

ACCOUNTABILITY FOR WOMEN'S AND CHILDREN'S HEALTH



2015 PROGRESS REPORT

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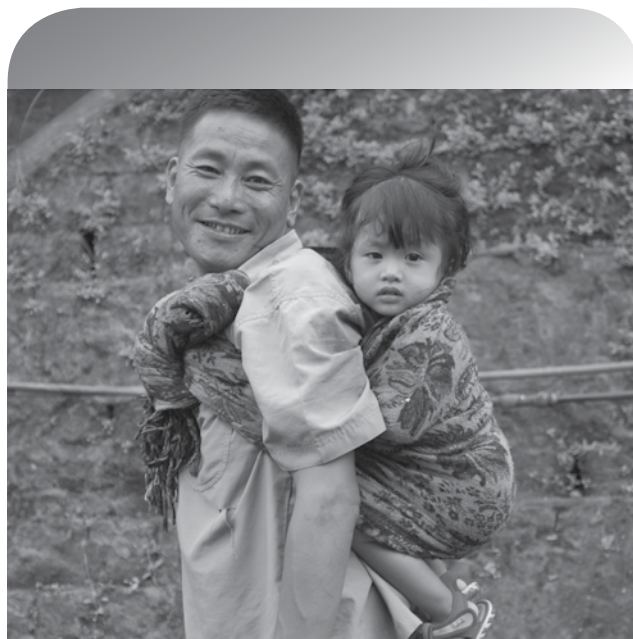
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Foreword

What gets measured gets done—a mantra we believe in and will continue to repeat. The accountability agenda for women's and children's health emerged because ten years into the Millennium Development Goals (MDG), progress on women's and children's health was lagging far behind. Since 1990 maternal deaths have been cut by almost half; some 17,000 fewer children die each day. This information is critical to measuring progress—without it we cannot hold ourselves to account. Yes, investments were being made nationally and globally, but it was almost impossible to know how much was being invested, and with what results.

The Commission on Information and Accountability for Women's and Children's Health (CoIA), chaired by President Kikwete of Tanzania and Prime Minister Harper of Canada, shifted this landscape. The Commission is fundamentally grounded on the premise that every woman and every child has the right to survive, and to develop and live in dignity. Believing that the world must do better for its women and children, the Commission put forth 10 ambitious recommendations -- for better accountability for results and for resources.

As the Commission's work draws to a close with the MDG deadline of 2015, this year's report highlights specific accomplishments from the last year towards realizing these recommendations, as well as the cumulative achievements since 2011. The recommendations spurred action in countries on some long-neglected basics – such as strengthening health systems to track every birth and every death. More countries are able to track resources spent, to register births, and to prevent future deaths by understanding why systems have failed women in childbirth. With strong country leadership and the generous support of many partners, notably the governments of Canada, Germany, Norway and the United Kingdom, accountability is making a difference in the lives of some of the poorest and most vulnerable women and children in the world.

Accountability has truly moved from the outskirts to the centre of the agenda for women's and children's health, and for health and development more broadly. We have witnessed important progress in country level accountability. Globally, the need for a strong accountability framework has taken root, and is non-negotiable in the emerging vision for the Sustainable Development Goals. The new *Global Strategy for Women's, Children's and Adolescent's Health* envisages an accountability framework that builds on the successes and insights of the Commission on Information and Accountability, recognizing the important contributions made by the independent Expert Review Group.

In this year of transition between the MDGs and the SDGs, we have many insights on accountability, particularly on how to strengthen country level accountability, social accountability and community engagement in accountability. We must maintain the progress on accountability: we must continue to track the money, we must continue to measure our progress, and we must take urgent action to stop the deaths and improve the lives of women and children.

DR FLAVIA BUSTREO,

Assistant Director-General, Family, Women's and Children's Health.

DR MARIE-PAULE KIENY,

Assistant Director-General, Health Systems and Innovation.

THE WORLD HEALTH ORGANIZATION

Executive Summary

Progress towards MDGs 4 and 5 accelerated in the preceding years thanks in large part to the contributions and energy stimulated by the United Nations Secretary-General's *Global Strategy for Women's and Children's Health*, and the related *Every Woman Every Child* movement. The need to ensure global reporting, oversight and accountability led to the establishment of the Commission on Information and Accountability for Women's and Children's Health.

This *2015 Progress Report*¹ provides an update on implementing the Commission's 10 ambitious yet practical recommendations² to fast-track improvements in women's and children's health. It also sets out the successes and lessons in implementing accountability frameworks; this information will be used to inform the revised *Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030*.

Progress reports from more than 30 countries show solid examples of strengthening national accountability. Accountability has taken root, with 68 countries demonstrating examples of accountability mechanisms through Country Accountability Frameworks (CAFs) that received a first phase of catalytic funding. Of these, 17 strong performers have been awarded a second phase of catalytic funding. A number of countries made progress despite facing serious challenges due to natural disasters, conflict or the Ebola epidemic.

Nearly all Country Accountability Frameworks have prioritized maternal death surveillance and response (MDSR) and civil registration and vital statistics (CRVS). One novel and significant finding is that each of these workstreams performs better when the two are done together.

Countries continue to strive to improve the collection of data on the 11 recommended indicators, and global level actors have agreed to a global reference list of 100 core indicators for health that streamline and lessen the reporting burden on countries. Various eHealth models and strategies have shown promise for harmonizing systems and expanding the reach of health services.

Significant strides have also been made in tracking budgets, resources and resource flows for reproductive, maternal, newborn and child health (RMNCH). More than 65 countries have adopted the methodology of System of Health Accounts 2011, and now 33 countries have data (compared to 18 last year), leading to a better understanding of domestic expenditures on health, and better harmonization of partners' financial and technical support. Reporting development aid for women's and children's health is also improving at the global level. After considerable work by the Organization for Economic Cooperation and Development (OECD), the policy marker for RMNCH expenditures was used for the first time by OECD-DAC members to better capture data on aid disbursements.

Compacts and similar partnership agreements are improving coordination among development partners to make health aid more effective, and civil society engagement in compacts and annual review processes is a positive trend. Civil society, uniquely positioned to track progress on country commitments, is contributing to greater transparency, advocacy and action, particularly with respect to government spending on RMNCH priorities.

Parliaments have strengthened their roles in promoting and supporting RMNCH. At their General Assembly in March 2015, the Inter-Parliamentary Union discussed progress in implementing their landmark resolution of 2012,³ and exchanged experiences on relevant legislative action and budget allocations.

The Commission recommendations will still be needed post-2015 and the insights and achievements in implementing accountability frameworks are vital to the new *Global Strategy for Women's, Children's, and Adolescent's Health*.

Key achievements from the past year are highlighted in the adjacent table, and more detailed information on progress across the Commission's 10 recommendations and across the 75 countries can be found in Annex 1 and 2 at the end of this report. It is clear that the demand continues to grow for independent, mutual and social accountability in countries and in the global health and development arena. The progress made, and

1. This report describes the progress on implementing the Commission's 10 recommendations up to April 2015.

2. http://www.who.int/topics/millennium_development_goals/accountability_commission/Commission_Report_advance_copy.pdf

3. Access to Health as a Basic Right: The Role of Parliaments in addressing key challenges to securing the health of women and children. Resolution adopted unanimously by the 126th IPU Assembly (Kampala, 5 April 2012)

the growing demand, demonstrate how a global movement with a small amount of catalytic funding can generate action and leverage the interest, resources and engagement of a global community.

Despite the considerable progress achieved to date, institutionalization of methodologies and scaling up activities to a national level are long-term processes. Looking ahead to post-2015, continued investments in accountability are critical to achieve the goals set out by the Commission. The accountability framework for the new *Global Strategy for Women's, Children's and Adolescents' Health* is a key vehicle to sustain the momentum and investments towards these achievements.

Highlights of the year's implementation

Accountability frameworks have been developed in 68 countries. Progress reports from more than 30 countries show solid examples of strengthening national accountability.

- ▶ **Countries show results:** 17 countries demonstrate strong results and move to a second round of targeted funding, principally for maternal death surveillance and response (MDSR), civil registration and vital statistics (CRVS) and eHealth.
- ▶ **Cross-regional progress despite challenges:** Progress has been seen in all countries with accountability frameworks, even those categorized as fragile states.⁴
- ▶ **Significant investments by countries to MDSR systems:** Of the 68 countries with accountability frameworks, 65 include actions to improve the MDSR system, 55 implement facility-based maternal death reviews and 30 implement community-based maternal death reviews.
- ▶ **Global community responds to country demand for CRVS guidance and investment.** The Global Financing Facility (GFF), led by the World Bank, and the governments of Norway and the United States is an important vehicle for aligned investments in CRVS. The Government of Canada committed US\$ 100 million to improving CRVS systems through the GFF and in support of *Every Woman Every Child*.
- ▶ **Marked improvement in tracking of resources:** 33 countries have now completed at least one year of implementing national health accounts, compared to 18 last year. Results from the poorest countries confirm that household expenditures remain the main source of funding and that countries spend on average US\$ 10 per person on reproductive, maternal, newborn and child health (RMNCH).
- ▶ **Government and civil society partnerships have been strengthened:** Of the 51 countries with an International Health Partnership (IHP+) Compact or similar partnership agreements, more than one in three include civil society engagement. Fifty-four countries have conducted health sector reviews that include a wider set of partners, particularly civil society.
- ▶ **Budget tracking and advocacy enhance mutual accountability for resources:** Civil society, parliaments and media from 21 countries are engaged in budget tracking, leading to increased funding for women's and children's health.
- ▶ **Parliaments sustain their commitments :** Parliaments in 30 countries have taken legislative action for women and children, including increased budget allocations for reproductive health.
- ▶ **Global reporting on aid for women's and children's health begins:** For the first time, members of the Organisation for Economic Cooperation and Development Cooperation Directorate (OECD-DAC) used the new RMNCH policy marker, to better capture data on aid in support of RMNCH. While reporting was low in this first round, it is expected that the use of the marker will yield fuller results in the subsequent round.
- ▶ **Independent accountability remains essential for the post-2015 period:** There is multi-stakeholder consensus on the need for independent accountability for women's and children's health post-2015, and this is a priority in the development of the new *Global Strategy for Women's, Children's and Adolescents' Health*.

4. According to the OECD, fragile states include countries that are recovering from conflict and embarking on peace and state-building process; they also include countries that are experiencing long-term insecurity, recurrent crises or localised conflict, or high levels of criminality and violence.

INTRODUCTION

Progress towards MDGs 4 and 5 accelerated in the preceding years thanks in large part to the contributions and energy stimulated by the United Nations Secretary-General's *Global Strategy for Women's and Children's Health*, and the related *Every Woman Every Child* movement. The need to ensure global reporting, oversight and accountability led to the establishment of the Commission on Information and Accountability for Women's and Children's Health (CoIA, or the Commission) co-Chaired by President Jakaya Kikwete of the United Republic of Tanzania and Prime Minister Stephen Harper of Canada. The Commission defined accountability as a cyclical process with three phases: monitor, review, act. In 2011 the Commission published *Keeping Promises, Measuring Results*,⁵ which puts forward ten ambitious yet practical recommendations (see Annex 3) to fast-track improvements in women's and children's health in the 75 countries that account for the majority of all maternal and child deaths in the world.

The present *2015 Progress Report* provides an update on implementing the Commission's ten recommendations up until April 2015. There has been an overwhelmingly positive response by countries to the Commission's recommendations and the majority of countries have adopted the recommendations by establishing country accountability frameworks (CAFs). The first section of this report provides detailed examples of progress achieved in countries, including countries facing serious challenges due to conflict, natural disasters, and the Ebola epidemic. The second section provides a more comprehensive account of progress across the Commission's 10 recommendations. A snapshot of progress towards all ten recommendations is available in Annex 1, and a more detailed view of country progress within selected work areas is available in Annex 2.

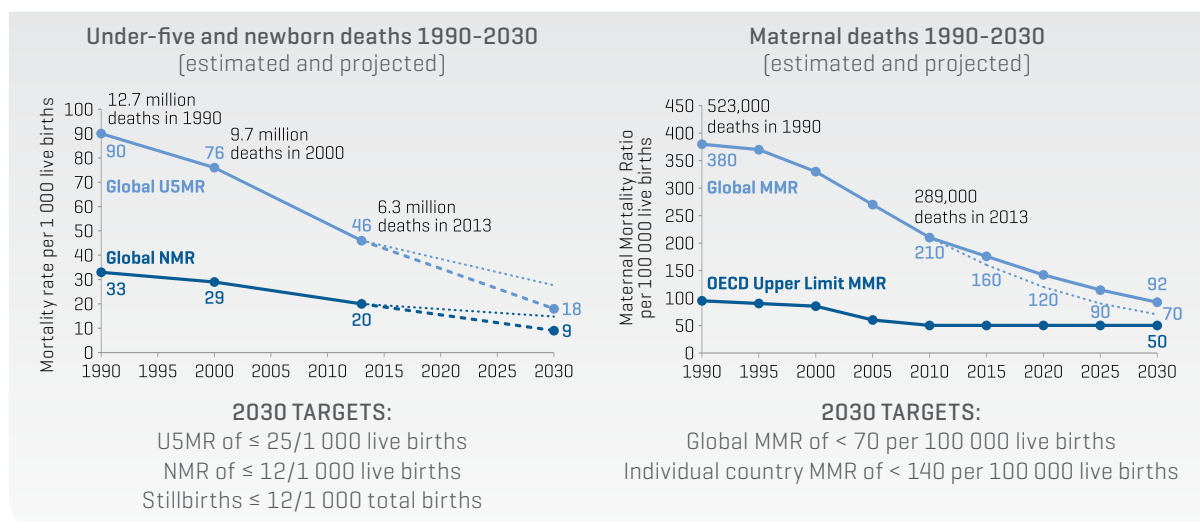
The third section of the *2015 Progress Report* is forward looking and takes stock of some of the key successes and challenges from four years of implementation in order to inform the ongoing discussions around accountability for the updated *Global Strategy for Women's, Children's and Adolescents' Health*. The launch of the updated *Global Strategy* will be central to advancing the agenda for women's, children's and adolescents' health in the period of the Sustainable Development Goals. At this critical juncture, it is of utmost importance that the accompanying accountability framework builds upon the significant progress made to date under the Commission's recommendations, and seeks to creatively and meaningfully address some of the stubborn challenges in tracking resources and results to improve the health of the world's women, children and adolescents.

Continued and increased investment will be required for countries to fully achieve the vision of better information for better results and accountability.

"...Looking back over the five years of the Global Strategy for Women's and Children's Health, I am proud of what we have achieved..."

Ban Ki-moon, United Nations Secretary General

Saving Lives Protecting Futures, Progress Report on the Global Strategy for Women's and Children's Health



5. http://www.who.int/topics/millennium_development_goals/accountability_commission/Commission_Report_advance_copy.pdf

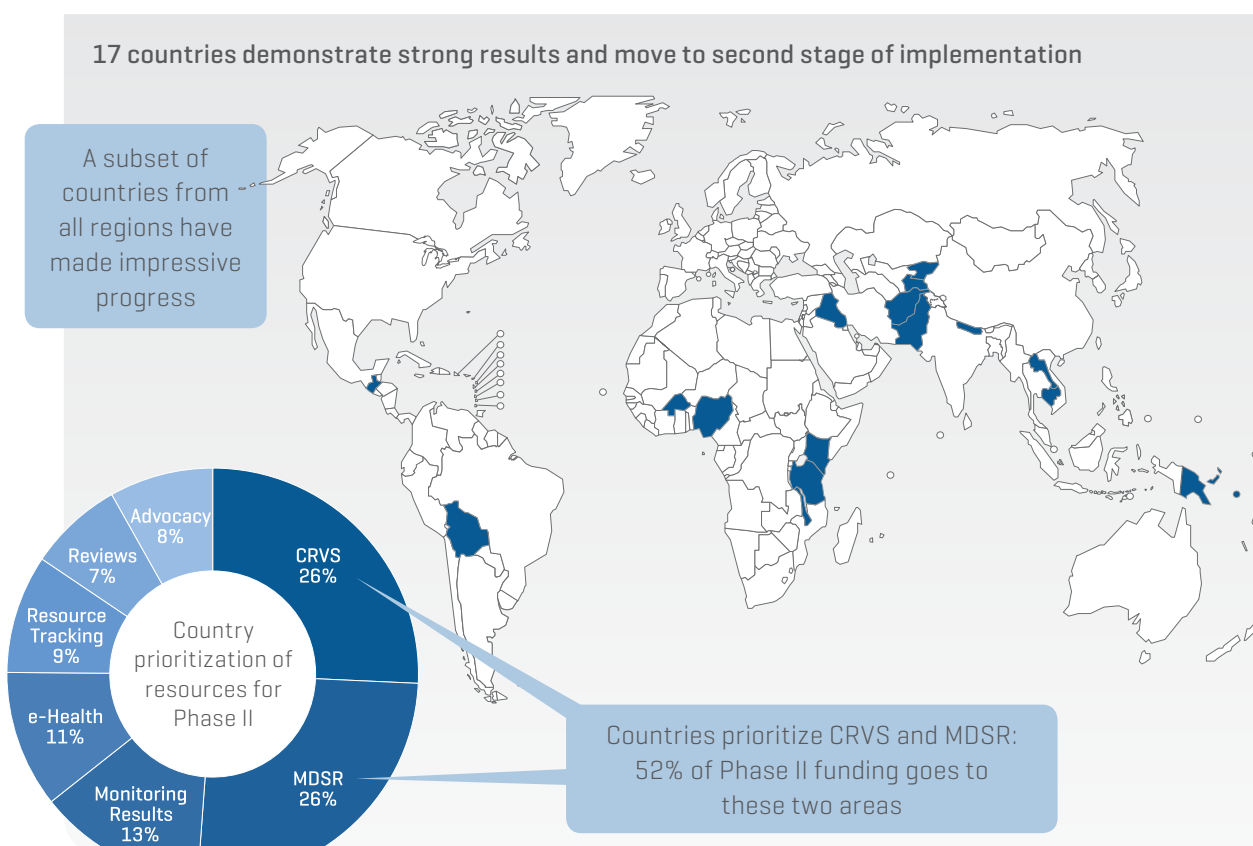
ACCOUNTABILITY HAS TAKEN ROOT IN COUNTRIES

After four years of implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health, reports from more than 30 countries⁶ show solid examples of strengthening national accountability. However, the processes to improve accountability – such as improving health information systems and changing paradigms of reporting and responsibility – require long-term investments and sustained political commitment. Actions initiated by countries will need time to grow beyond the MDG target date of 2015.

The following sections highlight examples of results achieved with catalytic funding and of progress despite special challenges.

Countries demonstrate strong results with catalytic funding

Of the 68 countries that received catalytic funding for their country accountability framework, those that completed their planned activities and that demonstrated clear results and continued commitment to the work were encouraged to submit proposals for a second phase of funding. Countries were asked to prioritize two to three streams of work in which they had shown progress, to develop proposals with wide stakeholder engagement and buy-in, and to maximize opportunities to leverage national and partner funding. A total of 17 countries⁷ were approved for Phase II funding; results of implementation are expected in early 2016.



6. Afghanistan, Bolivia, Botswana, Brazil, Burkina Faso, Cambodia, Comoros, Djibouti, Egypt, Eritrea, Gabon, The Gambia, Guatemala, Haiti, Iraq, Kenya, Kyrgyzstan, Lao People's Democratic Republic, Malawi, Mexico, Mozambique, Myanmar, Nepal, Nigeria, Pakistan, Papua New Guinea, Rwanda, Solomon Islands, Swaziland, Tajikistan, and the United Republic of Tanzania.

7. Afghanistan, Bolivia, Burkina Faso, Cambodia, Guatemala, Iraq, Kenya, Kyrgyzstan, Lao People's Democratic Republic, Malawi, Nepal, Nigeria, Pakistan, Papua New Guinea, Solomon Islands, Tajikistan, and the United Republic of Tanzania.

United Republic of Tanzania: improvements in CRVS, eHealth and advocacy

In the United Republic of Tanzania, accountability has proven to be a central framework that has catalysed action for women's and children's health. The past year has seen impressive gains, including the following:

- ▶ A new health facility reporting system is now in place that will allow the introduction of coding of causes of death according to the International Classification of Diseases [ICD-10]. An electronic district-based facility reporting system is operational.
- ▶ A national health accounts exercise was completed with a subaccount produced for RMNCH.
- ▶ An eHealth steering committee to provide overall leadership and governance for the roll-out of the eHealth strategy now exists. This includes an effort to develop one common system for eHealth governance, in line with the national strategy.
- ▶ The President leads several advocacy efforts, bringing political attention to women's and children's health and to accountability. For example, in May 2014, President Kikwete led a high-level "Countdown to 2015" event that brought together partners, civil society and the media. The event reviewed overall progress towards MDGs 4 and 5, including progress on the 11 core indicators, with a view to incorporating lessons into the health sector strategic plan that begins in 2016.

The accountability framework has catalysed a number of critical actions for women and children in the United Republic of Tanzania.

Lao People's Democratic Republic: strengthened review and surveillance of maternal deaths

The first national report on maternal death reviews in Lao People's Democratic Republic provides insights on the main causes of maternal deaths, and priorities for future action.

Maternal death reviews were first introduced in Lao People's Democratic Republic in 2010 and are now conducted in eight out of 17 provinces. According to the global Maternal Mortality Estimation Interagency group, the country is on track to achieve MDG 5. The maternal mortality ratio has been reduced by almost half, from 656 per 100 000 live births in 1995 to 357 per 100 000 live births in 2012. There is also a slight increase in the proportion of women delivering in the presence of a skilled birth attendant or delivering in health facilities, and in the percentage of women who receive antenatal care. The Ministry of Health acknowledges that maternal death reporting is incomplete due in part

to deaths occurring in remote locations having no contact with health services.

The country recently completed its first national maternal death report, which analyses 118 maternal deaths between 2011 and 2013 in eight provinces in addition to the capital, Vientiane. The report showed that a majority of women continue to deliver at home and to receive limited antenatal care; causes include low access to services, unavailability of health staff in health centres, perceived poor quality of services at facilities, families' perceptions and cultural beliefs, insufficient birth preparedness and inadequate knowledge about danger signs during pregnancy. The survey findings draw attention to the need to address inequalities in remote and rural areas, especially those with large populations.

Solomon Islands: strengthening routine data collection to support performance-based funding

In the Solomon Islands, four of the 11 indicators recommended by the Commission are available through the national web-based reporting system, DHIS 2. Five others are collected through household Demographic and Health Surveys [DHS], which occur every five years; and two indicators [HIV prophylaxis and pneumonia antibiotic treatment] are not yet well captured in the health information system.

In Solomon Islands, Phase II will focus on improving quality and transparency of data for the 11 core RMNCH indicators.

Funds awarded under Phase II will be used to strengthen the health information systems and improve the quality of the available indicators. Efforts will be made to ensure that the seven indicators not routinely collected at present will be available through the facility reporting system. The improved quality and transparency of information will be an important contribution to the national health sector reviews. These will be conducted on a yearly basis from 2015 onwards and linked to performance-based funding.

Bangladesh: new web-based platform improves information systems⁸

DHIS 2 has dramatically reduced administrative burdens in Bangladesh. Currently, over 50% of health facilities report electronically; by 2015, all 15 000 health facilities will be using the system.

One of Bangladesh's biggest challenges is a fragmented health information system that makes it difficult to provide policymakers with timely, comprehensive and quality data on health targets and interventions. Data generated by different providers are often not linked, and the multiple overlapping reporting systems result in heavy paperwork and poor-quality data. The Ministry of Health, with support from the German government (GIZ),⁹

has enabled public health facilities to report routine health information electronically through DHIS 2.

By the end of 2014, over 7 000 health facilities reported electronically through DHIS 2, and all 15 000 facilities are expected to do so by the end of 2015. DHIS 2 also acts as an electronic data repository that helps streamline the system and reduces silos, allowing previously distinct data sets to be linked in a national data warehouse.

The use of DHIS 2 has greatly reduced administrative burdens, as health facilities now report routine information electronically. The use of individual health records, particularly at community clinics, enable health workers to better track pregnant women and children over time, and help improve the overall quality of care provided.

Republic of Tajikistan: funding has been truly catalytic and leveraged other funds for accountability

The Government of Tajikistan has shown a high level of commitment to improving women's and children's health. The National development strategy and the National health strategy 2010-2020 emphasize the improvement of maternal and child health. Implementation of the CAF has proven to be truly catalytic, and the focus on accountability has revitalized efforts towards reaching MDGs 4 and 5. In a national workshop to define the priority areas for the CAF, the Government of Tajikistan was able to leverage financial and technical support from a number of partners.

The Commission's recommendations have revitalized efforts towards reaching MDGs 4 and 5 in Tajikistan, bringing together a wide range of partners to support the country accountability framework.

There has been an overall increase of resources for the portfolio, helping to advance the health of women and children

- ▶ **German Cooperation:** Quality of care and capacity-building on effective perinatal care;
- ▶ **European Union:** Strengthening health information systems through implementation of DHIS 2 and building capacity on ICD-10;
- ▶ **Japanese International Cooperation:** Project for improving maternal and child health care system at the regional level and building capacity on integrated management of childhood illness (IMCI);
- ▶ **USAID:** Implementing the first DHS and, under the Quality Health Care Project contributing to improving quality of care and strengthening MDSR in the country;
- ▶ **UNAIDS:** Maternal and child health capacity-building activities and advocacy;
- ▶ **UNDP:** Building capacity in the Ministry of Justice, and improving birth registration;
- ▶ **UNFPA:** Contributing to the DHS and supporting the "Beyond the numbers" initiative;
- ▶ **UNICEF:** Child survival and development, and the infant mortality causal analysis;
- ▶ **WHO and the Russian Federation:** Improving the quality of hospital care for children;
- ▶ **WHO:** Catalytic funding to the CAF. "Beyond the numbers" initiative to strengthen maternal death surveillance and response; supporting the National Health Strategy 2020 package of indicators, resource tracking, national adaptation of ICD-10, the joint annual review and media training.

8. http://health.bmz.de/good-practices/GHPC/A_Quiet_Revolution/HIS_Bangladesh_short_EN.pdf

9. *Gesellschaft für Internationale Zusammenarbeit (GIZ)*

Progress despite special challenges

Implementing in fragile states

Women and children bear the greatest health burden and risks in humanitarian contexts and in fragile states. Globally, 60% of preventable maternal deaths and 53% of under-five deaths occur in settings of conflict, displacement and natural disasters. Of the high-mortality countries unlikely to achieve MDGs 4 and 5, more than 80% have suffered a recent conflict, recurring natural disasters or both.¹⁰

Fragile states (as classified by the OECD) are the furthest from achieving the health MDGs; at the same time, the development aid that many of them receive is shrinking and they have limited access to alternative sources of financing.¹¹

Thirty-nine of the 51 fragile states have developed accountability frameworks using catalytic funding. Despite complex situations, a number of countries have made progress in strengthening their health systems and implementing accountability mechanisms. Iraq has demonstrated progress in each of the work streams included in the accountability framework.¹² In areas affected by conflict, CRVS is increasingly being seen as an essential tool for state-building and good governance, as demonstrated in Afghanistan. In Haiti, partners are focusing on strengthening the community health work force to improve health systems and MDSR.

"The Arab world is a region that has not been out of the news headlines, and more often than not, for the worst of reasons: conflict, crisis and man-made disasters. The number and magnitude of crises in this region is unprecedented. We now live in a region in which a state of emergency seems almost to have become a way of life. At any one time, we have more than half of the countries in the region affected by crises and emergencies."¹³

Dr Ala Alwan, Regional Director
WHO Eastern Mediterranean Region



ABU DHABI DECLARATION calls for accountability

Through the Abu Dhabi Declaration,¹⁴ published in February 2015, development partners and humanitarian experts called on the global community to urgently address reproductive, maternal, newborn, child and adolescent health and wellbeing in humanitarian and fragile contexts. One of the pillars of the Declaration is to use existing mechanisms to keep all partners accountable at present and after 2015. The Declaration strongly recommends rooting accountability in affected communities, recognizing the power that women and children wield in rebuilding communities in the aftermath of conflict or disaster.

10. OECD 2014. Fragile States 2014: Domestic revenue mobilisation in fragile states.

11. OECD 2014. Fragile States 2014: Domestic revenue mobilisation in fragile states.

12. Accountability includes the following work streams: civil registration and vital statistics, maternal death surveillance and response, monitoring of results and timely data available for monitoring the 11 core indicators, eHealth, tracking national resources (SHA 2011 methodology), compacts and health reviews, and advocacy.

13. http://applications.emro.who.int/docs/RD_Message_Speech_2015_EN_16284.pdf?ua=1

14. Abu Dhabi Declaration: upholding health and wellbeing for women, newborns, children and adolescents in humanitarian and fragile settings. http://www.unfpa.org/sites/default/files/event-pdf/The%20Abu%20Dhabi%20Declaration%20Feb%202015%207%20%281%29_0.pdf

Steady progress in Iraq despite on-going conflict and instability

The upheavals, violence and sectarian strife of the past two decades have overwhelmed health services. An estimated 40% of health facilities in Iraq have been damaged and there is a severe lack of adequately trained health professionals.

“The Global Strategy and the Commission on Information and Accountability created an unprecedented opportunity to strengthen the mother and child agenda through the accountability framework.”

Dr Hassan Hadi Baker
 Director General for Public Health and Preventive Health Care Department
 Central Ministry of Health, Baghdad

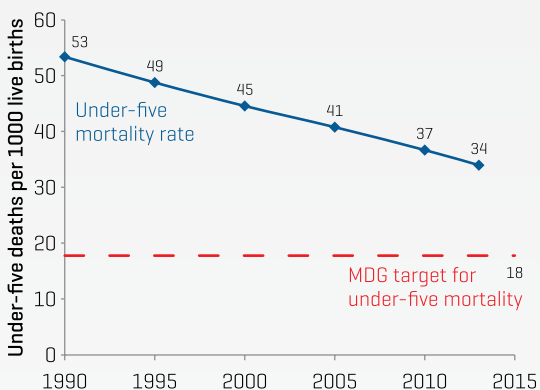
Despite ongoing instability and conflict, Iraq has made impressive progress in implementing its country accountability framework. Iraq is a signatory to the Dubai Declaration for accelerated action on MDGs 4 and 5.¹⁵ In December 2013, the same year it developed its CAF, Iraq launched its three-year National Acceleration Plan for Maternal and Child Health. The Plan aims to provide cost-effective interventions in nine high-burden governorates. The Ministry of Health has started to establish family practice as a model to ensure the population’s access to a comprehensive package of quality health care services.

Iraq carried out a rapid and comprehensive CRVS assessment,¹⁶ which formed the basis of a three-year improvement plan. A high-level steering committee and technical committee were established to oversee the implementation of this improvement plan, which has included a comprehensive review of the statistical forms being used. The number of forms utilized was cut by nearly half, helping to avoid duplication in reporting, reduce the burden on health workers and improve the accuracy and quality of statistical data.

A three-year MDSR plan outlined priority interventions to remedy system gaps, thus helping to prevent maternal mortality. MDSR tools, including death certificates and registers, were reviewed and updated. A comprehensive work plan for an internal evaluation of MDSR has been developed. Iraq is focusing its final year of implementation on strengthening its MDSR system and implementing a rapid assessment of deaths occurring in health facilities.

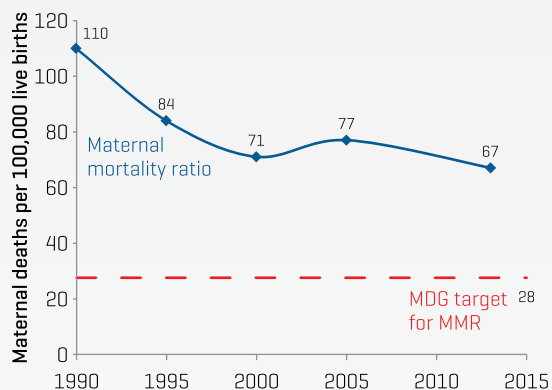
Iraq has also completed its second round of national health accounts in order to appropriately allocate financial resources to women’s and children’s health.

Trends in under-five mortality rates in Iraq, 1990-2013



Source: UNICEF, WHO, The World Bank and United Nations Population Division (2014). Levels and Trends in Child Mortality: Report 2014, New York: United Nations Children’s Fund

Trends in maternal mortality ratio in Iraq, 1990-2013



Source: WHO, UNICEF, UNFPA, The World Bank and United Nations Population Division (2014). Trends in Maternal Mortality: 1990 to 2013, Geneva: World Health Organization

15. <http://www.emro.who.int/about-who/strategic-directions/dubai-declaration.html>

16. The Rapid CRVS assessment took place on 16-17 December 2012 in Baghdad. It was followed by comprehensive CRVS assessment which was held from 7-11 April 2013.

Afghanistan makes strides to increase registration of vital events

Afghanistan is considered a fragile state, having suffered from conflict, widespread poverty and instability – all of which have had dire repercussions on the health system and the population. The maternal mortality rate in 2013, estimated at 400 per 100 000 live births, was a significant decline from 1990 estimates of 1 200 maternal deaths per 100 000 live births.¹⁷ Despite the improvements in health indicators, Afghanistan will not meet its MDG targets.

Afghanistan's CRVS system is 40 years old and the government is now taking steps to replace it. Although reports of births, deaths, marriages and divorces are mandatory in Afghanistan, the birth and death registration systems are not fully functional in 85% of the country. In 2014, only 30% of births were registered, and fewer than half of the 34 provinces registered divorces and engagements. In addition, the existing paper-based CRVS system exacerbates data losses and inefficiencies as transfers are made from health facilities to the Ministry of Interior.

In 2013, the Government of Afghanistan carried out a comprehensive CRVS assessment, followed by a CRVS workshop in line with Afghanistan's CAF. The assessment survey highlighted the achievements and lessons learnt. Selected achievements and insights include:

- ▶ Following training on ICD-10 medical terminology and death certification, staff in 10 hospitals will now be expected to collect data on mortality and cause of death on a regular basis.
- ▶ Hospitals are moving from paper-based systems to electronic management information systems (MIS), to be installed in all the country's hospitals. Ten hospitals currently use MIS, and ten more national, regional and provincial hospitals are expected to do so in the near future.
- ▶ Phase II funding will allow for work on the design of an electronic online management information system for reporting deaths.
- ▶ Legal support, a shared vision and inter-ministerial/inter-sectorial coordination are key in developing a functional CRVS system.
- ▶ Any long-term strategic plan and implementation plan need to clearly define the roles and responsibilities of each key stakeholder.
- ▶ The participation of civil society organizations and citizens in the CRVS development process will contribute to a more effective CRVS policy and allow for better implementation.



17. WHO, UNICEF, UNFPA, The World Bank and United Nations Population Division (2014). *Trends in Maternal Mortality: 1990 to 2013*, Geneva: World Health Organization.

Community health workers contribute to improved health system in Haiti

Haiti has the highest maternal mortality in the Americas, at 380 per 100 000 live births.¹⁸ It also has a limited work force for health. The already weak health system was debilitated after the 2010 earthquake, making health information systems more difficult to maintain. In the past few years, partners have come together to help strengthen the health system and gain efficiencies.

The Ministry of Public Health and Population in Haiti, along with H4+,¹⁹ and the US Centres for Disease Prevention and Control (CDC) are strengthening community-level health systems, including through the deployment of community health agents. A total of 10 000 community health agents are needed to cover the entire country. This cadre is responsible for identifying and notifying all deaths occurring in the community and for conducting verbal autopsies. Funds from the Country Accountability Framework have contributed to the training of health workers in Haiti's Northwest region – thus closing the gap in that department.

Impact of Ebola

While the Ebola epidemic has had a devastating impact in many affected countries, outcomes from a meeting in December 2014 include recognition from the international community that this crisis reinforced the urgent need to build stronger health systems.²⁰

Guinea, Liberia and Sierra Leone, the three countries hardest hit by Ebola Virus Disease (EVD), recently undertook an intense, multi-sectorial and inclusive process to develop plans for health sector recovery and resilience. This entailed an assessment of the health system, including the impact of Ebola on essential health services such as immunization, and reproductive, maternal and child health; a review of existing policies, guidelines and procedures; and the identification of tools needed to strengthen health systems and services in districts and communities. The process included participatory working sessions and multi-stakeholder dialogues. As a result, all three countries have developed costed national health sector recovery plans that define the key immediate and medium- to long-term interventions needed to build national resilient health systems.

Women and children are among the groups most affected by the EVD outbreak. Limited published evidence from previous outbreaks on the impact of EVD in pregnancy and childbirth indicate a potentially higher risk of dying from Ebola among pregnant women as compared to non-pregnant. Additionally, babies born to women affected with EVD do not usually survive, and most pregnancies end with spontaneous abortions or stillbirths.

Limited data available on the pregnancy status of women at the beginning of the latest outbreak have constrained the understanding of the implications of EVD for women and children, and an adequate response. This highlights the need to ensure that resilient health systems are ready to meet RMNCH needs, including the collection and use of adequate and appropriate data for prevention and response.

Sierra Leone: budget-tracking plan shifts to advocate for greater financing of Ebola response

In 2014, A country team comprised of civil society, media and parliamentarians participated in a budget advocacy workshop (see "Budget tracking and advocacy" section) coordinated by Save the Children. The workshop resulted in a budget advocacy plan for RMNCH, but with the outbreak of Ebola, the team was obliged to revise it with a focus on responding to Ebola. The skills gained in the workshop enabled civil society to understand and track total public and donor Ebola financial allocations and spending. Civil society used their seat on the National Ebola Response Center taskforce to advocate for increased donor support and a transparent system to efficiently utilise funds for Ebola interventions.

18. WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division [2014]. *Trends in Maternal Mortality: 1990 – 2013*, Geneva: World Health Organization. Maternal Mortality Estimation Inter-Agency Group.

19. The H4+ partnership comprises six United Nations agencies: UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank. These are the lead technical partners for the implementation of the Secretary-General of the United Nations (UNSG) *Global Strategy for Women's and Children's Health*.

20. Report of the High-Level Meeting on Building Resilient Systems for Health in Ebola- Affected Countries, 10-11 December 2014. Geneva Switzerland.

ADVANCES IN IMPLEMENTING THE COMMISSION'S RECOMMENDATIONS

Progress is evident on all of the Commission's recommendations, with countries prioritizing according to their needs and situation certain areas more than others. Implementation of some recommendations has changed the way business is done – creating new approaches and methodologies, such as MDSR and SHA2011, building platforms for bringing together different partners that historically have not worked together, and improving collaboration between civil society, media and parliaments.

CRVS leads to a shift towards universal registration of births, deaths, and causes of death

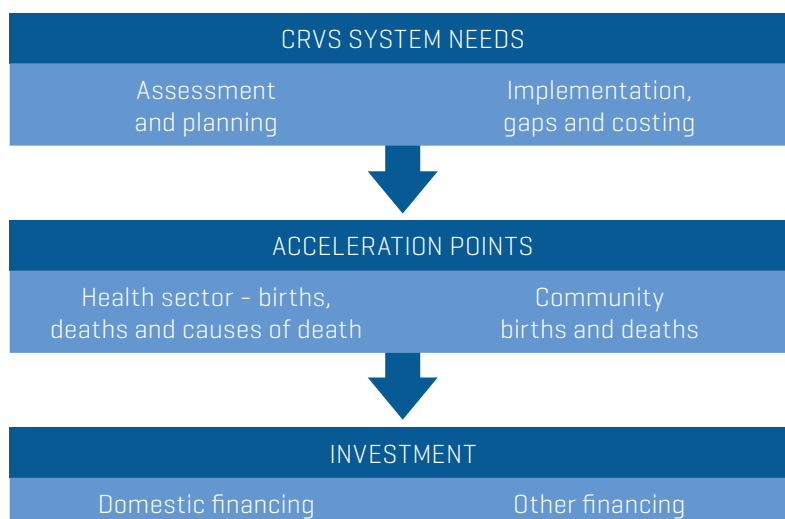
Political momentum in 2014 led to a clearly discernible global shift towards investing in the universal registration of births, deaths and causes of death. The publication of the WHO project on investment planning in April 2014 and the World Bank-WHO Global CRVS Scaling-up Investment Plan initiated a global conversation on investment in CRVS systems. The WHO project highlighted needs for CRVS implementation and investment in four countries: Bangladesh, Ethiopia, Mozambique and the Philippines. The World Bank-WHO plan has built on this foundation, setting targets for global CRVS improvement and highlighting a funding gap of US \$1.9 billion.

Greater agreement now exists around the need to invest in cohesive CRVS data systems. These initiatives and the continuing evidence of the importance of CRVS resulted in a specified opportunity for CRVS financing through the Global Financing Facility (GFF). Next steps will include using the opportunity of possible investment to ensure that CRVS systems are comprehensively and sustainably developed for the long term.

Health is both a beneficiary of CRVS systems, and also a strong contributor, and accordingly, the health sector has proven to be a critical partner in country CRVS system improvement. Many countries are accelerating their CRVS system results (improvements in birth and death recording, and causes of death) through the health sector. Countries such as Ghana, Mozambique, and the United Republic of Tanzania have improved their hospital cause-of-death recording, and Zambia is taking steps to improve its mortality reporting. Other countries are using the health sector to register birth and death events.

Country commitments to improving CRVS have not faltered. Catalytic investments from the accountability framework funding, along with strong partner commitments, mean that 64 countries now have CRVS assessments and national plans, or have these underway. This represents an increase from last year where 51 countries had completed assessments (see Annex 1). In Africa, ministers agreed on an Africa Programme of Accelerated Improvement in CRVS, accompanied by a regional medium-term plan. This was strengthened by the Yamassoukro Declaration in February 2015 (see box). In November 2014, the Asia-Pacific region endorsed the goal of universal civil registration and documentation by 2024, supported by a regional action framework.

Regions have continued to take a leadership role in stimulating political commitment for improving CRVS systems. For example, in May 2014, in partnership with the Inter-American Development Bank, Canada launched the *Canadian Fund for Civil Registration for Latin America and the Caribbean* to strengthen civil registrations and the collection of vital statistics in the region.



The Third Conference of African Ministers Responsible for Civil Registration

YAMOUSSOUKRO DECLARATION

African Ministers responsible for civil registration met in February 2015 in Yamoussoukro, Côte d'Ivoire, on the theme, "Promoting the Use of Civil Registration and Vital Statistics (CRVS) in Support of Good Governance in Africa". Participants agreed to the Yamoussoukro Declaration that puts forwards bold deliverables in the areas of capacity-building, rights particularly for displaced persons and in humanitarian settings, financing, technology, service delivery, advocacy and positioning for the post-2015 development agenda.

The Declaration takes note of the first ColA recommendation, "By 2015, all countries should have taken significant steps to establish a system for registration of births, deaths and causes of death, and have well-functioning health information systems that combine data from facilities, administrative sources and surveys". The Declaration encourages strong working arrangements between health and other relevant sectors to improve the delivery of registration services.

The Declaration also calls upon WHO, in collaboration with pan-African organizations and other partners, to intensify their efforts in developing national systems for real-time registration of information on deaths and causes of death.

This Declaration is an important vehicle to drive partnerships and action for strengthening CRVS systems in Africa. Ministers also recognize that achieving the goals of Agenda 2063, "The Africa we want", will require comprehensive, accurate and timely statistics generated from civil registration systems.



Maternal death surveillance and response (MDSR) – a new way of doing business

Understanding the preventable causes of deaths through maternal death reviews is vital to prompting an appropriate response. MDSR is one of the cornerstones of the accountability work, and since the launch of the methodology in 2012, 93% of the 68 CAFs have included relevant actions (see Annex 1 and 2). The accountability work has created a shift from simple maternal death reviews to a more comprehensive methodology of MDSR. This methodology includes early notification of maternal deaths ["surveillance"], an in-depth analysis of why each death occurred, and proposes a "response" that could prevent such deaths in the future. The intrinsic continuous action and surveillance cycle in the MDSR methodology permits tracking of recommended actions, hence boosting the accountability for maternal mortality prevention.

While there is information on national policies related to MDSR, little is known about the extent of MDSR implementation. There is a need to systematically collect data on MDSR implementation and to closely follow progress of implementation over time. A global MDSR progress report will be published in late 2015 to share experiences among countries about facilitating factors and barriers to successful MDSR implementation.

MDSR improves quality of care and its measurement

MDSR makes the issue of maternal deaths more visible at a local and national level, and sensitizes communities and health facility workers, thereby improving accountability towards ending preventable maternal mortality. The MDSR methodology provides real-time information on quality of care, and proposes actions to improve this and to prevent future maternal deaths in health facilities and in the community. Implementing MDSR has contributed to longer-term investments in improving health service delivery. In connecting actions to results, MDSR also allows an assessment of the impact of quality improvement processes. In Burkina Faso, for example, the CAF was a catalyst for institutionalizing MDSR and for including newborn deaths as part of the approach. Both maternal and newborn deaths are notified by health facilities and communities through the integrated disease surveillance and response network.

In Mexico, the CAF reinvigorated the Safe Motherhood Committee, a network of government, civil society, academia and experts in maternal health. National and sub-national data on maternal mortality are now available annually allowing policy makers to monitor trends in maternal and perinatal deaths. The Safe Motherhood Committee also reviews budget expenditures to ensure that allocations for maternal health are met.



MDSR and CRVS achieve more when implemented together

Nearly all countries with CAFs prioritized actions to improve both CRVS and MDSR. This resulted in some US\$ 7.5 million in catalytic funding invested to improve both systems. It also resulted in an unexpected but very welcome outcome: silos have been bridged at the country level, bringing together the bureau of statistics in the Ministry of Interior and departments of family/women's health in the Ministry of Health to improve statistics on mortality and causes death. Recent WHO guidance notes the importance of systems such as MDSR to long-term CRVS strengthening.²¹

21. http://www.who.int/healthinfo/civil_registration/CRVS_MortalityStats_Guidance_Nov2014.pdf



Nepal: sharing electronic information on cause of death

In Nepal, CRVS aims to standardize death certificates in all public and private hospitals. This will improve information on causes of death that can then be utilized to inform maternal and perinatal death surveillance and review (MPDSR) processes. In addition, CRVS and MPDSR will use the same verbal autopsy questionnaires to collect information on suspected maternal deaths. All information collected through the MPDSR and verbal autopsy will be synchronized with the integrated electronic cause-of-death reporting system. Ultimately, this system will share its information with the central vital events registration system to assign reliable cause of death for each event registered.

Cambodia: community plays an important role in linking MDSR and CRVS

In Cambodia, identification and notification of maternal deaths is part of the MDSR in the Ministry of Health. The Ministry of Interior is responsible for managing the routing of the civil registration system information that covers births, death and marriage data from the commune level. Community members including families, village health support groups and village chiefs play an important role in notifying maternal death cases to health centres, who then notify higher levels of the health system. The community also reports these deaths to the commune; in this way the commune council plays an important role in linking MDSR and CRVS. The effort to increase reporting on maternal deaths by community members under MDSR will eventually improve CRVS and vice versa.

Malawi: maternal mortality data collection to contribute to CRVS development

The Government of Malawi is committed to strengthening CRVS, as witnessed by the recent creation of a National Registration Bureau in the Office of the President and Cabinet. This is intended to overcome roadblocks faced by the CRVS system, such as non-mandatory registration and incomplete hospital reporting. ICD-10 is just starting to be implemented.

Catalytic funds are supporting the integration of current surveillance sites with government systems for registration of deaths (verbal autopsy and ICD) and other reporting related to vital statistics. The MDSR system is expected to improve CRVS through the collection of maternal mortality information using ICD-MM, which is the application of ICD-10 to maternal mortality, as well as by establishing the cause of death through verbal autopsy. Whether at health facilities or in the community, MDSR is also expected to lead the way for reporting causes of all deaths, and the system will provide the information needed to stimulate and guide actions to prevent future maternal deaths and improve surveillance.

Measurement and accountability post-2015: Commission recommendations spur concerted global action

Constructing a common agenda to improve and sustain country measurement and accountability systems for health results post-2015 has been a shared concern among governments, multilateral agencies and civil society. Global Health Agency leaders responded to the call from countries that there were too many indicators for reporting and too many reporting requirements leading to fragmented and inefficient investments in data generation. Leading global health agencies agreed to a global reference list of 100 core indicators for health that will be facilitated by the use of open access software, rationalized approaches among donors to country support, and global HIS standards, guides, and tools.

The Commission had earlier recommended the use of 11 indicators for women's and children's health, disaggregated for gender and other equity markers. Household surveys providing objective and disaggregated data are required to measure most indicators, which means that data are only available once every three to five years. Health facility data are increasingly available on a regular basis through web-based reporting and can be used for some indicators, disaggregated by district. The Commission's recommendations have enhanced efforts to improve the quality and transparency of such facility data. Annex 1 and 2 provide more detail on the number of countries using web-based reporting.

The movement "Countdown to 2015" has provided regular global and country assessments of progress towards the 11 core indicators. Increasingly, countries have developed their own national and subnational scorecards to assess progress and performance on RMNCH. The African Leaders Malaria Alliance (ALMA) has supported 20 countries in Africa to develop national RMNCH profiles and management scorecards that align with existing national review processes. In many countries, health officials use scorecards to track action and provide immediate feedback on indicators, helping to drive progress.

Global Summit on Measurement and Accountability post-2015

The Summit on Measurement and Accountability for Results in Health in June 2015 seeks to provide a vision for country health information systems in 2030 so they may gather the information they need for planning and managing of their health policies and programmes. The Summit will define the parameters for health measurement post-2015 in order to strengthen basic measurement systems and align partners and donors around common priorities.

Country experts and partners intend to develop a shared approach to measurement and accountability for the post-2015 development agenda. One of the outputs of pre-Summit consultations is the *Common Roadmap and five-point Call to Action for Health Measurement and Accountability Post-2015*. The draft five-point call to action for 2030 includes:

1. Increase investments by governments and development partners to strengthen the country health information system;
2. Strengthen country institutional capacity to collect, compile, share, analyse, disseminate and use data at all levels of the health system;
3. Ensure that all countries have well-functioning sources for generating population health data, including civil registration and vital statistics systems, census, and health surveys tailored to country needs;
4. Improve health facility and community information systems, through sound disease and risk surveillance systems, innovative ways of data analysis and automated systems of financial and health workforce accounts, empowering decision-makers with real-time access to information;
5. Promote accountability through monitoring and regular inclusive transparent reviews of progress and performance linked to the health-related SDGs.

Governance and transparency key to eHealth strategy development and innovation



The accountability work has been an important entry point for governments to integrate diverse eHealth projects and transition them to more sustainable programmes. CAFs have played a catalytic role in encouraging better governance of eHealth, including mHealth, by enabling a more systematic and inclusive approach to eHealth development at the national level. Through improved governance mechanisms, more stakeholders – particularly civil society – are able to make meaningful contributions.

There are currently 27 countries with eHealth strategies and an additional 25 countries expressing interest. Although the number of eHealth strategies has not increased since last year, there is greater awareness and demand from countries to establish an enabling environment for eHealth, such as developing legislation (privacy, security) and support to health data standardization [see Annex 1 and 2].

The multi-partner process for developing eHealth strategies supported by the accountability work has enabled countries to leverage other resources for eHealth. For example, UNICEF has adopted the WHO-International Telecommunications Union (ITU) National eHealth strategy approach and endorses it as a foundation of immunization supply-chain management in Lao People's Democratic Republic and Nepal. The initial entry point was the drive to improve effective management of vaccines. The ways by which innovative information and communication technology solutions contribute are increasingly seen to be part of the broader health system strengthening agenda.

Partnership and coordination critical to improved eHealth/mHealth in Kenya and Philippines

Stakeholder involvement takes considerable time and coordination, but an inclusive, well-run governance process leads to a more transparent, cohesive and coherent national eHealth environment. This benefits health system development efforts overall, and brings more certainty for long-term investments in eHealth development.

- ▶ As part of Kenya's CAF, the Ministry of Health has formed a successful partnership model to lead the eHealth/mHealth Forum, which includes representation from the private sector, government, NGOs, academic institutions, bilateral partners and the national teaching hospital. As an outcome of quarterly meetings, partners reduce duplication and increase sustainability by aligning projects with government priorities and policies. Prior to establishing the Forum, pilot projects were often initiated without consultation with the government or partners, leading to inefficiencies and unsustainable projects.
- ▶ The Philippines revised their strategy development approach – following a draft strategy that did not secure consensus – to include consultation with a wide range of stakeholders from the different government agencies, private firms and organizations, local government units, nongovernmental organizations, academia, research institutions and international organizations. The process of partnership and greater transparency culminated in strong stakeholder endorsement of the strategy, which is now being implemented. The Philippines has also established a national eHealth steering committee composed of representatives from key government agencies to oversee policies for eHealth. A national eHealth technical working group comprising information technology experts from government, academia and the private sector has also been established.

Using mHealth innovations to catalyse achievement of MDGs and improve accountability

The use of mobile technology for health – mHealth – is part of the broader eHealth landscape and has been leveraged to strengthen the performance of health systems and improve accountability. The UN Innovation Working Group Catalytic mHealth Grant mechanism improves the potential of expanding mHealth innovations to scale and contributing to improved maternal, newborn and child health. Since its inception in 2011, grants have been awarded to 26 projects in 15 countries with demonstrated potential for scale-up.

At least five of the supported projects have achieved national scale or are in negotiation with government stakeholders for institutionalization:

- **MomConnect** in South Africa, which registers pregnancies in the national health system and provides stage-based pregnancy messages to expectant mothers;
- **cStock** in Malawi, which provides supply-chain management support by providing real-time communication on stockouts of essential drugs and commodities;
- **mTRAC** in Uganda, which distributes SMS-based indicator reports to health care facilities in an effort to improve performance and service delivery through increased accountability and feedback;
- **Wired Mothers** in Zanzibar, which links women to health-care facilities through an automated SMS system and an emergency call system; and
- **Society for Elimination of Rural Poverty (SERP)** in India, which tracks data on the nutritional status, immunizations, antenatal care, postnatal care, and growth monitoring.

WHO has developed tools, for example, the mHealth Assessment and Planning for Scale (MAPS) handbook to guide scale-up, improve planning and optimize implementation with the aim of accelerating innovations. Other contributions include developing standardized approaches for classifying and cataloguing mHealth innovations, and establishing ways of representing innovations in a way that resonates with decision-makers who are focused on addressing health system constraints. The successful integration of “top-down” eHealth strategy development and normative guidance with “bottom-up” innovations from practitioners holds promise for transparent and transformative strengthening of health care services and improved accountability.

Better tracking of resources: country results emerging from the System of Health Accounts 2011 approach (SHA 2011)

Although health accounts have been in practice for over a decade, the revised SHA 2011 methodology represents a significant step towards improved resource-tracking for health, and more specifically for women's and children's health. UNAIDS, UNFPA, GAVI, The Global Fund, the Bill & Melinda Gates Foundation and WHO have endorsed SHA 2011, which standardizes the measurement of expenditure per beneficiary, including expenditure by disease/condition and by age, and allows for more efficient tracking of expenditures over time.

In response to the Commission's recommendation, the SHA 2011 methodology is now widely accepted by more than 65 lower-income countries. Of these, 33 have completed at least one year of implementing health accounts, of which 10 countries have data for at least two subsequent years. Important results are emerging from 25 countries that have produced expenditure data specific to RMNCH expenditures (see Annex 1).

Tracking expenditures over time allows for trend analysis that can guide policy. DRC and Burkina Faso and Niger have data covering several years. DRC data shows that domestic funding decreased slightly (as a percentage of total RMNCH expenditure) while donor (external) funding increased. Niger and Burkina Faso both show slight but steady increases in domestic funding (see figure).

Cambodia institutionalizes the SHA 2011 methodology

Cambodia conducted their first analysis on 2012 data, published in the 2014 Cambodia National Health Accounts (NHA) report. The analysis was repeated with data from 2013 and 2014, with an anticipated release in the third quarter of 2015.

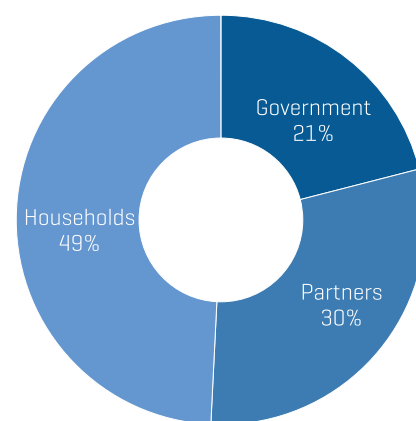
Key findings:²²

- ▶ Cambodia spent more than US\$ 1 billion on health care in 2012, which is considerably higher than estimates of previous years.
- ▶ Total health expenditure as a share of Gross Domestic Product (GDP) was the highest among low- and middle-income countries in the region. Government health expenditure as a share of GDP was lower than in most low- and middle-income countries in the region.
- ▶ Communicable diseases and non-communicable diseases accounted for 33% of spending.
- ▶ One quarter of spending was for reproductive, maternal and child health.
- ▶ 60% of total spending came from out-of-pocket expenditures by households.
- ▶ 20% of health expenditure was spent on salaries and incentives of health workers.

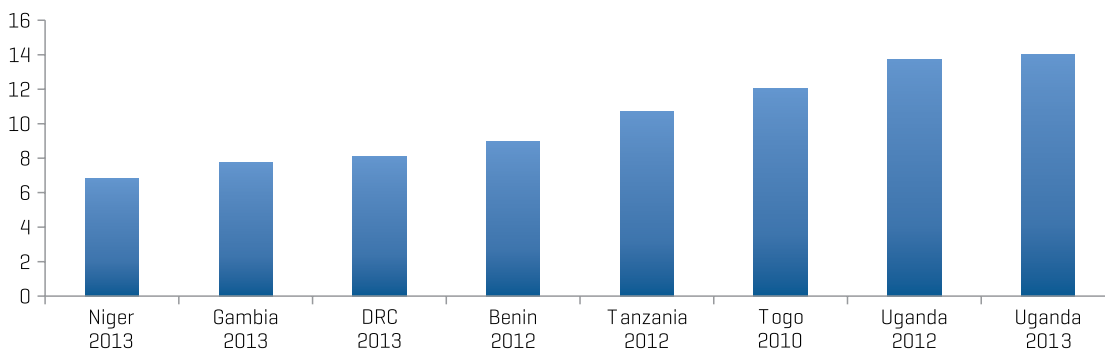
Out-of-pocket expenditure continues to be a major barrier to health care access and may be a cause of indebtedness and impoverishment for patients. In the 8 countries²³ with the lowest GDP per capita, households pay close to 50% of the costs of RMNCH services. Relying on out-of-pocket expenditure may also delay care seeking, which makes it more costly to treat patients when they do present to the health facility.

Looking at data from a selection of the poorest countries (lower than than US\$ 800 gross domestic product per capita), the average per capita expenditure on RMNCH is US\$ 10 per year. This varies widely, from a low of US\$ 7 in Niger to US\$ 14 in Uganda or Burkina Faso. On average, RMNCH expenditure is 34% of current health expenditure, ranging from 26% in Tanzania and Togo to 47% in Benin.

Households still pay nearly half the costs for RMNCH



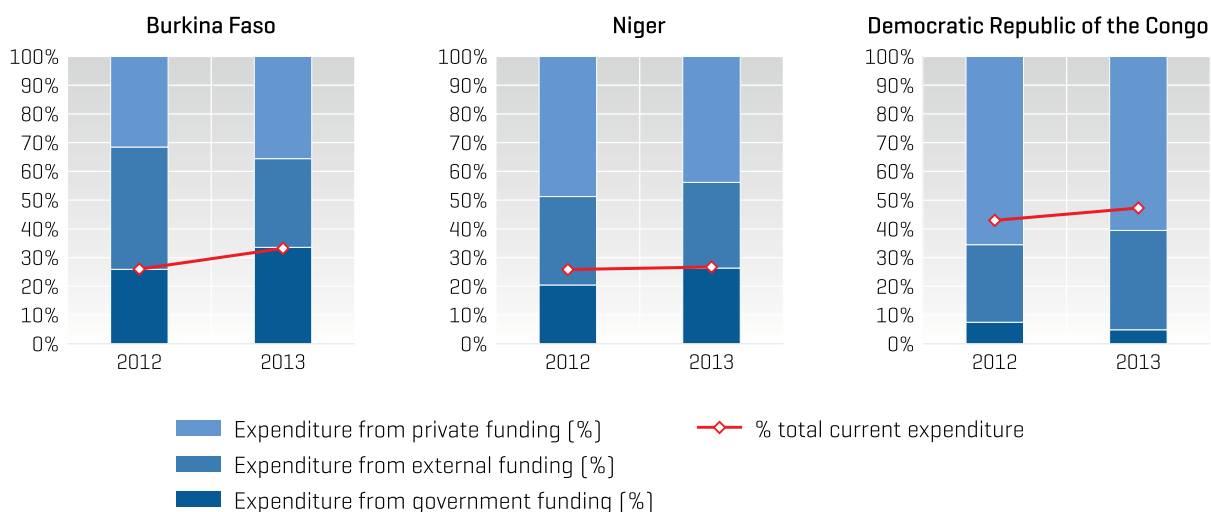
In low income countries, average expenditure on RMNCH is US\$ 10 per person (GDP per capita of less than 800 US\$)



22. Estimating Health Expenditure in Cambodia: National Health Accounts Report (2012 Data). Kingdom of Cambodia. Ministry of Health. Bureau of Health Economics and Finance of the Department of Planning and Health Information with support from the World Health Organization and the Clinton Health Access Initiative; October 2014.

23. Data from 8 countries with high quality data and where governments have agreed to disseminate data.

Trends in current expenditure on reproductive and child health



Insights gained after four years of investing in the SHA 2011 methodology:

- ▶ Credible results are emerging on health accounts that can inform decision-making. It is important to recognize that institutionalizing SHA 2011 requires four to five years.
- ▶ The quality of health accounts data is related to the level of support provided by high-level decision-makers in the health sector. Countries with the greatest difficulties (lengthier production, stalling, lower quality data) are those with little institutional support.
- ▶ Published results, in particular expenditure by disease or by condition, generate more interest and demand for the data. This in turn secures support for health accounts for future years. It may take more than one year of results before the country team gets full support.
- ▶ The cost of rolling out SHA 2011 and producing yearly health accounts is high during the first few years. After four to five years of regular implementation, countries can produce yearly health accounts with an average annual budget of US\$ 20 000 plus five months of one full-time equivalent position. These investments need to be maintained in order to continue with the information and analysis for decision-making.
- ▶ The key advantage of SHA 2011, producing yearly results, is that it holds stakeholders accountable for fluctuations in trends.
- ▶ Development compacts or partnership agreements often include reference to the establishment and use of mechanisms for tracking expenditures, public expenditure reviews, donor financial reporting to governments, and health accounts.

Country compacts and health reviews play a vital role in the accountability cycle

Compacts or similar partnership agreements serve to improve cooperation among donors and development partners and to make health aid more effective. The agreements outline common management arrangements for finance and implementation, based on a single country health strategy, a single results framework and a single budget. Compacts have historically been signed by governments and development partners; signature by civil society organizations is an increasing trend. While not legally binding, compacts carry a moral obligation for signatories to comply with commitments, and thus contribute to improved mutual accountability.

The 2014 International Health Partnership (IHP+) Results monitoring report shows that in the 24 participating countries, 34% to 98% of development partners' expenditures were aligned with the country results framework, and 71% of external funds for health were recorded in the national budget. The report also showed that both countries and development partners support the engagement of CSOs in policy dialogue, including in joint annual reviews, sector coordination mechanisms, thematic working groups, development of the health sector plan. Although governments reported a high participation of civil society organisations (CSOs) in health reviews, CSOs are less likely to be included in budget development.

Civil society organizations increasingly engaging in compacts and health reviews

CSOs are important partners in IHP+. Women's groups in particular bring to the table insights into gaps in health service delivery and identify challenges that must be addressed in order to improve health. CSOs also play an important role in offering practical solutions and generating greater transparency by holding governments and partners to account.

Before mid-2010, only three out of 11 country compacts had been signed by CSOs (in Kenya, Mozambique and Viet Nam). Since mid-2010, CSOs have signed 10 out of 14 new IHP+ compacts.²⁴ Some CSO signatories are directly involved in delivering services to mothers and children (e.g. Church Health Associations of Kenya and Sierra Leone), while others are strong advocates for maternal and child health (e.g. Save the Children and "Bien-être de la femme et de l'enfant" in Niger).



Lessons learnt from country compacts:

- ▶ Countries value the role of compacts in bringing together all development partners in support of a single country health strategy. The process of developing a compact or partnership agreement builds trust and improved dialogue among country partners.
- ▶ Compacts have supported, enabled or co-existed with the development of other tools and instruments to improve health aid management. For example, Ethiopia and Nepal established joint financial arrangements with development partners as part of the compact implementation, and Sierra Leone conducted a joint financial management assessment. Ethiopia, Mali, Nigeria, and Sierra Leone each developed a results and accountability framework at the same time as, or soon after, their compact was signed.

Strengthened mid-term review of National Health Strategic Plan 2011-2016 in Zambia

Zambia is currently implementing the revised National Health Strategic Plan 2011 to 2016. In 2014, a mid-term review of the implementation and performance of this plan was conducted in a joint exercise including the Ministry of Health, the Ministry of Community Development, Mother and Child Health, other ministries, CSOs such as the Churches Health Association of Zambia (CHAZ), the private sector and other partners. CSOs provided key input on district-level activities and co-organized field visits to selected health sites, for partners to get a better sense of practical issues the communities face in health facilities.

It was found that many targets had not been achieved, particularly in areas such as immunization and maternal health. As a result, one of the main recommendations was to revise the Basic Package of Services to make it more suitable to the health needs of the population. Another important recommendation was to communicate and disseminate findings from the review to relevant stakeholders to help shape policy, planning, programming, implementation, and monitoring and evaluation efforts, and to improve implementation. The mid-term reviews and findings are crucial guiding documents to inform planning until the end of 2016 as well as for the development of the next National Health Strategic Plan.

24. Burundi, Cape Verde, Mauritania, Niger, Senegal, Sierra Leone, Sudan, Togo, Uganda, and Zambia.

Civil society contributes to better transparency, advocacy and action

CSOs are uniquely positioned to track progress on commitments made for women's and children's health. They have an important role in sharing on-the-ground knowledge of successes and challenges in delivering essential interventions and life-saving commodities, insisting on transparency in budget allocations, and demanding full implementation of national policies to improve women's and children's health.



Budget tracking and advocacy

CSOs, media and parliaments are crucial to increasing transparency on national budgets for women's and children's health. Budget analysis and advocacy are central parts of accountability. Analysing health budgets in relation to costed plans and expenditures enables a range of stakeholders to hold policymakers accountable for their commitments.

PMNCH, WHO and partners have trained CSOs, parliamentarians, media, ministries of finance and ministries of health to use budget- and resource-tracking information to monitor government spending on RMNCH priorities. This has served to strengthen the capacity and engagement of these constituencies to promote accountability and shape policy through budget analysis and advocacy. A total of 16 country teams²⁵ were trained in collaboration with Harmonization for Health in Africa, the Asian Development Bank, Save the Children, the Inter-Parliamentary Union, Family Care International, UNICEF, UNFPA, World Bank, WHO, World Vision International and White Ribbon Alliance.

Seed funding in Liberia brings about important achievements in budget tracking:

Representatives of national parliaments, civil society, and media from Liberia participated in the Anglophone Africa regional workshop on budget tracking and advocacy. During this workshop, the Liberia team developed a plan and received US\$ 20 000 in funding to kick-start an initiative to increase the budget allocation for RMNCH.

Achievements to date include:

- ▶ Enhanced social accountability tools, such as social audits that review official expenditure records, have generated evidence and facilitated engagement between government officials and communities on issues related to RMNCH and sexual and reproductive health services.
- ▶ A Member of Parliament is introducing a bill to mobilize and secure financial resources to fund RMNCH and sexual and reproductive health services.
- ▶ Civil society is engaging with the legislative and executive wings of government on health budget and policy implementation.
- ▶ There is increased reporting on RMNCH issues in the media, and in parliamentary speeches.

25. Burkina Faso, Democratic Republic of the Congo, Ghana, Mali, Malawi, Niger Nigeria, Senegal, Zambia and Zimbabwe. Francophone workshop held in May 2014 in Dakar, Senegal; Anglophone workshop held in January 2015 in Harare, Zimbabwe; Asian workshop, organized by the Asian Development Bank held in April 2015 in Manila, Philippines for Bangladesh, Cambodia, Indonesia, Myanmar, Nepal and Philippines.

Nigeria: Civil society works to implement the newly adopted National Health Act

In December 2014, Nigeria adopted the National Health Act, creating a Basic Health Care Provision Fund to provide Nigerians with access to basic health care services. The Act aims to contribute to universal health coverage, to achieving the health MDGs and to reducing mortality rates; it will provide health coverage for pregnant women and children under the age of five as well as essential vaccines and commodities. The Act is to be financed by a 1% contribution from the Federal government's Consolidated Revenue Fund as well as grants from international development partners. During the budget advocacy workshop, civil society, media and parliamentarians agreed to focus their efforts on implementing the Act, and the White Ribbon Alliance for Safe Motherhood is leading efforts to establish an implementation committee.

Parliamentarian action

The Inter-Parliamentary Union (IPU) has proposed a mechanism to ensure accountability for the implementation of its landmark resolution of 2012.²⁶ Representatives from more than 130 parliaments and 23 international and regional parliamentary organizations met at the 132nd IPU Assembly in Hanoi, Viet Nam in March 2015 and reviewed progress on implementing the resolution. They paid particular attention to the important role that parliaments must continue to play in improving women's and children's health, and heard examples of how parliaments across the globe have put in place relevant political changes, revised legislation, and adjusted budgets.

30 countries have taken legislative action for women and children, including increased budget allocations for reproductive health.

Thirty countries reported having taken legislative action on women's and children's health since 2012 (see Annex 1). For example, the United Arab Emirates adopted legislation on violence against women and is in the process of approving a law that protects children. The Philippines adopted a law on reproductive health, and Azerbaijan has regulated marriage registration.

Many parliaments referred to increased budget allocations for health that have led, in the cases of Cambodia, India, Uganda and Viet Nam, to increased funding for reproductive health issues, training of health workers, and the construction of health settings for safe deliveries. Parliamentarians also exchanged examples of good practices, particularly in the area of oversight of government action. Bangladesh highlighted how digitalization of data on maternal deaths allowed parliament to hold the heads of hospitals accountable for deaths in their facilities – a powerful motivation to reduce these numbers.

Effective implementation of legislation was identified as a key challenge by many parliaments. Parliaments committed to continuing to monitor budget allocations as well as laws and policies, in order to ensure that they have indeed led to the intended actions and impact. They called for continued support to building capacity in parliaments to address issues linked to women's and children's health and praised the role of the IPU in this regard.

"In Uganda the IPU resolution was instrumental in creating political momentum on MNCH. Much has been accomplished in the last few years... and the resolution remains a relevant instrument for parliamentary action."

Sylvia Ssinabulya
Member of Parliament, Uganda

"Parliaments serve as a bridge between citizens and their governments... they can – and must – lead the way, galvanizing action and fostering accountability and implementation."

Amina Mohammed
UN Assistant Secretary-General and special advisor
on post-2015 development planning²⁷

26. 'Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children'. <http://www.ipu.org/conf-e/126/res-3.htm>

27. <http://www.everywomaneverychild.org/global-strategy-2/news/1075-women-s-and-children-s-health-at-the-132nd-ipu-assembly>

National Citizens' Hearings

Starting in early 2015, the International Planned Parenthood Federation, Save the Children, the White Ribbon Alliance and World Vision joined with partners to host community and national Citizens' Hearings. These hearings have taken place in 27 countries²⁸ and have brought together community and government leaders to listen to, and act on the views of citizens on national priorities for women's, children's, newborns' and adolescent's health. Citizens' Hearings have been organized to:

- discuss new targets for women's, children's, newborns' and adolescents' health beyond 2015;
- inform new national accountability mechanisms, including for the updated UN Secretary-General's *Global Strategy on Women's, Children's and Adolescents' Health*; and
- develop a clear pathway for citizen engagement in accountability mechanisms at national and global levels.

The outcome of each Citizens' Hearing is a plan that sets out how government will engage with citizens and civil society in tracking progress.

The first of these hearings were held in Lira and Kabale districts in Uganda, each bringing together over 400 citizens to share their views on accountability for women's and children's health. Decision-makers – including Members of Parliament and district leaders – were present at both hearings. Citizens discussed the impact of recent citizen-led accountability that contributed to the government accelerating the delivery of its commitment to provide emergency care for pregnant women in health centres nearer their homes. Citizens made clear recommendations on immediate priorities and called on the leaders to ensure citizens are engaged in setting future priorities, as well as in budget tracking and monitoring of services. Decision-makers in the districts and the Minister of Health responded positively to these inputs, setting out a course of action for future engagement, and the citizens' recommendations were taken to the Prime Minister.



"We need to involve citizens in our work. We are going to sit together as a committee and prioritize the issues raised by citizens... I encourage reporting from the community. I will ensure we have dialogue meetings and talk shows to get the citizen's views".

Ms. Betty Akullu
Deputy Speaker of Lira District, Uganda

28. Afghanistan, Bangladesh, Burkina Faso, Democratic Republic of Congo, Ethiopia, India, Indonesia, Kenya, Malawi, Mali, Nepal, Niger, Nigeria, Pakistan, Uganda, United Republic of Tanzania, and Yemen.

Transparency on aid flows: OECD first-year report on aid for women's and children's health

The Creditor Reporting System (CRS) of the Organisation for Economic Co-operation and Development (OECD) Development Co-operation Directorate (DCD-DAC) collects data from the largest funders of aid in order to define and monitor global standards in key areas of development. The DAC has 29 members²⁹ who each year report individual aid activities to this system, as do 17 non-DAC countries, multilateral organizations and the Bill & Melinda Gates Foundation. The CRS has become the internationally recognized source of comprehensive data on the geographic and sectorial breakdown of aid recipient countries. However, this system was unable to collect data on aid in support of RMNCH, because relevant activities range across a multitude of sectors.

The Commission requested the OECD-DAC to modify the reporting system to capture data on aid in support of RMNCH. As a result, the OECD-DAC members agreed to test collecting data on RMNCH-relevant aid through a new policy maker that allows tracking across sectors.

How do donors report on aid using the policy markers?

In OECD, members reporting to the DAC CRS are requested to indicate whether each activity does or does not target RMNCH as one of its policy objectives. An aid activity is to be classified as RMNCH if it contributes to achieving improved maternal, newborn and child health based on the RMNCH continuum of care. The criteria for eligibility are:

- ▶ improving access for women and children to a comprehensive, integrated package of essential health interventions and services along the continuum of care;
- ▶ strengthening health systems in order to improve access to and deliver integrated high-quality RMNCH specific services;
- ▶ building RMNCH-specific workforce capacity, ensuring skilled and motivated workers in the right place at the right time, with the necessary infrastructure, drugs, equipment and regulations.

The RMNCH policy marker was introduced in 2014 to report on 2013 aid flows. It will be evaluated after a two-year trial period. Of the 29 DAC members expected to report, 19 (close to 70%) began reporting on the new policy marker (see Annex 1). However, the reporting showed that less than half of sector-allocable aid was screened against the new RMNCH marker, and it is premature to draw conclusions. For next year's reporting, it will be important to monitor which countries and organizations apply the policy marker in scoring their RMNCH activities to ensure that the marker is being used and can provide the information needed. It is expected that as more countries report, a better overall picture of aid flows for women's and children's health will be available.

Of the 29 DAC Members, 19 began reporting on the new policy marker and less than half of development aid was screened against the new marker.

29. Australia, Austria, Belgium, Canada, Czech Republic, Denmark, European Union, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, the Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, United Kingdom and the United States.

Independent Accountability – an innovative model driving global health policy

The Commission recommended the creation of a global oversight mechanism. The resulting independent Expert Review Group (iERG) is a unique model of accountability for women's and children's health. The members openly review and critique progress by the *Every Woman Every Child* community in implementing the *Global Strategy*, and report yearly to the UN Secretary-General on progress on the Commission's recommendations. In their annual reports, discussed among *Every Woman Every Child* stakeholders, the iERG has also generated additional recommendations. The overarching process of the iERG has helped shaped the direction of global health policy for women, children and adolescents. Some examples include:

- ▶ **Global investment for women's and children's health:**³⁰ In 2013, a global investment framework³¹ was developed that quantified the resources required to eliminate maternal and child deaths.
- ▶ **Results-based financing facility:** The results of the global investment framework contributed to the recommendation³² to develop a financing mechanism to support women's and children's health. The World Bank, the governments of Canada, Norway and the United States and H4+ partners are in the final stages of developing the Global Financing Facility (GFF) that will pool investments for women's, children's and adolescents' health. The new mechanism should be launched in July 2015.
- ▶ **Take adolescents seriously:** The iERG recommended an increased focus on adolescent health. Several actions have taken place, including the publication of the comprehensive, interactive WHO report on adolescent health, *The Health of the World's Adolescents*.³³ Adolescents are now included in the new *Global Strategy for Women's, Children's and Adolescents' Health*, and youth organizations around the world have been highly engaged in its development.³⁴
- ▶ **Human rights-based approaches:** In each report, the iERG highlights the need to focus on human rights-based approaches to women's and children's health. This has included a greater focus on quality of care and on drawing attention to gender and social inequities. The more recent recommendation to establish a Human Rights Commission is under consideration by partners contributing to the *Global Strategy*.
- ▶ **A new, broader and more inclusive strategy:** The new *Global Strategy*, to be launched in September 2015, responds to the iERG recommendations, including the focus on adolescents and human rights.
- ▶ **Governance structure for independent accountability:** This structure will monitor, review and propose actions to accelerate global and country progress for the new *Global Strategy*. The lessons from the current iERG structure are important contributions to these discussions.

Commission on Ending Early Childhood Obesity (ECHO) builds on lessons and successes of independent accountability

The complexity of many of the health issues confronting the international community requires concerted global efforts, enhanced political will and demonstrable commitments from all stakeholders. Achieving tangible results and making meaningful progress, however, depend on translating these commitments into concrete and measurable actions through a whole-of-society approach.

Following the encouraging progress in implementing the CoIA recommendations and the significant traction gained by the CAFs, the Director-General of WHO has convened an Ad hoc Working Group on Implementation, Monitoring and Accountability for Ending Childhood Obesity to develop an inclusive, transparent and robust accountability framework, building on the lessons learnt from the CoIA. This will engage all stakeholders, including governments, UN agencies, civil society and the private sector to ensure optimal implementation of the policy options that ECHO will recommend in its final report.

30. http://www.who.int/maternal_child_adolescent/news_events/news/2013/global-investment-framework/en/

31. IERG 2012 Report available at: http://www.who.int/woman_child_accountability/iERG/reports/2012/IERG_report_low_resolution.pdf?ua=1

32. iERG 2014 Report available at: http://apps.who.int/iris/bitstream/10665/132673/1/9789241507523_eng.pdf?ua=1

33. www.who.int/adolescent/second-decade

34. IERG 2013 Report available at: http://apps.who.int/iris/bitstream/10665/85757/1/9789241505949_eng.pdf?ua=1

INSIGHTS ON ACCOUNTABILITY FOR THE NEW GLOBAL STRATEGY

The framework proposed by the Commission on Information and Accountability in 2011 was based on four accountability principles: focus on national leadership, strengthen country capacity to monitor and evaluate, reduce the reporting burden and strengthen and harmonize mechanisms to track progress on commitments. As the global RMNCH community looks beyond the deadline of the MDGs in 2015, there is broad agreement on the need for a continued accountability framework as well as a robust mechanism to strengthen accountability for results for women's, children's and adolescents' health.

At a high-level stakeholders meeting in Geneva, November 2014, *Every Woman Every Child* partners agreed that the current *Global Strategy for Women's and Children's Health* had mobilized political and financial commitment and played an important role in accelerating the rates of reduction of maternal and child mortality. However, it is clear that the job is not yet done, and there is an urgency to maintain and expand the momentum for women, children and adolescents – especially those who are most difficult to reach due to poverty, inequity, and the challenges of humanitarian and fragile settings.

A multi-partner process was therefore launched to update the *Global Strategy*. The accountability work stream, led by the Governments of Canada and the United Republic of Tanzania with the involvement of many partners, set itself the following objectives:

- ▶ Update the accountability framework and mechanisms at both country and global levels for the revised *Global Strategy*, including incorporating aspects of adolescent health and the social determinants of health (as guided by work on the Conceptual Framework);
- ▶ Establish/confirm relevant indicators, and linkage with SDG goals and targets;
- ▶ Provide input/recommendations on the overall architecture and/or governance for oversight of the revised *Global Strategy* as it relates to accountability.

The accountability work stream produced a working paper with several options for the accountability framework and mechanism post-2015, with an eye to alignment with the eventual accountability framework for the SDGs. While discussions are ongoing, there is consensus on the need for both mutual and independent accountability, the need to strengthen support for country-level accountability, the need to further coordinate and harmonize accountability efforts at the country and global level, for greater engagement at regional level; and the need to strengthen remedial action.

In this moment of transition, it is useful to take stock of some of the ongoing challenges in the hope that these will help to shape and strengthen the model for accountability as we move forward.

Challenges at country level: Countries have not accelerated progress evenly across the various recommendations in the accountability framework, and no country has fully achieved its targets. Countries are still without functioning CRVS systems, most countries do not have management information systems to capture all 11 core indicators on a regular basis, and in many countries, national health accounts and MDSR remain at a pilot phase. Accelerated support to countries is needed to fully implement the Commission's ten recommendations, which remain relevant beyond 2015.

It is also noteworthy that some of the most impressive actions at country level only took off two years after the launch of the Commission on Information and Accountability in 2011, as it took time to build the political support, to convene partners to agree on one plan, and to begin implementation. Many countries are now starting to institutionalize the accountability work within their health systems, and investments need to be sustained. As much as possible, the accountability work under the new *Global Strategy* should continue to build on existing plans, structures and investments.

The accountability framework for the new *Global Strategy* should build on existing plans, structures and investments, instead of launching new processes.

Challenges at global level: At the global level, the current *Global Strategy* aimed to have one accountability framework for a number of various initiatives. Nonetheless, the current accountability framework is spread over different agencies with often separate reporting systems, resulting in the very inefficiencies and duplication that the Commission was trying to address. Further thought needs to be given to how to best harmonize accountability efforts at the country and global level.

The current accountability framework is spread over different agencies and initiatives. Further thought needs to be given on how to better harmonize accountability efforts.

Insights on accountability for the updated *Global Strategy*: In view of these and other challenges, there are some cross-cutting lessons on accountability that partners should consider in the updated *Global Strategy* and its accompanying accountability structure. These include:

- ▶ **Country ownership is vital to success.** Countries must drive the agenda. The parallel initiatives and data demands by development partners must be harmonized and reduced.
- ▶ **Equity and human rights are at the heart of the accountability agenda.** The accountability framework, both at country and global levels, needs to have increased focus on the most vulnerable populations and economic quintiles. The information gathered needs to be disaggregated by gender, income level and geographical location to ensure that appropriate priorities and resources can be applied.
- ▶ **Independent accountability mechanisms remain important:** In order to strengthen accountability, there is the need for robust and independent monitoring; transparent and participatory review; and effective and responsive action.
- ▶ **Communication and dissemination must be enhanced.** Reports and outcomes derived from accountability processes must be more widely and strategically communicated to global, regional and national institutions to ensure widespread discussion, feedback and strengthened remedial action at all levels.
- ▶ **Engagement of civil society is key and must be strengthened.** Participation of civil society and parliaments in accountability processes has been increasing. Models of civil society review and participation in RMNCH in a number of countries should be examined and replicated.
- ▶ **Parliamentarians important for enhanced transparency.** Parliamentarians represent citizen voices and must continue to play a role in revising legislation, allocating budgets, improving oversight and advocating for women's and children's health.
- ▶ **Data needs to be transparent and freely accessible, in usable formats.** Scorecards are an example of open access to data, but progress and availability of this information is uneven. Global agencies also need to ensure open access to data and investments for RMNCH in countries.
- ▶ Finally and of critical importance, there need to be much stronger **linkages between the three parts of the accountability framework: monitoring, review and act.**

The accountability framework has proven to be a powerful tool to guide global, regional and country action, increasing participation and transparency aligning investments, and improving health information systems. A vigorous and independent mechanism for accountability is essential post-2015. Implementation of the ColA recommendations remain relevant and should continue to inform and shape the new accountability framework, and support its implementation.

"The Global Strategy generated unprecedented momentum, and catalysed a coming together of many partners to overcome the most stubborn health challenges for women and children. Thanks to the Commission on Information and Accountability, the global community was able to demonstrate better results, better tracking of financial resources and better oversight for women's and children's health within a short timeframe."

Dr Margaret Chan
Director-General, World Health Organization



ANNEX 1: SNAPSHOT OF PROGRESS TOWARDS THE COMMISSION'S 10 RECOMMENDATIONS

Work Area	Recommendation	Target	Results April 2015
Country Accountability Framework (CAF)	Countries have plans for strengthening national accountability processes.	50 countries with CAFs by 2013	68 countries are in the final stages of implementing country accountability frameworks. 17 countries demonstrate results and were awarded additional catalytic funds.
1 Vital events and Maternal Death Surveillance and Response (MDSR)	By 2015, countries improve systems for registration of births, deaths and causes of death and health information systems.	50 countries with civil registration and vital statistics (CRVS) assessments and plans by 2015	64 countries have conducted an assessment of their CRVS system, or have an assessment underway.
		50 countries making improvements in MDSR by 2015	51 countries have national policy requiring all maternal deaths to be notified. 55 countries are implementing facility based maternal death reviews. 30 countries are implementing community-based maternal death reviews.
2 Health Indicators	By 2012, countries using the same 11 indicators on RMNCH, disaggregated for gender and other equity considerations.	50 countries use and have accurate data on the core indicators Global partners have streamlined reporting systems	51 countries using web-based facility reporting (e.g DHIS 2). The majority of other countries conduct regular household surveys, and 20 countries have introduced data quality improvement mechanisms.
3 eHealth and Innovation	By 2015, countries integrating Information and communication technologies in national health information systems and health infrastructure.	By 2015, 50 countries developed and implementing national eHealth strategies	27 countries have an eHealth strategy. Additional 20 countries set to undertake joint (health and ICT) eHealth planning and implementation in 2015.
4 Resource Tracking	By 2015, countries are tracking and reporting: 1) total health expenditure by financing source, per capita; and 2) total RMNCH expenditure by financing source, per capita.	By 2013, 50 countries have and use accurate data on the two indicators, as part of their monitoring and evaluation systems	New System of Health Accounts 2011 methodology accepted by countries and global partners (GAVI, Global Fund, USAID). 65 countries have adopted the SHA 2011 methodology. 33 countries have data on RMNCH expenditure.
5 Country Compacts ³⁵	By 2012, "compacts" in place between governments and development partners.	By 2015, 50 countries have formal agreements with donors	51 countries ³⁶ have compact or similar partnership agreements for the health sector in place. Since 2010, more than one in three of these compacts have been co-signed by civil society or non-state actors.
6 Reaching Women and Children	By 2015, governments have capacity to review health spending and relate spending to commitments, human rights, gender and equity goals and results.	Linked to Recommendations 2 and 4	PMNCH tracks implementation of commitments and spending. Budget advocacy workshops held for 21 country teams of media, civil society and parliaments to better understand national budget expenditures for RMNCH.

Work Area	Recommendation	Target	Results April 2015
7 National Oversight [Health Sector Reviews, Advocacy and Action]	By 2012, countries have transparent and inclusive national accountability mechanisms.	50 countries have regular national health sector review processes	54 countries have reported undertaking an annual, or mid-term review, or a similar process [such as a health summit].
		20 countries are engaging political leaders and financial decision-makers in health	Parliaments in 30 countries have engaged in legislation and/or increased budget allocation to improve the health of women and children.
		50 countries have held a Countdown event	Countdown to 2015 has been providing regular global and country assessments of progress towards the 11 core indicators.
8 Transparency	By 2013, stakeholders publicly sharing information on commitments, resources and results achieved annually, at both national and international levels.	50 countries with mechanisms for sharing and disseminating data Global partners with databases on women's and children's health, and dissemination on core indicators	Global partner databases for 11 core indicators are publicly available through Countdown to 2015. Web-based facility reporting systems [DHIS 2.0] make information publicly available. 27 countries organizing civil society hearings on women's, children's, adolescents' health. OECD-DAC reporting on aid flows for RMNCH.
9 Reporting Aid for Women's and Children's Health	By 2012, OECD-DAC to agree on improvements to Creditor Reporting System [CRS] to capture RMNCH health spending by development partners.	By 2012, development partners agree on the method By 2013, OECD has developed guidance and instruction to support new method, and donors using new method	19 DAC member countries began reporting on the RMNCH policy marker.
10 Global Oversight	2012–2015, an independent Expert Review Group [iERG] reporting to the United Nations Secretary-General on the results and resources related to the <i>Global Strategy</i> and progress on CoA recommendations.	Members appointed Reports due September 2012 and every year until 2015	Three reports delivered to the UN Secretary-General with recommendations to accelerate progress on the <i>Global Strategy for women's and children's health</i> .

35. The Commission suggested a target date of 2012 for this recommendation. However, during the stakeholder meeting that resulted in the original strategic workplan for implementing the recommendations, the date of 2015 was deemed more realistic.

36. This includes non-CoA countries: Bosnia and Herzegovina, Fiji, Seychelles, Tunisia.

ANNEX 2: SNAPSHOT OF COUNTRY PROGRESS WITHIN SELECTED WORKSTREAMS³⁷

Country	Country accountability framework	CRVS (assessment completed, plan developed and in progress) ³⁷	MDSR system in place ³⁸	Timely and accurate data available for monitoring core indicators ³⁹	National eHealth strategy developed and being implemented	Country reporting on expenditure indicators by financing source	IHP+ compact or similar partnership agreement operational	National health sector review process with stakeholder participation
Afghanistan								
Angola								
Azerbaijan								
Bangladesh								
Benin								
Bolivia								
Botswana								
Brazil								
Burkina Faso								
Burundi								
Cambodia								
Cameroon								
CAR								
Chad								
China								
Comoros								
Congo								
Côte d'Ivoire								
Djibouti								
Democratic People's Republic of Korea								
Democratic Republic of the Congo								
Egypt								
Equatorial Guinea								
Eritrea								
Ethiopia								
Gabon								
Gambia								
Ghana								
Guatemala								
Guinea								
Guinea-Bissau								
Haiti								
India								
Indonesia								
Iraq								
Kenya								
Kyrgyzstan								
Lao People's Democratic Republic								
Lesotho								
Liberia								
Madagascar								
Malawi								
Mali								

Country	Country accountability framework	CRVS (assessment completed, plan developed and in progress) ³⁷	MDSR system in place ³⁸	Timely and accurate data available for monitoring core indicators ³⁹	National eHealth strategy developed and being implemented	Country reporting on expenditure indicators by financing source	IHP+ compact or similar partnership agreement operational	National health sector review process with stakeholder participation
Mauritania								
Mexico								
Morocco								
Mozambique								
Myanmar								
Nepal								
Niger								
Nigeria								
Pakistan								
Peru								
Philippines								
PNG								
Rwanda								
Sao Tome and Principe								
Senegal								
Sierra Leone								
Solomon Islands								
Somalia								
South Africa								
South Sudan								
Sudan								
Swaziland								
Tajikistan								
Togo								
Turkmenistan								
Uganda								
United Republic of Tanzania								
Uzbekistan								
Viet Nam								
Yemen								
Zambia								
Zimbabwe								

Legend:

- Result is achieved or is likely to be achieved by 2015
- Progress is being made, but a continued effort is necessary to achieve results
- Workstream has not been prioritized / work has not begun

37. Progress in the workstreams may not be solely attributable to country accountability framework activities.

38. Countries where a policy exists for maternal death notification plus facility based death review and/or community maternal death review.

39. Countries where web-based reporting system [DHIS 2.0] is operational/in progress and where data quality mechanisms are in place.

ANNEX 3: COMMISSION ON INFORMATION AND ACCOUNTABILITY'S 10 RECOMMENDATION

Better information for better results

1. **Vital events:** By 2015, all countries have taken significant steps to establish a system for registration of births, deaths and causes of death, and have well-functioning health information systems that combine data from facilities, administrative sources and surveys.
2. **Health indicators:** By 2012, the same 11 indicators on reproductive, maternal, newborn and child health, disaggregated for gender and other equity considerations, are being used for the purpose of monitoring progress towards the goals of the *Global Strategy*.
3. **Innovation:** By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.

Better tracking of resources

4. **Resource tracking:** By 2015, all 75 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: 1) total health expenditure by financing source, per capita; and 2) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.
5. **Country Compacts:** By 2012, in order to facilitate resource tracking, “compacts” between country governments and all major development partners are in place that require reporting, based on a format to be agreed in each country, on externally funded expenditures and predictable commitments.
6. **Reaching women and children:** By 2015, all governments have the capacity to regularly review health spending (including spending on reproductive, maternal, newborn and child health) and to relate spending to commitments, human rights, gender and other equity goals and results.

Better oversight of results and resources: nationally and globally

7. **National oversight:** By 2012, all countries have established national accountability mechanisms that are transparent, that are inclusive of all stakeholders, and that recommend remedial action, as required.
8. **Transparency:** By 2013, all stakeholders are publicly sharing information on commitments, resources provided and results achieved annually, at both national and international levels.
9. **Reporting aid for women's and children's health:** By 2012, development partners request the OECD-DAC to agree on how to improve the Creditor Reporting System so that it can capture, in a timely manner, all reproductive, maternal, newborn and child health spending by development partners. In the interim, development partners and the OECD implement a simple method for reporting such expenditure.
10. **Global oversight:** Starting in 2012 and ending in 2015, an independent Expert Review Group is reporting regularly to the United Nations Secretary-General on the results and resources related to the *Global Strategy* and on progress in implementing the Commission's recommendations.



LIST OF ACRONYMS

ALMA	African Leaders Malaria Alliance
CAF	Country Accountability Framework
CoIA	Commission on Information and Accountability
CRVS	Civil Registration and Vital Statistics
CRS	Creditor Reporting Systems
CSO	Civil Society Organization
DAC	Development Assistance Committee (OECD)
DHIS 2.0	District Health Information Software version 2.0
EVD	Ebola Virus Disease
EWEC	<i>Every Woman Every Child</i>
GFF	Global Financing Facility
H4+	Health 4+ (UNFPA, UNICEF, UNAIDS, WHO, World Bank, UN Women)
ICD-10	International Classification of Diseases 10 th Revision
ICT	Information and Communication Technology
iERG	independent Expert Review Group
IHP+	International Health Partnership
IPU	Inter-Parliamentary Union
MDG 4	Millennium Development Goal 4: Reduce child mortality
MDG 5	Millennium Development Goal 5: Improve maternal health
MDSR	Maternal Death Surveillance and Response
mHealth	Mobile health technology and systems
ODA	Overseas Development Assistance
OECD	Organisation for Economic Co-operation and Development
PMNCH	Partnership for Maternal, Newborn & Child Health
RMNCH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SHA 2011	System of Health Accounts 2011

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