Strategic Plan 2016 - 2018

Contents

Women and Children First – who we are and what we do

Of the more than 130 million pregnancies and births occurring each year, an estimated 303,000 result in the mother's death, 2.6 million in stillbirth and another 2.7 million in a newborn death.[1] Almost six million children die before the age of five[2] and 70,000[3] adolescents[4] die from pregnancy related causes. The majority of these fatalities occur in poor communities in developing countries and are largely avoidable.

Women and Children First is an international development organisation dedicated to addressing these issues. Established in 2001, the charity has an excellent 15-year track record of providing technical support and assistance to partners to deliver projects which have a proven impact on maternal and newborn health.

Women and Children First works primarily in poor rural communities in Africa and Asia to improve the health of women, children and adolescents.

We support the formation and facilitation of women's groups using a participatory learning and action approach that empowers communities to take action to improve reproductive, maternal, newborn, child and adolescent health

Participatory Learning and Action

Participatory Learning and Action is inspired by a commitment to the participation of people in health care after the Alma Ata Declaration (1978) and draws on Paolo Freire's work[5] that provides insights applicable to health:

- many health problems are rooted in powerlessness and can be addressed by social and political empowerment;
- health promotion is more empowering if it involves dialogue and problem solving, rather than message giving;
- communities can develop critical consciousness to recognise and address the underlying social and political determinants of health.

Women's groups empower communities, particularly women, to take action by facilitating members through a four-phase participatory learning and action cycle of meetings. In Phase 1 groups identify and prioritise problems during pregnancy, delivery and postpartum. In Phase 2 they plan and in Phase 3 they implement locally appropriate strategies to address the priority problems. In Phase 4 they assess their activities.

We also promote improvements in the quality and accessibility of reproductive, maternal, newborn, child and adolescent care provided in health facilities; and support our partners to advocate at local and national level to strengthen policies and provide adequate resources for reproductive, maternal, newborn child and adolescent health.

[1] WHO 2015

[2] WHO 2015

[3] UNICEF 2009

[4] WHO defines adolescents as aged 15-19 years of age

[5] Pedagogy of the Oppressed (1968)

Funding for Women and Children First's work comes from a range of sources including the UK government, the World Health Oorganisation, the UK national lottery, charitable trusts, corporate supporters and individual donors.

Vision, Mission and Values

Women and Children First's **Vision** is an equitable world where all women, children and adolescents have good health.

Women and Children First's **Mission** is to improve reproductive, maternal, newborn, child and adolescent health where inequalities exist.

Our contribution to sustainable development is achieved by empowering women and their wider communities and building the capacities of health care workers and decision-makers, to address the determinants of reproductive, maternal, newborn, child and adolescent health.

Women and Children First **values**:

Collaboration

- We respect and value each other, thrive on our diversity, and work to empower partners and communities to make a difference in the lives of women, children and adolescents.

Rights

- We understand that health for women, children and adolescents is an issue of social justice. We believe all women and girls have the right to make their own decisions and control their own lives and those of their children.

Excellence

- We are demanding of ourselves and our colleagues, use evidence to inform our work, set challenging goals and are committed to improving the quality of everything we do for women, children and adolescents.

Accountability

- We take personal responsibility for using our resources efficiently, achieving measurable results, and being accountable to supporters, partners and, most of all women, children and adolescents.

Integrity

- We aspire to live the highest standards of personal honesty and behaviour; we never compromise our reputation and always act in the best interests of women, children and adolescents.

The issues Women and Children First addresses

Although maternal and child survival have improved markedly during the Millennium Development Goal era (2000 – 2015), Millennium Development Goals 4 and 5 remain mostly unfulfilled and maternal, newborn and child mortality rates remain unacceptably high.

Key facts about maternal and newborn mortality[6]

- The global maternal mortality ratio has fallen around 45 per cent over the past two decades, but about 303,000 women still die each year in pregnancy and childbirth.

[6] Countdown to 2015, 2015

- The majority of maternal, newborn, child and adolescent deaths occur in poor rural communities in developing countries.
- Adolescents face a high risk of complications and death as a result of pregnancy. About 70,000 adolescent girls die annually from complications during pregnancy. Maternal mortality is the leading cause of deaths among adolescents in Africa and the second leading cause worldwide.
- Two decades ago stillbirths were not visible as a public health problem, but recent estimates show a major burden of 2.6 million third-trimester stillbirths per year – 1.2 million of them during the intrapartum period.
- Global under-five mortality has fallen by 53 per cent since 1990, but almost six million children die before the age of five. Newborns account for 45 per cent of these deaths.

Key facts about the factors which contribute to maternal and newborn mortality

The factors which contribute to high levels of maternal and newborn mortality are complex. Within the overarching political and socio-economic systems which affect everyone's lives, cultural norms and values, individual health status and access to quality health services can all impact on maternal and newborn mortality:

- Poverty and gender inequality act as barriers or filters and mediate an individual woman's ability to translate demand for healthcare into effective use of health knowledge and services.
- Nutrition is crucial and almost half of child deaths are attributable to undernutrition.[7]
- Intimate partner violence and sexual violence, experienced by 35 per cent of women globally, can lead to induced abortions, gynaecological problems and sexually transmitted infections etc.
- Between 2003 and 2009 more than 50 per cent of maternal deaths worldwide were due to haemorrhage, hypertensive disorders and sepsis.
- Preterm birth complications and other neonatal causes account for 45 per cent of deaths among children under five years of age. Other causes of deaths include pneumonia (16 per cent), diarrhoea (9 per cent), malaria (5 per cent) and AIDS (1 per cent).[8]
- Coverage of most interventions, such as sexual and reproductive health information and services, access to safe abortion, prevention of mother to child transmission of HIV and management of maternal and newborn complications remains low. They fail to reach one third or more of the women and children who need them, predominantly the poorest. Services requiring an effective health system have least coverage.

Key facts about the solutions

- The majority of maternal, newborn and under-fives' deaths are preventable through proven interventions from pre-pregnancy to childhood.
- High equitable coverage of these interventions can be achieved through actions including mobilising communities, improving health systems and financing, and promoting supportive policies. This is in line with the World Health Organisation (WHO) Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) that promotes community engagement, health system resilience, financing for health and country leadership.

The new global **Sustainable Development Agenda** for 2016-2030 comprises 17 Goals. In line with its core strengths, Women and Children First will focus on two Goals:

[7] Countdown to 2015, 2015
[8] Countdown to 2015, 2015

Goal 3 – Promote healthy lives and wellbeing for all at all ages. Targets include ensuring universal access to sexual and reproductive health-care services, reducing global maternal death rates and ending the AIDS epidemic by 2030.

Goal 5 – Achieve gender equality and empower all women and girls. Targets include the elimination of all forms of violence against women and girls, the end of all forms of gender-based discrimination, and the elimination of harmful practices such as child marriage and female genital mutilation (FGM). It also calls for ensuring universal access to sexual and reproductive health and reproductive rights.

Women and Children First's work will make a direct contribution to the following Sustainable Development Goal targets:

- **Target 3.1** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- **Target 3.2** By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births.
- **Target 3.7** By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- **Target 5.6** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

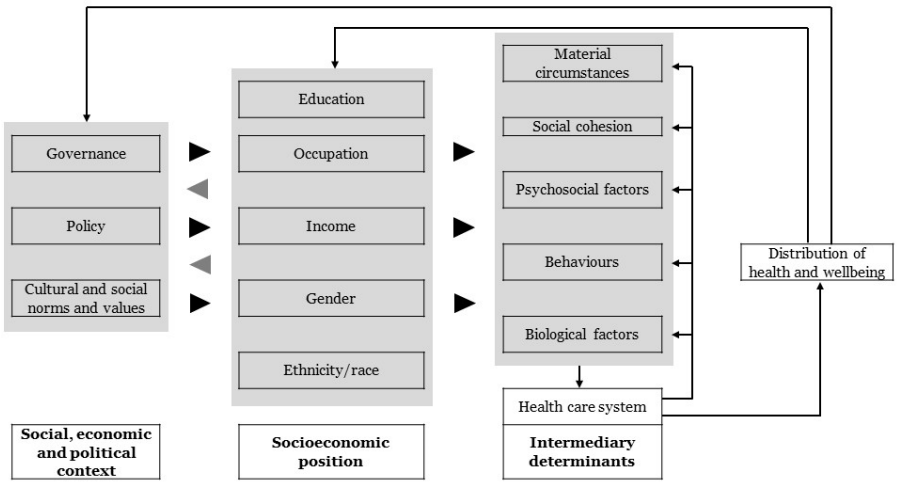
Women and Children First's work will also contribute to:

- **Target 3.3** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- **Target 5.2** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
- **Target 5.3** Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

Women and Children First's theory of change

The social-determinants model of health[9] helps to explain why the poorest of the poor have the worst health.

[9] Solar and Irwin, 2010



The model illustrates how the social and political contexts within which people live divide society into social strata. This stratification determines the degree of people's vulnerability to the specific determinants of health status which mediate the ability of women, children and adolescents to survive and thrive.

Women and Children First seeks to improve the ability of women, children and adolescents to survive and thrive. It does this through supporting action by women, communities, health workers, policy makers and decision-makers on the social and political contexts which stratify people and the specific determinants of their health status.

Social and political contexts in which people live

These are complex, macro-level issues which require sophisticated multi-sectoral responses from a range of stakeholders. They include:

1) **Governance**: processes of governance at the global, national and local level.
2) **Policy:** global and national economic, social and public policies.
3) **Cultural and societal norms and values:** biases, norms and values within society.

Women and Children First's approach makes a contribution by empowering communities and building the capacities of health workers and decision-makers to take action to transform these contexts, thus enabling women, children and adolescents to survive and thrive.

Specific determinants of health status

These are the direct and indirect drivers of reproductive, maternal, newborn, child and adolescent health. They include:

1) **Behavioural factors:** this includes care (e.g. maternal and newborn home-care practices, nutrition) and care-seeking behaviours (e.g. antenatal care, skilled birth attendance, postnatal care).
2) **Biological factors:** this includes genetic factors and health status.
3) **Health-care system:** this includes the quality and accessibility of health services.
4) **Material circumstances:** this includes factors such as housing and neighbourhood quality consumer potential and the physical work environment.

5) **Social cohesion**: this includes the distance between social strata and the level of solidarity and community spirit.
6) **Psychosocial factors:** this includes psychosocial stressors, stressful living circumstances and relationships, and social support and coping styles, or lack thereof.

Women and Children First's approach empowers communities, particularly women, and builds the capacities of health workers and decision-makers, to take action to address these specific determinants of reproductive, maternal, newborn, child and adolescent health and thus enable women, children and adolescents to survive and thrive.

Women and Children First's approach

Our target groups are girls and women (aged 10 - 49 years), particularly those who are pregnant or new mothers, newborns, and children under five years of age.

Our priority is to work in settings where inequalities exist in reproductive, maternal, newborn, child and adolescent health.

We focus on enabling women, children and adolescents to survive, thrive and transform their lives:

- Survive – our work reduces maternal, newborn and under-five mortality and the prevalence of HIV, TB and malaria
- Thrive – our work seeks to reduce malnutrition, promoting universal access to sexual and reproductive health-care services and rights, good quality early childhood development for girls and boys and universal health coverage
- Transform – our work contributes to eradicating extreme poverty, eliminating harmful practices and discrimination and violence against women and girls and achieving universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene.

Based on our theory of change, our approach encapsulates three interdependent components:

1. Community mobilisation through women's groups

Our women's groups approach is recommended by WHO[10] as an effective intervention to improve maternal and newborn health, particularly in rural settings with low access to services. Scale up of women's groups has been endorsed as a key approach under the Every Newborn Action Plan[11], a global roadmap for reducing preventable newborn mortality. It also has the potential to promote community engagement, a key action area under the WHO Global Strategy for Women's, Children's and Adolescents' health (2016-2030).[12]

Working in collaboration with the WHO, we have developed a training course for community health workers to deliver the women's groups approach.

In addition to its proven effect on maternal and newborn survival, we believe that the women's groups approach has the potential to help children under-five and adolescents to survive and women, children under-five and adolescents to thrive. In addition to its proven effect in rural

[10] WHO, 2014
[11] WHO and UNICEF, 2014
[12] WHO, 2016

settings we believe the approach has potential to also bring benefits to these groups in urban settings.

2. Health system strengthening
We support health system strengthening to develop the capacity of health workers to plan, manage and deliver high-quality reproductive, maternal, newborn, child and adolescent healthcare that is equally accessible across communities.

3. Policy and advocacy to create an enabling environment
We deliver and support advocacy to influence the policies and practice of governments and international institutions to improve reproductive, maternal, newborn, child and adolescent health.

Strategies

We have six strategies which will work towards achieving our Mission and contribute to the Sustainable Development Goals.

Strategy 1:

- **Increase the scale and impact of our work to improve maternal and newborn health**

We will draw on the existing evidence base to support partners by leveraging funding and providing technical assistance to implement women's groups to promote maternal and newborn survival in rural settings with low access to services.

We will work with our implementing partners to improve the quality and accessibility of reproductive maternal, newborn, child and adolescent care provided by health facilities in our programme catchment areas. This will be achieved by improving the knowledge and skills of healthcare staff, including midwives and community healthcare workers. Together, with our partners, we build capacity to support human resource and referral systems at district level.

Strategy 2:

- **Increase the scale and reach of the women's groups approach by providing Technical Assistance to other organisations**

We will train and support NGO and Government staff to successfully deliver the women's groups approach to improve reproductive, maternal, newborn, child and adolescent health in rural and urban settings.

Strategy 3:

- **Build southern partners' capacity to influence policies and funding for reproductive, maternal, newborn, child and adolescent health**

We will build the capacity of our partners to use their programmatic evidence to advocate for change at community, district, regional and national levels. These advocacy efforts may include research, policy analysis, lobbying and networking to create formal policy changes, drive implementation or create an enabling environment for reproductive, maternal, newborn and adolescent health change. Our ultimate goal is to ensure that services are appropriate, accessible and affordable to users.

Strategy 4:

- **Innovate and evaluate the women's groups approach**

We will work with partners to innovate and evaluate the effectiveness of the women's group approach on: maternal and newborn survival in urban settings, the survival of children under-five in rural and urban settings, and the ability of women, children under-5 and adolescents to thrive in rural and urban settings.

Strategy 5:

- **Ensure the required financial resources are in place to deliver the plan**

We will develop and deliver financial and fundraising strategies which will ensure we secure and manage the financial resources required to deliver strategies 1 - 4.

Strategy 6:

- **Ensure optimum human resource is in place to deliver the Strategic plan**

We will ensure staff knowledge, skills and expertise are appropriate to deliver annual plans.

Strategic Framework - SMART Objectives and Indicators

Strategy	Objectives	Indicators	Means of verification
1. Increase the scale, impact and quality of our work to improve maternal and newborn health	1.1 Each year, manage 8 grants with partners and support them to manage 1,200 women's groups attended by 36,000 group members.	Annually: ▪ Number of grants managed ▪ Number of women's groups established by grant partners ▪ Number of members registering with women's groups established by grant partners	Project dashboards
	1.2 By the end of 2018 improve 4+ ANC, SBA and 48hr PNC by an average of 10 per cent, 10 per cent and 10 per cent respectively	▪ Average percentage change in 4+ ANC attendance ▪ Average percentage change in SBA attendance ▪ Average percentage change in PNC attendance within 48 hours	Project dashboards
	1.3 On an ongoing basis meet all donor requirements on all grants regarding: narrative and financial reporting; communications, disbursement of funds, etc.	▪ Donor reports submitted on time ▪ Positive feedback on donor reports ▪ Donor's confirmation of projects closed to their satisfaction	Donor report calendar Donor report and final feedback
2. Increase the scale and reach of the women's groups approach by providing Technical	2.1 By Dec 2016 have in place a pool of 5 people and by the end of 2018 a pool of 10 people with the knowledge, skills and ability to develop and deliver the technical assistance service	▪ Number of staff, trustees and consultants trained to deliver technical advice	▪ Training reports/registers

Strategy	Objectives	Indicators	Means of verification
Assistance to other organisations	2.2 By the end of 2018 a pool of 12 regional trainers trained	▪ Number of regional trainers trained to deliver technical advice	▪ Training reports/registers
	2.3 By end of 2016 finalise the development of the WHO PLA group training course and related materials	▪ PLA group field-test completed in Bangladesh and Uganda and signed off by WHO ▪ Training course materials (manuals and films) finalised and signed off by WHO	▪ Field test reports ▪ Training course materials
	2.4 By end of 2016 a business plan to market the women's groups approach in place	▪ Business plan developed	▪ Business plan
	2.5 By end of 2018 deliver 12 technical assistance contracts to partners to establish 900 women's groups and recruit 27,000 group members	▪ Number of technical assistance contracts delivered ▪ Number of women's groups established by technical partners ▪ Number of members registering with women's groups established by technical partners	▪ Partner MEL systems
3 Build southern partners' capacity to influence policies and funding for reproductive, maternal, newborn, child and adolescent health	3.1 All projects will contain a clear focus on building advocacy capacity (ongoing)	▪ Every project which has an advocacy element has an advocacy strategy in place ▪ Project records show that advocacy milestones have been achieved ▪ Project learning disseminated and used to inform advocacy messaging	▪ Project advocacy strategies

Strategy	Objectives	Indicators	Means of verification
4 Innovate and evaluate the women's groups approach	4.1 By end of 2018, taken 2 opportunities to evaluate innovations of the women's group approach on maternal and newborn mortality in urban settings.	▪ Number of opportunities taken including – new projects, operational research within existing projects and evaluation of TA projects	▪ Women's group innovation design reports ▪ Evaluation reports
	4.2 By end of 2018, taken 2 opportunities to evaluate innovations of the women's group approach on under-5 mortality in rural and/or urban settings.	▪ Number of opportunities taken including – new projects, operational research within existing projects and evaluation of TA projects	▪ Women's group innovation design reports ▪ Evaluation reports ▪ Operational research reports
	4.3 By end of December 2018, taken 2 opportunities to evaluate innovations of the women's group approach on the ability of women, children and adolescents to thrive in rural and/or urban settings.	▪ Number of opportunities taken including – new projects, operational research within existing projects and evaluation of TA projects	▪ Women's group innovation design reports ▪ Evaluation reports
5 Ensure the required financial resources are in place to deliver the plan	5.1 Financial plan for the full strategic framework period in place by October 2016	▪ Funding streams and potential for income identified ▪ 3-year budget developed	▪ Financial plan completed
	5.2 Sources of funding to run Women and Children First's UK office and operations and projects secured annually	▪ Voluntary fundraising strategy and communications strategy updated by the end of 2016 ▪ Projects funding base encompassing new potential project donors in place	▪ Fundraising monitoring reports ▪ Management accounts ▪ KPI reports
	5.3 Income targets as per the annual operating budget achieved annually	▪ £1m p.a. funded by institutional donors p.a.	▪ Management accounts

Strategy	Objectives	Indicators	Means of verification
		▪ Technical assistance contracts to the value of £x in place p.a. ▪ Applications to small (30) medium (10) and large trusts (5) submitted p.a. and income targets met ▪ Individual giving fundraising plans delivered and targets met ▪ Corporate giving fundraising plans delivered and targets met	▪ KPI reports ▪ Fundraising monitoring reports
	5.4 Maintain sufficient unrestricted reserves to meet the WCF Reserves policy each year	▪ Annual income targets met ▪ Annual expenditure within budget	▪ Management accounts ▪ Annual financial statements
6 Ensure optimum human resource is in place to deliver the Strategic Plan	6.1 Each member of Women and Children First's staff undergoes an annual appraisal to identify their contribution of knowledge, skills and expertise to deliver the Strategic Plan	▪ Annual appraisal reports completed	▪ Appraisal reports
	6.2 An audit of staff and trustee knowledge, skills and expertise to deliver the Strategic plan will be carried out annually.	▪ Annual audits completed	▪ Skills audit report
	6.3 The feasibility of addressing the gap, if any, between staff and trustee contribution and organisational requirements for knowledge, skills and expertise will be assessed and plans made to address gaps in line with resources.	▪ Report on analysis completed ▪ Action plan devised ▪ Action plan delivered	▪ Report and follow up action plan

Appendix 1 SWOT Analysis

This organisational analysis of strengths, weaknesses, opportunities and threats was carried out in November 2015. Consideration of how to build on strengths and opportunities and how to address weaknesses and reduce the impact of the threats was taking into account during the development of the 2016-2019 Strategic Plan.

STRENGTHS	**WEAKNESSES**
• Strong Mission • Proven methodology • History and credibility – good track records for delivering projects • Good reputation • High calibre, experienced staff • Trustees with wide range of skills and knowledge • Expertise in maternal and newborn health (MNH) • Great partners • Lack of bureaucracy • Small and agile, can embrace change • Fundraising improving	• Small staff team is often overstretched • Insufficient capacity for external networking and building wide range of relationships • "Porpoise" effect – we are so busy with the day to day we can't anticipate and plan • Dependent on a small pool of funders • Evidence base only relates directly to maternal and newborn health (MNH) • Not working in areas with highest mortality rates • Small partner base • Packaging the "product" • Lack of fundraising capacity • Communications/messaging
OPPORTUNITIES	**THREATS**
• Current international interest in community mobilisation (WG) work • Partnering with UCL – e.g. to explore nutrition issues, adolescent health • Develop work in coalition with others • Explore work on Female Genital Mutilation with suitable partners • Integrate our approach with organisations that are already working with women's groups on other issues (e.g. micro-credit) • Build relationships with diaspora communities in the UK • Develop in-country advocacy • Link with partners who have expertise in health system strengthening • Social media can be used to promote the brand	• Health is not as prominent in the Sustainable Development Goals as it was for the Millennium Development Goals • Not known whether funders will dedicate resources to MNH within their support for the Sustainable Development Goals • DFID's new priorities are not known. It has recently had a focus on women and girls and gender, but reproductive, maternal and newborn health (RMNH) have not been very visible • RMNH agenda is driven by the US • Other, very "loud" community mobilisation models (e.g. the care group model) could drown us out • Increased scrutiny of UK charities, especially in relation to fundraising methods and Charity Commission regulation could discourage individual giving • Level of donations from the public reducing or going to other causes • Unhelpful political agenda in some countries