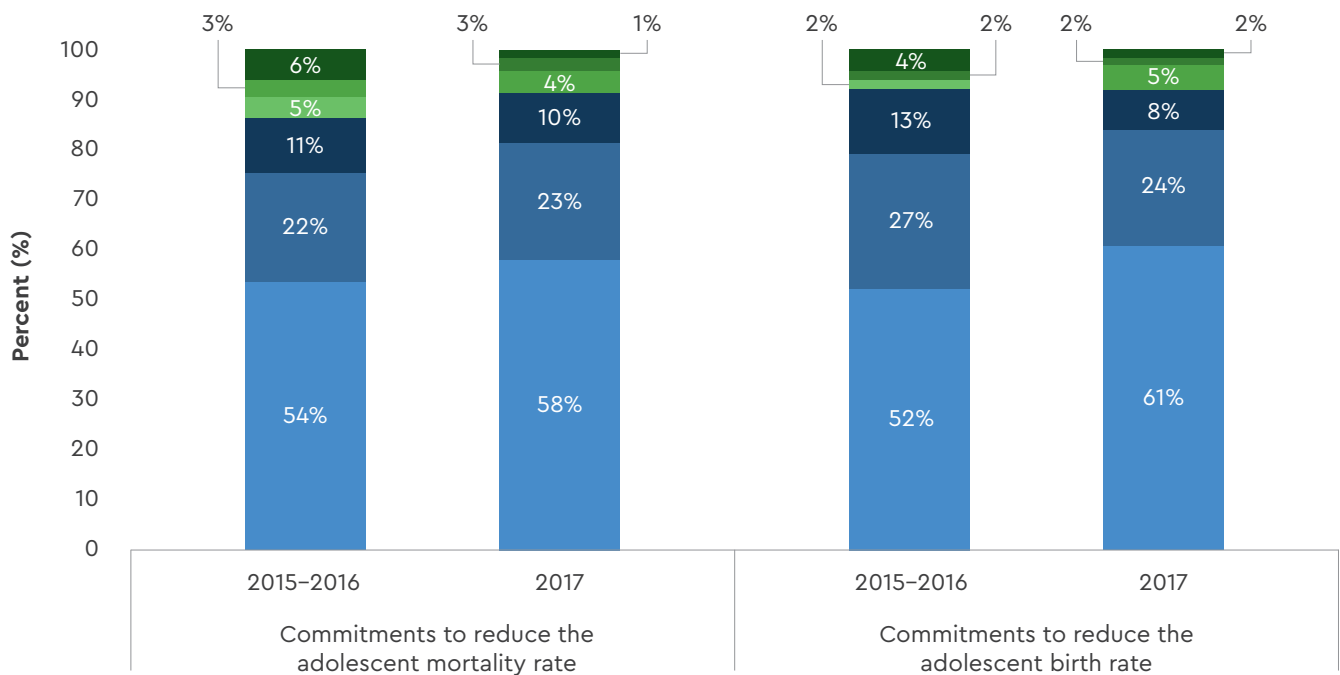


**Figure 7A.** Commitments in support of at least one of the 16 EWEC *Global Strategy* key indicators within the "survive," "thrive," and "transform" objectives, September 2015 – December 2017, by commitment-maker group



- Governments
- CSOs & NGOs
- Business Community
- UN, Multilateral Organizations, & Partnerships
- Joint Commitment
- Others

**Figure 10A.** A new focus on adolescent health in 2017 – *Global Strategy* commitments to adolescent health by type of commitment-maker, 2015–16 vs. 2017



- Governments
- CSOs & NGOs
- Business Community
- UN, Multilateral Organizations, & Partnerships
- Philanthropy & Funders
- Joint Commitment
- Others



## Appendix 2: Methods for estimating financial commitments

### Estimation of financial commitment value

The value of financial commitments to the EWEC *Global Strategy* was estimated based on the available commitment data. The value of the financial commitment was either taken directly from the commitment text and forms, or in the case of LICs and MICs calculated based on the following approach: Many LICs and MICs pledged to increase their domestic health expenditures to 15% of their total government budget by or before 2030, so the incremental funding could be estimated assuming a linear increase from current baseline spending. Baseline data came from the WHO's Global Health Expenditure Database.<sup>84</sup> This approach is in line with previous PMNCH accountability reports on *Global Strategy* commitments. The approach was initially developed in 2009 to estimate the value of financial commitments made to the first *Global Strategy* (2010–2015).<sup>85</sup>

### Double-counting of financial commitments

The amount of committed financing was adjusted to control for double-counting. Double-counting occurs when both a source and a channel of financing count the same funding as part of their commitment. For example, when a donor

country channels funding through an NGO, and when both – the donor (source) and the NGO (channel) – count this funding as part of their commitment, the overall commitment amount would be inflated because of double-counting. To control for double-counting, adjustments were made based on self-reported survey data, and a review of financial documents (e.g. budgets; annual financial reports).

For this year's report, it was also important to control for another type of double-counting. Double-counting can also occur when the same actor pledges the same funding at two different points in time. For example, a commitment-maker could have made a pledge in 2015/16. On top of this pledge, the commitment-maker might have made another commitment in 2017 – for example at the FP2020 summit. It was thus required to also analyze if 2017 commitments overlapped with earlier commitments from previous years. Through a review of commitment data, it was also controlled for this type of double-counting.

### Additionality of financial commitments

The available commitment data is often vague regarding the additionality of financing, and as such assumptions had to be made to estimate the amount of new and additional funding. Additionality is defined as funding pledged above baseline spending. For example, if a commitment-maker spent US\$100 million in 2015 (the baseline year for the updated *Global Strategy*), and commits to US\$120 million in 2016, US\$20 million is new and additional funding.

Most of the funding committed by LICs and LMICs is new and additional because these countries usually pledge to increase their current domestic health expenditures to 15% out of the general government budget. For donor governments, the DAC database was used to estimate baseline spending, and this baseline spending was then compared with the committed amounts. For non-governmental commitment-makers, financial information from commitment applications and the survey was used.

## Appendix 3: Additional information on target populations self-reported to be reached by commitment-makers

To supplement section 5 of the report, the following tables 1–5 provide further detail on the target populations reached by commitment-makers, and the services provided.

**Appendix 3, Table 1:** Newborns reached through service delivery activities

Organization Name	Newborns reached	Service delivery activity
Johnson & Johnson	5,300,000	community engagement & capacity building
Medela AG	50,000	critical care newborns (breastfeeding)
International Federation of Gynecology and Obstetrics / International Confederation of Midwives / International Pediatric Association	10,000	improved midwifery services
Discovery Limited	4,386	postnatal care
General Board of Global Ministries	2,540	community engagement & capacity building
Adara Group	2,213	critical care newborns (NICU care)
Touch Foundation	83	critical care newborns (emergency care)
<b>Total newborns reached</b>	<b>5,369,222</b>	
<b># of commitment-makers</b>	<b>7</b>	

**Appendix 3, Table 2:** Children reached through service delivery activities

Organization Name	Children under 5 reached	Service delivery activity
Gavi, the Vaccine Alliance	62,000,000	immunizations
United Nations Foundation (UNF)	17,593,323	immunizations
Nestlé	14,400,000	nutrition
Unilever	7,927,231	WASH
General Board of Global Ministries	185,700	community engagement & capacity building
Amway Corporation	102,000	nutrition
General Board of Global Ministries	21,757	HSS
Let There Be Light International	18,000	HSS
mothers2mothers	14,093	community engagement & capacity building
Discovery Limited	5,963	clinical services
World Health Partners	2,242	clinical services
Adara Group	25	community engagement & capacity building
<b>Total children reached</b>	<b>102,270,334</b>	
<b># of commitment-makers</b>	<b>12</b>	

**Appendix 3, Table 3:** Adolescent girls and young women (age 10–24) reached through service delivery activities

Organization Name	Adolescent girls and young women (age 10–24) reached	Service delivery activity
Pathfinder International	12,000,000	SRHR education & services
Marie Stopes International	1,600,000	safe abortion & post abortion care
mothers2mothers	219,284	HIV services
Restless Development	74,986	SRHR education & services
General Board of Global Ministries	15,782	youth development
Adara Group	14,888	SRHR education & services
Banka BioLoo	28,000	WASH
Medicins du Monde/Doctors of the World USA	11,742	SRHR education & services
Noor Community Welfare Trust	5,400	job training
PSI – Population Services International	4,800	family planning
Jhpiego	2,687	SRHR education & services
Bhuddhist Tzu Chi Foundation	1,500	school
AMOREPACIFIC GROUP	617	job training
Organization of Africa Youth Kenya	500	advocacy
Women Deliver	350	advocacy
Jhpiego	134	family planning
Nestlé	500,000	nutrition
United Nations Foundation (UNF)	40,000	SRHR education & services
Together for Girls	20,000	violence prevention
World Vision International	15,000	SRHR education & services
Let There Be Light International	14,000	other
Advance Family Planning / JHU	12,500	family planning
Spark Minda Foundation	1,326	SRHR education & services
<b>Total adolescent girls and young women reached</b>	<b>14,583,496</b>	
<b># of commitment-makers</b>	<b>23</b>	

**Appendix 3, Table 4:** Women (age 25–49) reached through service delivery activities

Organization Name	Total women (age 25–49) reached	Service delivery activity
Johnson & Johnson	8,000,000	community engagement & capacity building
Merck MfM	3,780,000	family planning
Marie Stopes International	2,000,000	safe abortion & post abortion care
Aman Foundation	1,378,066	family planning
Ipas	1,075,336	community engagement & capacity building
Sanofi Espoir Foundation	870,000	safe motherhood
AMOREPACIFIC GROUP	238,384	cancer prevention
BSR – Business for Social Responsibility	218,085	family planning
NST Global Corporation	150,000	community engagement & capacity building
General Board of Global Ministries	54,740	community engagement & capacity building
General Board of Global Ministries	50,766	HSS
Medela AG	50,000	safe motherhood
WaterAid	40,200	WASH
Novo Nordisk A/S	24,052	safe motherhood
Adara Group	17,462	community engagement & capacity building
Piramal Foundation	12,793	safe motherhood
Noor Community Welfare Trust	12,300	nutrition
White Ribbon Alliance	11,462	safe motherhood
International Federation of Gynecology and Obstetrics / International Confederation of Midwives / International Pediatric Association	10,000	safe motherhood
Discovery Limited	6,220	safe motherhood
World Health Partners (WHP)	4,923	SRHR
Medtronic Foundation	4,300	safe motherhood
NST Global Corporation	1,816	family planning

Organization Name	Total women (age 25–49) reached	Service delivery activity
AMOREPACIFIC GROUP	1,645	community engagement & capacity building
mothers2mothers	1,639	HIV services
Medicins du Monde/Doctors of the World USA	511	safe abortion & post abortion care
Touch Foundation	396	safe motherhood
Spark Minda Foundation	327	family planning
Banka BioLoo	100	WASH
<b>Total women (25–49) reached</b>	<b>18,015,523</b>	
<b># of commitment-makers</b>	<b>26</b>	

**Appendix 3, Table 5:** Men and boys (age 10–49) reached through service delivery activities

Organization Name	Total men and boys (age 25–49) reached	Service delivery activity
Nestlé	500,000	Nutrition
Ipas	365,099	SRHR
Restless Development	60,338	SRHR/advocacy
Banka BioLoo	28,000	WASH
General Board of Global Ministries	19,927	Youth Development
Let There Be Light International	14,000	HSS
Advance Family Planning / JHU	12,500	Family planning
NST Global Corporation	1,816	family planning
Organization of Africa Youth Kenya	500	Advocacy
Spark Minda Foundation	327	family planning
Women Deliver	175	Advocacy
Banka BioLoo	100	WASH
<b>Total men and boys (10–49) reached</b>	<b>1,002,782</b>	
<b># of commitment-makers</b>	<b>11</b>	

**Appendix 3, Table 6:** Total people reached through digital platforms

Commitment-maker	Description	Total People Reached
Royal Philips	<ul style="list-style-type: none"> <li>Investing in medical devices in low-income settings to improve primary health care</li> <li>Developing IT information technology solutions to digitize healthcare in low resource settings, to improve data, monitoring, and population health management</li> <li>Supporting health systems in adopting new technologies to improve systems and quality</li> </ul>	289,000,000
Women's Health and Education Center	<ul style="list-style-type: none"> <li>E-learning platforms with evidence-based guidelines on maternal and child health, available in multiple languages and designed for healthcare providers and the general public</li> </ul>	87,000,000
Cycle Technologies	<ul style="list-style-type: none"> <li>Mobile platform that provides women with free, direct access to information about their fertility and reproductive health</li> </ul>	500,000
<b>Total</b>		<b>376,500,000</b>

## Appendix 4: Questions on thematic commitment progress in the EWEC Progress Reporting Questionnaire

The diagram below displays the progression of questions that non-governmental survey respondents were asked to answer in relation to how their commitment-related activities contribute to themes of the EWEC *Global Strategy*. This diagram is only for illustrative purposes and does not reflect the full suite of questions included in the Progress Reporting Questionnaire. It shows a model tree for the

sexual and reproductive health and rights focus area only, but the respondents answer the same set of possible questions for each of the EWEC focus areas, which also include: early childhood development; adolescent and young adult health and well-being; quality, equity, and dignity in services; empowerment of women, girls, and communities; and humanitarian and fragile settings.

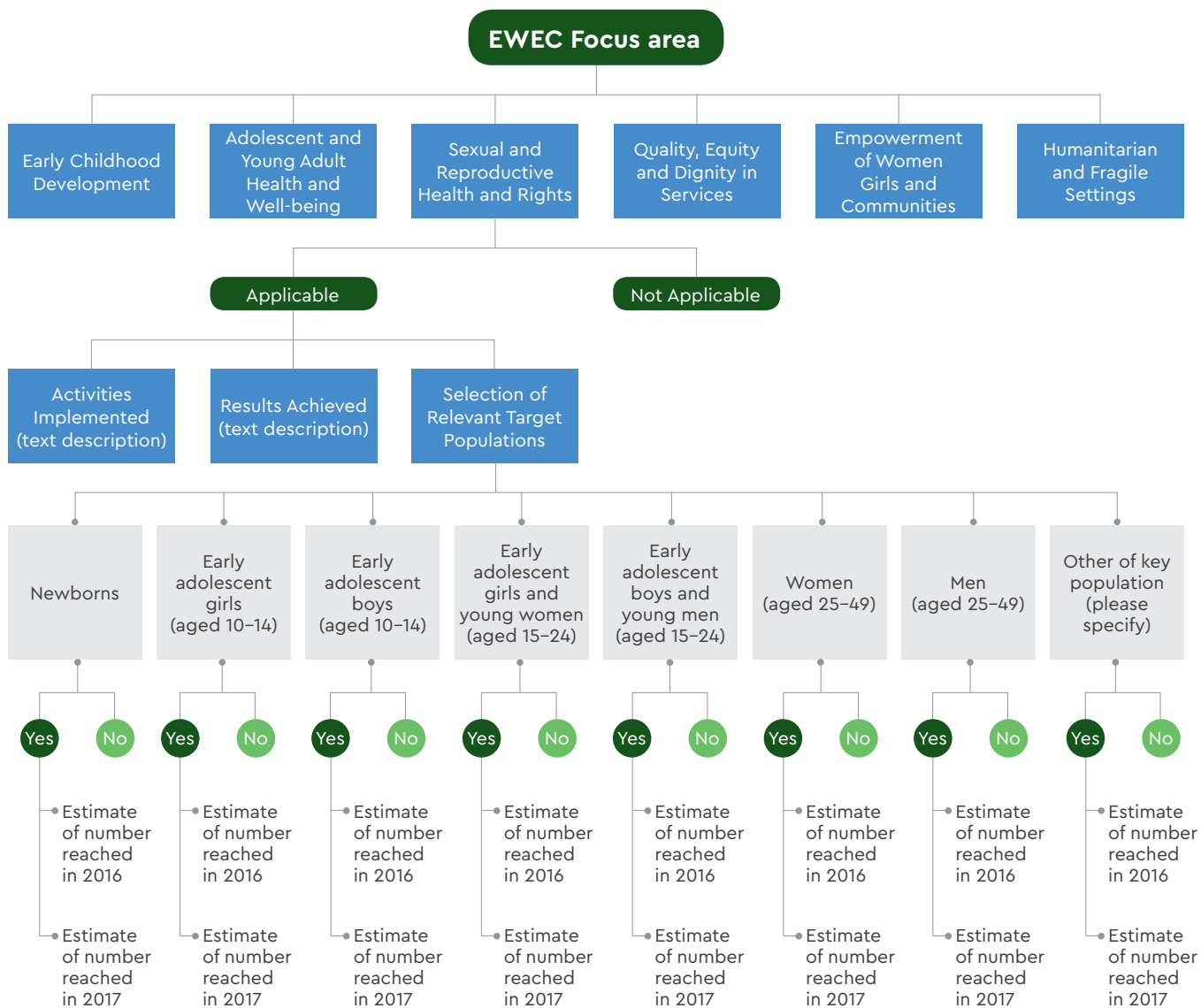
First, commitment-makers report if commitment-related activities are applicable to each of the six EWEC focus areas. For each focus area selected, commitment makers can then report on the key activities implemented and results achieved, and whether or not commitment-related activities include service

delivery. If service delivery is included, commitment-makers have the option to provide information on the relevant target populations reached and the number of people reached for each target population by year.

Not all questions are compulsory. For example, the structure of the survey allows for a commitment-maker to indicate that they have implemented commitment-related activities related to sexual and reproductive health but not provide an estimate of the

number of women reached. In instances when a commitment-maker marked a focus area as applicable but did not provide an estimate of beneficiaries reached, text responses describing the activities implemented and results achieved were evaluated to identify information about the number and target population of beneficiaries. Still, a number of commitment-makers that marked an EWEC focus area as applicable did not provide any quantitative estimate of the number of beneficiaries reached (see Figure 15).

**Appendix 4, Figure 1**





# NOTES AND REFERENCES

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2. The International Development Statistics online databases of the Organisation for Economic Cooperation and Development, and the Global Health Expenditure Database of the World Health Organization.
3. For details on the Muskoka method, please refer to: <http://www.g8.utoronto.ca/summit/2010muskoka/methodology.html>
4. Additionality is defined as funding pledged above baseline spending. More details are provided in Appendix 2.
5. The six focus areas are: early childhood development; adolescent and young adult health and well-being; sexual and reproductive health and rights; quality, equity, and dignity in services; empowerment of women, girls, and communities; and humanitarian and fragile settings.
6. WHO, UNAIDS, UNFPA, UNICEF, UN Women, The World Bank Group. *Survive, Thrive, Transform. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): 2018 monitoring report: current status and strategic priorities*. Geneva: World Health Organization; 2018.
7. <https://www.everywomaneverychild.org/about/>
8. The *Global Strategy* was developed through an extensive consultation process involving governments, civil society, the private sector, UN agencies, and other constituencies. More than 7,000 individuals, organizations, and government representatives participated in the consultations during the World Health Assembly, through face-to-face and online consultations, as well as through the development of evidence-based background papers.
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10. The GFF is a country-led model of development finance that brings together multiple sources of financing in a synergistic way to support countries' priorities. It is EWEC's financing arm. Please refer to Box 2 below for more details on FP2020.
11. These reports are collected together at <http://www.who.int/pmnch/activities/accountability/reports/en/>
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22. Please refer to Appendices 2 and 4 for further information on the methods. More details can also be found in previous PMNCH accountability reports, which are available at: <http://www.who.int/pmnch/activities/accountability/reports/en/>. Please also see the supplementary materials from the 2017 *Global Strategy* progress report prepared by SEEK Development: Commitments to the *Global Strategy for Women's, Children's, and Adolescents' Health – Focus and Progress in Implementation*. Supplementary materials to the *Global Strategy* Progress Report. Available at: <http://gsprogressreport.everywomaneverychild.org/wp-content/uploads/2017/07/PMNCH-2017-Supplementary-materials-SEEK-Final.pdf>
23. See EWEC: What is a Commitment? At: <http://www.everywomaneverychild.org/what-is-a-commitment/>
24. This includes six commitments to FP2020 that were formally rolled over to the EWEC *Global Strategy* through the online survey. These commitments are from Advance Family Planning, the Aman Foundation, the Bill & Melinda Gates Foundation, CARE, the Guttmacher Institute, and Intrahealth International.
25. <http://www.everywomaneverychild.org/commitments/>
26. In addition to providing a commitment text, all non-governmental commitment-makers filled out a commitment form and submitted it to the EOSG. Governments did not fill out these forms. For governments, the commitment text and other supplementary materials were assessed. The EOSG, which manages the application procedure, provided access to the commitment forms to PMNCH and the research team. The commitments are available on the EWEC and FP2020 websites. For the years 2015 and 2016, the content analysis builds on previous assessments conducted by SEEK Development for PMNCH. We thank SEEK for sharing the commitment data.
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31. There are also differences in the commitment-making for commitments made through FP2020.
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40. FP2020. Summary of Commitments. Accessed May 14, 2018. <http://summit2017.familyplanning2020.org/commitment.html>
41. Commitment-makers may have made multiple commitments to the *Global Strategy*.
42. The three subnational commitments are from Chinese provincial governments: Hubei, Sichuan, and Zhejiang. The national government of China also committed to the updated EWEC *Global Strategy* in 2015.
43. The percentages do not add up to 35% due to rounding.
44. Of these 68 countries, 15 were HICs, 25 LICs, 20 LMICs, and 8 UMICs.
45. These commitments were made by governments on the World Bank's "Harmonized List of Fragile Situations FY 18": Afghanistan, Burundi, Chad, Comoros, the Democratic Republic of Congo, Cote D'Ivoire, Eritrea, Haiti, Liberia, Mali, Mozambique, Sierra Leone, South Sudan, Sudan, Togo, and Zimbabwe.
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49. While many commitments were made by commitment-makers from Northern regions, like North America and Europe, the commitments usually target populations in low- and middle-income countries from Southern regions, such as sub-Saharan Africa and Southeast Asia.
50. Governments do not fill out commitment forms. For governments, the commitment text was coded to identify commitment types.
51. As with the commitment types, a formal commitment by a commitment-maker usually refers to multiple EWEC *Global Strategy* objectives, action areas, key indicators etc. As for the commitments types and all other results presented in the Section 3, the analysis was based on an assessment of commitment forms and the commitments text.
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54. WHO, UNAIDS, UNFPA, UNICEF, UN Women, The World Bank Group. Survive, Thrive, Transform. *Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): 2018 monitoring report: current status and strategic priorities*. Geneva: World Health Organization; 2018.
55. World Health Organization, Global Database on Child Growth and Malnutrition, at <https://data.worldbank.org/indicator/SH.STA.STNT.ZS>
56. GBD 2016 Risk Factors Collaborators. Global, regional, and national comparative risk assessment of 84 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet* 2017;390:1345–1422.
57. <http://www.who.int/en/news-room/fact-sheets/detail/household-air-pollution-and-health>
58. *Every Woman Every Child* and Partnership for Maternal, Newborn & Child Health. Progress in Partnership: 2017 Progress Report on the *Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health*. Geneva: World Health Organization; 2017 (WHO/FWC/NMC/17.3). Available at: [http://www.who.int/pmnch/activities/advocacy/globalstrategy/2016\\_2030/gspr/en/](http://www.who.int/pmnch/activities/advocacy/globalstrategy/2016_2030/gspr/en/)
59. This finding should thus not be interpreted as being representative for the broader trend in the global health community, which may still not give sufficient attention to adolescent health.
60. EWEC. *Global Strategy for Women's, Children's and Adolescents' health (2016–2030)*. New York: *Every Woman Every Child*; 2015. See also: WHO 2017: Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation. [http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/framework-accelerated-action/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/)
61. A recent study shows that in LICs and MICs, between 1970 and 2010, 14% of reductions in under-five mortality and 30% of reductions in adult female mortality can be attributed to gains in female schooling. Schäferhoff, M., Jamison DT et al. 2016: Estimating the Economic Returns of Education from a Health Perspective. Available at: <http://report.educationcommission.org/resources/>
62. The Data for Health initiative by Bloomberg Philanthropies has engaged with 20 countries to improve data collection and standardization for both birth and death statistics. The goal is to partner with governments in LICs and MICs to strengthen public health data and therefore improve policy decision-making and public health investments. Also, Horizon 2020, the biggest European Union's Research and Innovation program, funded the Research and Innovation Action MyHealthMyData. The initiative is poised to be the first open biomedical information network centered on the connection between organizations and individuals using Distributed Ledger Technologies (or Blockchain). See: <https://www.bloomberg.org/about/>; <http://www.myhealthmydata.eu/>
63. Schäferhoff, M., Jamison DT et al. 2016: Estimating the Economic Returns of Education from a Health Perspective. Available at: <http://report.educationcommission.org/resources/>
64. O'Mara-Eves A, Brunton G, McDaid D, et al. Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. Southampton (UK): NIHR Journals Library; 2013 Nov. (Public Health Research, No. 1.4.) Available from: <https://www.ncbi.nlm.nih.gov/books/NBK262817/> doi: 10.3310/phr01040
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67. This estimate is corrected for double-counting of financing across both commitment-makers (where a commitment from one commitment-maker draws on financing from the commitments of others) and time (where the value of a more recent commitment is subsumed within an earlier commitment made by the same commitment-maker). See also Appendix 1.

68. Thirteen LICs and LMICs have pledged to increase their public expenditure on health as a share of overall public expenditure to 15% by or before 2030, while others made commitments directly related to additional spending on more specific areas, such as family planning. HICs and non-governmental commitment-makers made financial commitments that spanned the spectrum of RMNCH through both bilateral and multilateral support.
69. An important caveat to this analysis is that many commitment-makers – especially non-governmental commitment-makers and those from the business community – do not publicly disclose the financial value of their commitments. This results in an underestimate of the total value of financial commitments, especially for non-governmental commitment makers. Figure 13 reports financial commitments only and does not display the relatively large pledge that the business community and CSOs & NGOs made in terms of non-financial commitments (47% and 39%, respectively, of an estimated US\$15.1 billion value). A discussion of the estimated value of non-financial commitments is included in Section 3.
70. The 2017 *Global Strategy* progress report estimated a total of US\$28.4 billion in financial commitments. Since the release of the 2017 report, WHO's Global Health Expenditure Database, the main source of data for the calculation of pledges by low- and middle-income, was updated. Because of this update and a reassessment of the 2015/16 commitments, the amount of the funding pledged between September 2015 and December 2016, increased.
71. The calculated 2017 funding includes all financial pledges made through FP2020 which completed the formal EWEC commitment-making process at the time this report is written (May 2018). As a few commitments have not fully completed the administrative process, the amount pledged at the FP2020 summit is higher than the amount reported here. An overview of FP2020 commitments made at the summit is available at: <http://progress.familyplanning2020.org/en/fp2020-and-global-partners/the-family-planning-summit-for-safer-healthier-and-empowered-futures>
72. Additionality is defined as funding pledged above baseline spending. For example, if a commitment-maker spent US\$100 million in 2015 (the baseline year for the EWEC *Global Strategy*), and commits to US\$120 million in 2016, US\$200 million is new and additional funding. See also Appendix 2 for more details.
73. Calculations of donor disbursements are based on OECD DAC data. The Muskoka methodology was used to calculate contributions to SRMNCH financing. Expenditure data for LICs and LMICs was collected through a review of financial documents; in addition, data for selected countries was shared by WHO and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, among others. Non-governmental commitment-makers provided disbursement data through the online survey.
74. More than US\$5.8 billion of this funding was disbursed by the US government – the largest RMNCH donor country.
75. These six countries are: Burkina Faso, India, Lesotho, Mozambique, Uganda, and Zimbabwe.
76. Global Financing Facility: business plan. Washington DC: World Bank; 2015 (<http://www.worldbank.org/en/topic/health/brief/global-financing-facility-business-plan>)
77. The Global Financing Facility: 2016–2017 Annual Report; see also: <http://www.imf.org/external/datamapper/datasets/WEO>
78. The 67 GFF countries are listed in Annex 1 of the GFF Replenishment document: [https://www.globalfinancingfacility.org/sites/gff\\_new/files/First-GFF-Replenishment-Documents-EN.PDF](https://www.globalfinancingfacility.org/sites/gff_new/files/First-GFF-Replenishment-Documents-EN.PDF)
79. Accelerated progress, more commitments, better aligned action across sectors and among all partners engaged in implementing the EWEC *Global Strategy*, and stronger mutual accountability mechanisms are all needed. In response to these needs, partners developed the 2020 EWEC Partners' Framework. See GSPR 2017, Chapter 3.
80. The number of survey respondents that reported they are active in each focus area is different than the number of people that the survey respondents reported reaching in each focus area. For instance, 32% of survey respondents (34) report implementing activities related to early childhood development. Eleven of these respondents also provided estimates of the number of people reached through their early childhood development activities, with reports ranging from 14,000 to 17.6 million.
81. This definition of "service delivery activities" was included in the EWEC Instructional Guide for the Annual Progress Reporting Questionnaire for Non-State Commitment Makers.
82. Black MM, Walking SP, Fernald LCH, Andersen CT, DiGirolamo AM, Lu C Grantham McGregor S. Early childhood development coming of age; science through the life course. *Lancet*. 2017. Vol 389, No. 10064, p77–90. [https://doi.org/10.1016/S0140-6736\(16\)31389-7](https://doi.org/10.1016/S0140-6736(16)31389-7)
83. Twelve commitment-makers provided estimates for the number of people reached but did not include estimates by target population. Many of these commitment-makers described reaching people across target populations. For instance, 3.3 million women of reproductive age and health providers were reached through programming to improve maternal health. In addition, 400,000 women, girls, and their communities were educated about their health rights.
84. PMNCH accountability reports are available at: <http://www.who.int/pmnch/activities/accountability/reports/en/>. See also: Commitments to the *Global Strategy for Women's, Children's, and Adolescents' Health – Focus and Progress in Implementation*. Supplementary materials to the *Global Strategy* Progress Report. Available at: <http://gsprogressreport.everywomaneverychild.org/wp-content/uploads/2017/07/PMNCH-2017-Supplementary-materials-SEEK-Final.pdf>
85. United Nations Global Strategy Finance Working Group. Background paper for the *Global Strategy for Women's and Children's Health*: Financial estimates in the Global Strategy. New York, UN, 2010.







For more information see:  
<http://www.who.int/pmnch/en/>