

Prioritising women's, children's, and adolescents' health in the post-2015 world

Lor Jougall and colleagues set out a three point agenda for strengthening advocacy: invest in multipartner national platforms for action; innovative communication circuits to unite advocacy; and multidonor funding mechanisms to scale up advocacy efforts

Since their adoption, the millennium development goals (MDGs) have played a crucial role in improving global health. The MDGs raised awareness of key priorities for health and development, stimulated policy and budget attention, and created a common agenda for action. Child health was prioritised by MDG 4 calling for a two thirds reduction of deaths in children under 5 years old, maternal health was promoted by MDG 5a calling for a three quarters reduction in maternal deaths by 2015, and the MDG 5b ambition was to ensure universal access to reproductive health. Despite significant progress, MDGs 4 and 5 will not be met. Other health goals, including MDG 6 (on HIV/AIDS, malaria, and tuberculosis) and MDG 1c (hunger), are marked by major gaps in progress for women and children.

Launched in 2010, the Global Strategy for Women's and Children's Health ("Global Strategy") has fuelled efforts to deliver the MDGs. The Global Strategy and the Every Woman Every Child advocacy movement have promoted collective action, joint messaging, and effective partnerships. These efforts have led to more money, improved policies and service delivery, and a new focus on accountability and multi-stakeholder partnerships (box 1).¹

To sustain progress beyond 2015, the Global Strategy is being updated to build on

KEY MESSAGES

Strengthening citizen led local action is core to the mission of advocacy and communication for the Global Strategy

Effective action requires investment in strong coordinating platforms among diverse stakeholders, led by respected champions

Building a robust investment case for advocacy requires greater attention to developing clear performance monitoring and evaluation indicators

Creating stronger advocacy partnerships within the health domain, and between health and other related sectors, is required to deliver the vision of the sustainable development goals

Advocacy is the process of bringing evidence and information to bear on the decision and ability to act in response to people's needs. Advocacy and communication shape opinion, crystallise common or shared thinking, mobilise action, and drive decision making. The result of advocacy and communication can be political will, the decision to mobilise resources, policy and planning, reprioritisation, and stronger accountability.

lessons learnt during the MDG era and to reflect the priorities of the new sustainable development goals to be adopted by governments in September 2015.

How did women's and children's health rise on the global agenda, and what can be learnt about how to sustain attention beyond 2015? What was the role of advocacy and communications in framing and communicating evidence, highlighting solutions and results, promoting joint action, and enabling voice and action among women, youth, families, and communities?

Applying Shiffman's health policy analysis framework of stakeholder power, ideas, context, and issue characteristics (table),⁷⁻⁹ we look at the experience of Every Woman Every Child during the past five years as a key factor in explaining the rise in prominence of these issues. Going forward, we consider how the updated Global Strategy can improve its performance as an advocacy

instrument for women's, children's, and adolescents' health, and then set these findings against an analysis of gaps and challenges, which inform the main section of this paper. We conclude with a three point agenda for action for advocacy and communications in the updated Global Strategy.

Methods

In the following sections, we summarise the findings of three qualitative approaches used to better understand the role and impact of the updated Global Strategy for Women's, Children's and Adolescents' Health, as well as lessons learnt from the initial years of the Global Strategy (2010-15). The first approach was a global stakeholder consultation process in late 2014 and early 2015 that captured the views of 4550 respondents.¹⁰ The second was to synthesise the views and conclusions from three teleconferences held during February

BOX 1: EVERY WOMAN EVERY CHILD: A JOINT PLATFORM FOR ACTION

In 2010, there was a high degree of consensus and commitment among stakeholders in reaching the 2015 millennium development goals (MDGs). There was a concentration on a "continuum of care" approach—in which reproductive, maternal, newborn, child, and adolescent health are understood to be inextricably linked—enhanced by integrated care across the life cycle and from home to hospital. A positive message of, "Progress is possible, it pays to invest" was adopted by partners based on best available evidence of epidemiological and economic progress. In an increasingly global public health environment of private-public alliances, the Every Woman Every Child movement was launched by UN secretary general Ban Ki-moon as a common advocacy platform for diverse stakeholders to work together to implement the Global Strategy for Women's and Children's Health and the MDGs.

The pay-off has been substantial: by 2014, there were more than 300 commitments from a diverse range of stakeholders (figure) through the Every Woman Every Child platform—a threefold increase from the launch in 2010.³⁻⁵ Financial pledges have risen to nearly \$60bn, with many additional, uncosted commitments aimed at strengthening policy, service delivery, and advocacy.² The Global Strategy has drawn attention not only to more resources, but to better use of those resources, brokering agreement on cost effective interventions, integrated efforts for scaling up, innovation, and joint funding channels.⁵

Such global campaigns can be a timely "hook" for stimulating national dialogue and brokering consensus about priorities and resources. They can also be a promise of greater external coordination and resource exchange, as well as an aid to mobilising new commitments among global stakeholders. For example, the G8 Muskoka Declaration in June 2010 of an additional \$5bn for maternal and child health⁶ paved the way to a successful launch of the Global Strategy for Women's and Children's Health in September 2010, which itself built on years of active health advocacy and increased visibility for maternal health issues.

Framework of determinants for political priority for the Global Strategy for Women's and Children's Health (2010-2015)

Description	Factors shaping political priority
Stakeholder power —The strength of the individuals and organisations concerned with the issue	Policy cohesion, leadership, guiding institutions, mobilisation of civil society—The EWEC movement, championed by UN secretary general Ban Ki-moon, brings together reproductive, maternal, newborn, child, and adolescent health stakeholders working through coordinating platforms such as the H4+ multilateral agencies, PMNCH (including more than 400 NGO members), Women Deliver, the Network of Global Leaders, and the Global Campaign for the Health MDGs.
Ideas —The ways in which those involved with the issue understand and portray it	Positioning within the health sector and among health and related sectors—The adoption of a RMNCAH “continuum of care” conceptual model has facilitated consensus across diverse policy constituencies, including governments, NGOs, health professionals, donors, private business, the UN, and academia. Positioning is important to ensure women's and children's health is seen as a human right as well as a determinant, outcome, and indicator of economic, social, and political development.
Political contexts —The environments in which stakeholders operate	Policy windows, global governance structure, convening and driving the process—The 2015 MDG framework, with twin goals on maternal and child health, opens policy window for urgent action. The Global Strategy legitimised as an agenda for national and regional action through inter-governmental resolutions and communiqués (UN 2010, World Health Assembly 2011, UN Human Rights Council on maternal mortality 2011, Inter-Parliamentary Union 2012) and frameworks (African Union integrates Global Strategy into policy frameworks, building on Maputo Plan of Action for SRHR, CARMMA, and Abuja Declaration).
Issue characteristics —Features of the problem	Credible data, evidence of gaps (severity of the problem), effective interventions available—Robust evidence on causes, solutions, trends, and gaps increasingly available through a wide range of sources, including Countdown to 2015, UN reports, <i>Lancet</i> special series, and others. Multi-stakeholder consensus on effective interventions brokered at global level, offering clear policy directions.

EWEC=Every Woman Every Child. PMNCH=Partnership for Maternal, Newborn & Child Health. NGO=non-governmental organisation. MDG=millennium development goal. RMNCAH=reproductive, maternal, newborn, child and adolescent health. SRHR=sexual and reproductive health and rights. CARMMA=Campaign for Accelerated Reduction of Maternal Mortality in Africa.

and March 2015 with advocacy leaders of the women's and children's health community and those who contributed to the Global Strategy consultation process. Thirdly, we conducted a literature search on definitions, theories, and examples of successful advocacy and communications practice as well as relevant conceptual frameworks for agenda-setting and issue-framing. The literature search enabled us to expand on the findings of the expert consultations and triangulate our own observations.

Problems

The implementation of the Global Strategy has been marked by challenges that have inhibited civic leadership and national ownership, and implementation of the top priorities identified within the strategy itself. Three of these challenges are discussed.

Lack of awareness and ownership of national commitments

While engagement with the Global Strategy has been consistently strong among global level stakeholders, at the country level it has been more variable. For example, in the first consultation report on the 2010-15 Global Strategy published in January 2015, respondents at country level commented that lack of country engagement with the Global Strategy was an important limitation (see www.womenchildrenpost2015.org). Important national stakeholders, including parliamentarians, have been unaware of pledges made by their country. This has inhibited their ability to engage with relevant policy and budget planning.

Many national stakeholders lack access to relevant platforms for policy dialogue and information sharing. Sub-national and national accountability systems, if rigorously monitored and connected to global

processes, are critical for ensuring monitoring, review, and remedial action. Civil society coalitions at sub-national, national, regional, and global levels can gather evidence for multi-stakeholder review processes and recommend remedies (see box 2). A large scale stakeholder survey on the Global Strategy (April 2015) found that more than 80% of respondents thought that global accountability did not affect country level processes. This indicates a clear role for local, citizen led processes.¹⁰

Stronger monitoring and evaluation for advocacy impact

Effective advocacy is the product of a complex mix of actors, context, and opportunity, making the impact of individual contributions difficult to measure.¹¹ Even so, advocates benefit from robust monitoring and evaluation approaches to assess progress and improve practices.⁴ Two specific prob-

BOX 2: STAKEHOLDER POWER DRIVES ISSUE ATTENTION: CITIZEN LED COALITIONS

Tanzania

The White Ribbon Alliance for Safe Motherhood Tanzania united civil society members, health professionals, academics, donors, and UN partners in a three year (2013-15) campaign to improve access to comprehensive emergency obstetric and newborn care (CEmONC) at health centres and with the help of qualified health workers. The campaign calls for a specific budget line item with funds for CEmONC in Tanzania's council health plans. As a result of tactical outreach aimed at communicating the gaps in access to CEmONC and its major causes (poor financing for CEmONC), media campaigning, and one-on-one meetings with key champions, the prime minister of Tanzania on the White Ribbon Day (15 March 2014) gave a directive that all councils establish a budget line for CEmONC with funds to ensure that these lifesaving services are available at health centres. The campaign has also yielded a petition on CEmONC signed by 16 428 citizens and 96 members of parliament.

Nigeria

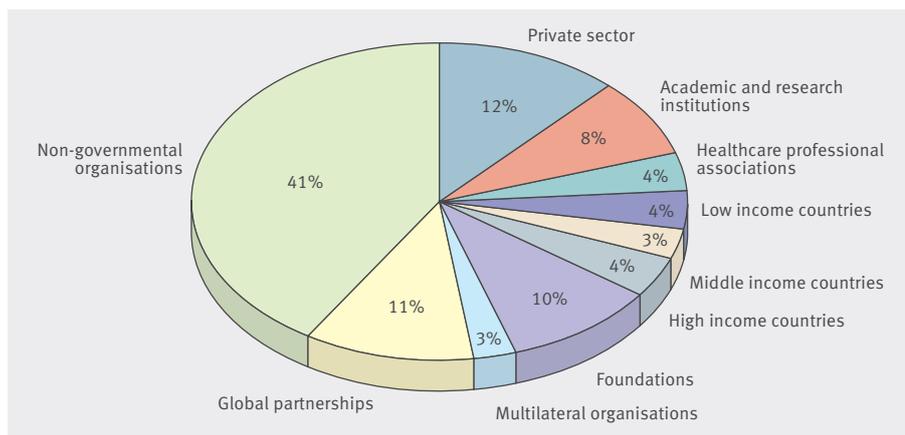
In support of improving accountability and aid alignment, including in relation to maternal and child health, CHESTRAD International and the IHP+Results Consortium worked with Nigeria's Senate Committee on Appropriations and the National Planning Commission to document the flow of official development assistance (ODA) into health and education and recommend improvements in managing aid flow. This report led to a parliamentary multi-stakeholder dialogue hosted by the Senate and Nigeria's Federal Ministry of Finance and the National Planning Commission, with participation from development partners and civil society. The dialogue resolved to better align ODA flows with appropriation processes, expand efforts at inclusive national budgeting and transparency, and establish a civil society aid effectiveness and accountability fund. This process also catalysed the creation of a new parliamentary committee on coordination and engagement with development partners in Nigeria.

Data sources:

Partnership for Maternal, Newborn & Child Health. *Progress report. Budget advocacy for improved women's and children's health: experiences from national civil society coalitions*. 2013. www.who.int/pmnch/media/events/2013/progress_report.pdf?ua=1

Statement: parliamentary stakeholder dialogue on aid effectiveness and results. National Assembly Complex, Abuja, Nigeria 16-17 May 2011. www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Nigeria/StatementParliamentaryDialogue-25.05.2011.pdf

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Advocacy commitments for the Global Strategy for Women's and Children's Health by constituency (data from the PMNCH 2013 report²)

lems (both vital ingredients for success) are, firstly, the availability of adequate data and evidence with which advocates can take action and, secondly, robust methods for tracking advocacy impact.

Data and evidence—While the MDGs and the Global Strategy have been useful tools for advocacy, the lack of costed implementation plans and consolidated mechanisms for tracking resources and results have hampered its effectiveness. Greater transparency of government data and information, supported by stronger national data collection systems, will benefit advocacy efforts, as would greater emphasis on community based efforts to improve accountability. Examples of this policy effort are the national and sub-national “citizen hearings” bringing stakeholders and policymakers together in policy dialogue (see also: <http://whiteribbonalliance.org/campaigns/citizens-hearings-2015/>).¹²

Tracking impact—In regard to evaluating the effect of advocacy, the lack of standard indicators, processes, and structures for monitoring and reviewing the Global Strategy and Every Woman Every Child has hindered efforts to improve quality and impact. It has also made it more challenging to build an investment case for advocacy. For example, while it is relatively simple to measure “interim” or “process” indicators, such as the number of commitments made or media hits (box 3), it is often difficult to determine the extent to which a particular activity by a particular stakeholder or coalition contributes to broader national impact on policies or budgets.

Scaling financing for advocacy

Underfunding remains a barrier to successful advocacy. A recent survey of civil society organisations in Africa indicated that lack of financing was the most commonly cited barrier

to participating in multi-stakeholder platforms for reproductive, maternal, newborn, child, and adolescent health (see, for example, <http://chestrad-ngo.org/communications/publications-reports/>). Yet relatively few donors fund such advocacy, especially at national level. Governments often prefer not to make investments that could put them in the “line of fire.”

A review of progress of Global Strategy commitments made between 2010 and 2013 found that reproductive, maternal, newborn, and child health organisations were often understaffed. This resulted in a limited capacity for advocacy because of poor staff training and reluctance by donors to fund advocacy and related staff positions. The financial crisis of 2008 and the subsequent poor economic climate further destabilised funding for advocacy and thus the ability of partners to conduct advocacy.²

Priority actions

Successful advocacy in the post-2015 era will depend on the ability to identify how investments can deliver multiple goals across sectors, including in complex settings such as during a humanitarian emergency or conflict, where ill health is disproportionately clustered. This section sets out a three point agenda for effective advocacy and communications around the Global Strategy beyond 2015.

Invest in national multi-stakeholder platforms for advocacy and accountability
Uniting partners with disparate skills, disciplines, epistemic traditions, and networks for joint advocacy and providing these advocacy networks with timely information about commitments is critical to ensuring the implementation of the Global Strategy. This requires investment in leadership, coordination, and communication skills at all levels.

In 2012-13, for example, the Partnership for Maternal, Newborn & Child Health provided a small level of support for national coalitions of civil society organisations in 10 countries. This enabled joint advocacy and improved accountability, including for national commitments to the Global Strategy. In most of the participating countries, these are the first coalitions of civil society organisations to cover the entire continuum of care from preconception to child and adolescent health. The partnerships have resulted in a number of innovative approaches, such as a joint advocacy toolkit in Tanzania to increase the enrolment of youth in midwifery training; in Ghana, Indonesia, and Uganda, voluntary contribution schemes have been created to cover the cost of alliance activities.¹³

The most successful of these coalitions have established relationships with parlia-

BOX 3: MEASURING MEDIA IMPACT: BORN TOO SOON

Media advocacy can promote consensus on framing and solutions, generate attention on policy, and prompt united action among different stakeholders. An example is the 2012 launch of Born Too Soon: The Global Action Report on Preterm Birth, which highlighted preterm birth as the leading cause of newborn mortality. A communications campaign coordinated by the Partnership for Maternal, Newborn & Child Health brought together more than 50 partner organisations to advocate for attention to preterm birth. This included civil society groups such as the March of Dimes, corporations such as Johnson & Johnson, and health professional groups such as the International Paediatric Association, the International Confederation of Midwives, and the International Federation of Gynecology and Obstetrics.

The campaign reached an estimated media audience of 1.1 billion through the *Hindu*, the Xinhua news agency, the front page of the *New York Times*, and others. This was complemented by a television advert on CNN International with celebrity singer and parent Celine Dion, as well as a global Twitter “relay” and an interactive map on which Facebook members could “pin” their own stories of preterm birth. In total, Born Too Soon resulted in more than 30 new Every Woman Every Child commitments to preterm birth and newborn health. It catalysed the expansion of World Prematurity Day, with events in 70 countries in 2014. It also set the foundation for a broader policy effort, the Every Newborn Action Plan, supported by a resolution by 194 member states of the World Health Assembly in 2014.

Data sources:

March of Dimes, Partnership for Maternal Newborn & Child Health, Save the Children, World Health Organization. *Born Too Soon: the global action report on preterm birth*. WHO, 2012.

Howson CP, Kinney MV, McDougall L, Lawn JE. Born Too Soon: preterm birth matters. *Reprod Health* 2013;10:S1.

BOX 4: IDEAS DRIVE ATTENTION TO ISSUES: LONDON SUMMIT AND FP2020

Family planning was framed in the Global Strategy as an important issue for investment and policy, creating a new hook for advocates to align and take action. A good example of this is the Family Planning 2020 (FP2020) initiative, which has emerged from the London Summit on Family Planning in 2012. The summit gained commitments from more than 20 governments and donor funding of \$2.6bn, elevating political commitment to modern contraceptives and reproductive health in support of the wider remit of the Global Strategy. Since 2013, more than \$1.3bn has been disbursed for family planning programmes. This has resulted in more than 8.4 million extra girls having access to modern contraception and at least 77 million unintended pregnancies avoided. The FP2020 example illustrates how global and national health advocacy fosters and builds on widespread agreement on the urgency of an issue.

Data source: Family Planning 2020 (FP2020). www.familyplanning2020.org.

ments and the media. In many countries in Asia and Africa, private media are a major growth industry. The media can be a powerful platform for voice and accountability, capturing public energy and anger, and shifting cultural norms. Yet, too often, the media are seen as a target for pre-packaged public relations campaigns and not as viable partners with essential networks and skills. Investment in partnerships with leading national and regional media networks, especially those focused on young media consumers, is an essential area for development. Social and behavioural change campaigns that stimulate positive individual behaviours, as well as positive changes within policy environments, are important ways of promoting community health and improving policy impact.¹⁴

Beyond 2015, these advocacy networks will need to integrate partners from health enhancing sectors, including those engaged in education, women's political and economic participation, access to clean water and sanitation, poverty reduction, and economic growth in line with the evidence of the importance of these sectors on health.¹⁵

Build digital platforms for knowledge and action

Advocacy operates in real time. National, regional, and global advocacy coalitions require timely, cost effective information "circuits" to source new evidence for action and to identify new opportunities for advocacy.

Improving the circulation of information increases the effectiveness of transnational advocacy. This is likely to be especially true beyond 2015, as the number and distribution of partners seeking to collaborate across sectors increases. Regional platforms can provide relevant support in this process. For instance, the African Union/CARMMA (Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa) has developed scorecards of indicators and a user friendly online database of indicators, helping member states track progress towards regional commitments such as the Maputo

Plan of Action on Sexual and Reproductive Health and Rights and the Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (see Africanhealthstats.org and <http://carmma.org/scorecards> for more information). When geared to local needs and priorities, and properly promoted for use, innovative web and mobile phone based approaches hold much promise, including in relation to advocacy, communication, and coalition development.¹⁰

Build flexible, multidonor funding mechanisms for advocacy

Effective advocacy requires reliable yet flexible financing to capture sudden and unexpected opportunities as well as to address longer term strategic goals. In the past, donor funding for advocacy has too often prioritised individual strategic plans, missing an opportunity to invest in broad based coalitions supporting collective goals. Recent promising efforts include the multidonor "Amplify Change" fund for sexual and reproductive health and rights, as well as support to the Every Woman Every Child movement from such donors as the Bill & Melinda Gates Foundation, Canada, Norway, and the Rockefeller Foundation.

Experience from the global nutrition community also bears out the benefits of pooled financing mechanisms. For example, pooled donor funding for civil society partners as part of the multipartner trust fund for the SUN (Scaling Up Nutrition) movement has enabled greater coordinated action. Of the 33 established and active SUN civil society alliances in countries, 27 are funded through this trust fund or by bilateral donors (see <http://scalingupnutrition.org/the-sun-network/civil-society-network>).

In line with the goals of Every Woman Every Child, the new Global Financing Facility (GFF)¹⁶ is designed to encourage increased commitments of domestic resources for health.¹⁷ This is a promising development, requiring multipartner domestic budget advocacy, including with media and parliamentarians, to mobilise and sustain domestic allocations for

health. Without such national and sub-national advocacy, the GFF ambitions are unlikely to be fully realised. It is important, therefore, for the GFF facility to support national advocacy, both in principle and in fact.

Conclusion

Advocacy and communication matter not for their own sake but because they are essential in facilitating the social and political pact that drives forward the Every Woman Every Child movement.

There are important lessons from the recent Global Strategy experience, especially in promoting country ownership and engaging with national and regional policy processes. Stronger evidence is needed about what works in advocacy, why it works, and how to measure and improve advocacy in the future. The updated Global Strategy provides an opportunity to further that learning and apply new techniques.

Going forward, advocacy success must be measured not by the quantity of global commitments taken in the name of citizens and countries, but the extent to which people themselves demand to be at the centre of the dialogue, insisting on their right to monitor, review, and act upon that to which they are entitled.

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