Commission on information and accountability for
Women's and Children's Health

TRANSLATING RECOMMENDATIONS INTO ACTION

FIRST PROGRESS REPORT ON IMPLEMENTATION OF RECOMMENDATIONS

November 2011–June 2012

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EVERY WOMAN
EVERY CHILD

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This is a preliminary report covering activities that have been carried out since November 2011, when the Strategic Workplan for Accountability (strategic workplan) was endorsed in a stakeholders' meeting in Ottawa, co-hosted by the Government of Canada and WHO. Working groups were formed to implement the strategic workplan.

The first few months of work focused on institutional accountability processes by establishing national frameworks and global support activities. Results will become more apparent in the course of the upcoming implementation year. This report is prepared to inform the independent Expert Review Group for its progress report to the United Nations Secretary-General.

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Terminology

AIDS	Acquired Immune Deficiency Syndrome
ALMA	African Leaders Malaria Alliance
APR	Annual Programme Reviews
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CIDA	Canadian International Development Agency
COIA	Commission on Information and Accountability
CRVS	Civil Registration and Vital Statistics
CRS	Creditor Reporting Systems (OECD)
CSO	Civil Society Organization
DAC	Development Assistance Committee (OECD)
DHS	Demographic and Health Survey
EmOC	Emergency Obstetric Care
EWEC	Every Woman Every Child
Global Strategy	United Nations Secretary-General's Global Strategy for Women's and Children's Health
H4+	Health 4+ (UNFPA, UNICEF, WHO, World Bank, UNAIDS, UNWOMEN)
HMN	Health Metrics Network
HRH	Human Resources for Health
HSR	Health Sector Review
ICT	Information and Communication Technologies
iERG	independent Expert Review Group
IHME	Institute for Health Metrics and Evaluation
IHP+	International Health Partnership
IPPF	International Planned Parenthood Federation
IPU	Inter-Parliamentary Union
MDGs	Millennium Development Goals
MDG4	Millennium Development Goal 4: Reduce child mortality
MDG5	Millennium Development Goal 5: Improve maternal health
MDSR	Maternal Death Surveillance and Response
MICS	Multiple Indicator Cluster Survey

MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
Norad	Norwegian Agency for Development Cooperation
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
ODA	Overseas Development Assistance
OECD	Organisation for Economic Co-operation and Development
PMNCH	The Partnership for Maternal, Newborn & Child Health
RMNCAH	Reproductive, Maternal, Newborn and Child Health
SWAp	Sector-Wide Approach
SIDA	Swedish International Development Agency
Strategic Workplan	Strategic Workplan for Accountability for Women's and Children's Health
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNGASS	United Nationals General Assembly Special Session
UNSG	United Nations Secretary-General
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

Two of the eight Millennium Development Goals (MDGs) concerned with improving the health of women and children are the furthest from being achieved. In September 2010, in an effort to accelerate progress on MDGs 4 and 5, the Secretary-General of the United Nations, Ban Ki-moon, launched the ***Global Strategy for Women's and Children's Health*** (Global Strategy). The main goal of the Global Strategy is ***to save the lives of 16 million women and children by 2015 and accelerate progress to achieve MDGs 4 and 5***.

In order to reach the goals of the Global Strategy, countries have made specific commitments to accelerate action towards the achievements of the MDGs. More than 200 commitments have been made to advance the Global Strategy. Other global initiatives and events are tackling different aspects of implementing the Global Strategy, including the Child Survival Call to Action (June 2012 in Washington), The Family Planning Summit (July 2012 in London) and the United Nations Commission on Life-Saving Commodities for Women and Children. All of these efforts contribute to the goals of the Global Strategy.

The Global Strategy called for a process to ensure global reporting, oversight and accountability on women's and children's health. In response, the Commission on Information and Accountability (CoIA) was convened and delivered a report, *Keeping Promises, Measuring Results*. The report highlights 10 ambitious yet practical recommendations to fast track results for women's and children's health in 75 countries, which account for 98% of all maternal and child deaths in the world. The 10 recommendations are categorized under the headings: *better information for better results*; *better tracking of resources;* and *Better oversight of results and resources: nationally and globally*.

The initiative has facilitated broad-based partnerships with more than 40 partner institutions representing technical health experts, planning and statistics specialists, health information systems and information technology experts, advocates, politicians, and the private sector. Multi-partner working groups were formed and are implementing the Commission's recommendations based on the joint strategic workplan, which includes 11 work areas. This report represents the first progress report to the independent Expert Review Group (iERG) on implementation towards the Commission's 10 recommendations. This report is prepared to inform the iERG for their progress report to the United Nations Secretary-General.

Of the various work areas, five are on track (or even exceeding targets), five are making progress and one recommendation has mixed progress. The first months of implementation were critical to establish processes supporting countries to develop Country Accountability Frameworks (CAFs). CAFs define priority actions for countries to improve women's and children's health aligned with the Commission's recommendations. Countries are making remarkable progress and are laying the groundwork for sustainable achievements to improve women's and children's health. By the end of 2012, almost 75 priority countries will have draft CAFs. The 39 countries that currently have developed CAFs are at the phase of implementation to produce long-term sustainable results. To ensure commitments are met, it is critical to maintain investment and momentum from all stakeholders.

Snapshot of progress towards the Commission's 10 Recommendations

Work Area	Recommendation	Target	Result	Status
Country Accountability Framework (CAF)	Countries have plans for strengthening national accountability processes	50 countries with Country Accountability Frameworks by 2013	39 countries have developed CAFs	On track
1 Vital events and Maternal death surveillance and response (MDSR)	By 2015, countries improve system for registration of births, deaths and causes of death and health information systems	50 countries with CRVS assessment and plan by 2015	29 countries have completed CRVS assessment	On track
		50 countries making improvements in MDSR	29 countries making improvements in MDSR	
2 Health Indicators	By 2012, countries using the same 11 indicators on RMNCAH, disaggregated for gender and other equity considerations	50 countries use and have accurate data on the core indicators	72 priority countries have data on the core indicators	On track
		Global partners have streamlined reporting systems	GAVI, Global Fund and UNAIDS streamlining reporting system	
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 a national eHealth strategy and plan	Making progress
4 Resource Tracking	By 2015, countries are tracking and reporting: (i) total health expenditure by financing source, per capita; and (ii) total RMNCAH by financing source, per capita	By 2013, 50 countries use and have accurate data on the two indicators, as part of their M&E systems	17 countries (partially) tracking RMNCAH expenditure	Making progress
5 Country Compacts	By 2012, "compacts" in place between governments and development partners	By 2015, 50 countries have formal agreements with donors	17 countries with compact or equivalent partnership agreement	Making Progress
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	Linked to recommendations 2 and 4	Making Progress
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	37 countries have conducted an annual health sector review (in the last year)	On track
		20 countries engaging political leaders and financial decision makers in health	Parliamentarians from 10 countries engaged	Making progress
		50 countries have held a Countdown event	13 countries planning a national Countdown event	Making progress
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 partner databases for key 11 indicators publicly available through Countdown to 2015	Making progress
		Global partners with databases on women's and children's health, and dissemination on core indicators		

Work Area	Recommendation	Target	Result	Status
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 RMNCAH health spending by development partners	By 2012, development partners agree on the method	Members of the OECD-DAC's Working Party on Statistics (WP-STAT) agreed to use a scoring system of five values to tag RMNCAH investments in the CRS	On track
		By 2013, OECD has developed guidance and instruction to support new method and donors implementing it		
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 Global Strategy and progress on Commission recommendations	Members appointed	Independent Expert Review Group members selected	On track
		Report due September 2012	Report in progress	

Background

In September 2010, the United Nations Secretary-General launched the ***Global Strategy for Women's and Children's Health*** (Global Strategy), which brings together countries and partners committed to achieve MDGs 4 and 5 and save 16 million lives by 2015. The Global Strategy focuses on 49[1] of the poorest countries and an additional 26[2] countries which are part of the Countdown to 2015. Together, these 75 countries account for 98% of all maternal and child deaths in the world. In order to implement the Global Strategy, countries have made specific commitments to accelerate action towards achieving the MDGs, in particular MDGs 4 and 5. More than 200 commitments have been made to advance the goals of the Global Strategy, including commitments from countries, donors, foundations, NGOs, the private sector, health professionals and academia.

The Global Strategy is rallying global leaders and partners to tackle different aspects of implementing the Global Strategy. The recent Child Survival Call to Action held in June 2012 in Washington, hosted by the governments of the United States, India and Ethiopia, joined with UNICEF to intensify efforts to end preventable child deaths. Similarly, the United Kingdom and the Bill & Melinda Gates Foundation co-hosted a Family Planning Summit in London that aims to generate political commitment and resources to meet the family planning needs of women in the world's poorest countries by 2020. The United Nations Commission on Life-Saving Commodities for Women and Children, spearheaded by the President of Nigeria and the Prime Minister of Norway, aims to produce recommendations that lead to action to increase access to essential health commodities. These global movements are all contributing to the goals of the Global Strategy.

The Global Strategy called for the World Health Organization (WHO) to chair a process to "determine the most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health". In response, the Commission on Information and Accountability (CoIA) was convened by President Kikwete from the United Republic of Tanzania and Prime Minister Harper from Canada. The Commission included 30 members representing Ministers, heads of bilateral, civil society and UN agencies, presidents of foundations, private sector and other institutions, academics and other prominent leaders. The Commission delivered a report, *Keeping Promises, Measuring Results*, that presented 10 ambitious but practical recommendations to fast track results for women's and children's health and achieve the goals in the Global Strategy (see **Table 1**). The recommendations are based on **the following key principles**:[3]

- **Encourage national leadership and ownership** of results;
- **Strengthen countries' capacity** to monitor and evaluate;

1 Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Cote d'Ivoire, Eritrea, Ethiopia, The Gambia, Ghana, Guinea, Guinea-Bissau, Haiti, Kenya, Democratic People's Republic of Korea, Kyrgyz Republic, Lao People's Democratic Republic, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, Tajikistan, Tanzania, Togo, Uganda, Uzbekistan, Vietnam, Yemen, Zambia and Zimbabwe.

2 Angola, Azerbaijan, Bolivia, Botswana, Brazil, Cameroon, China, Congo, Djibouti, Egypt, Equatorial Guinea, Gabon, Guatemala, India, Indonesia, Iraq, Lesotho, Mexico, Morocco, Peru, Philippines, South Africa, South Sudan, Sudan, Swaziland and Turkmenistan.

3 Additional principles were added to include recommendations based on principles of human rights, and achieving equity in health; as well as principles such as monitoring, reviewing and acting.

TABLE 1: THE COMMISSION'S 10 RECOMMENDATIONS	
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 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: (i) total health expenditure by financing source, per capita; and (ii) 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.

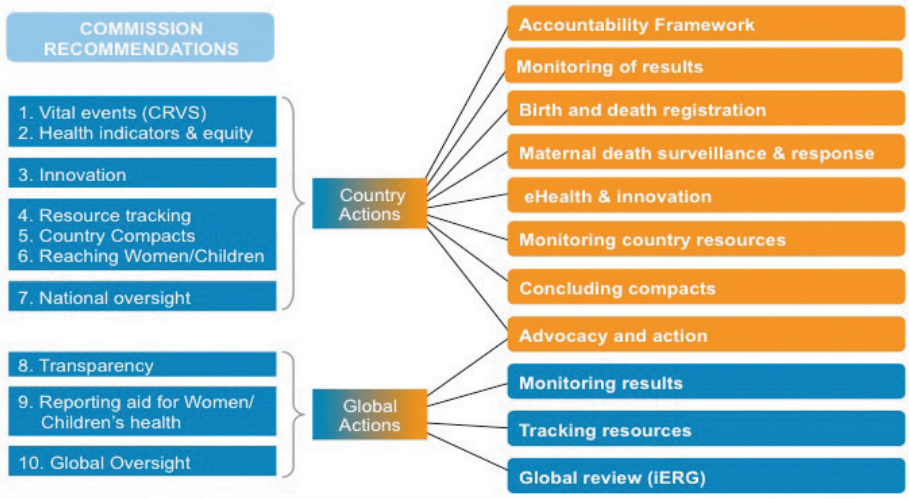
- **Reduce the reporting burden** by aligning efforts with existing national systems;
- **Strengthen and harmonize existing international mechanisms** to track progress on all commitments.

The Commission's report was officially published at an **Every Woman Every Child** event in September 2011 before the United Nations General Assembly in New York.

WHO convened stakeholders in order to translate the 10 recommendations into a common strategic workplan with a series of global and country actions required to enhance accountability. In November 2011, during the Second Stakeholder Meeting, held in Ottawa, Canada, the strategic workplan was finalized and interagency working groups were established to lead implementation. Figure 1 presents the key actions emanating from the recommendations at country and global levels. During the Ottawa meeting, stakeholders recognized that additional working areas were required to focus on maternal death surveillance and response, and advocacy and action. These two areas were added as crossing-cutting actions to contribute to various recommendations. In addition, as per the Commission's Recommendation 10 (Global Oversight), an independent Expert Review Group (iERG) was established[1] to assess the extent to which all stakeholders

1 iERG co-Chairs: Richard Horton, *The Lancet*, and Joy Phumaphi, African Leaders Malaria Alliance. iERG members: Carmen Barroso, International Planned Parenthood Federation/Western Hemisphere Region; Zulfigar Bhutta, Aga Khan University; Dean Jamison, University of Washington; Marleen Temmerman, Ghent University in Belgium; Miriam Were, Global Workforce Alliance.

FIGURE 1: IMPLEMENTING THE 10 RECOMMENDATIONS



honour their commitments to the Global Strategy and to assess progress on the implementation of the Commission's Recommendations.

This report represents the first progress report to the iERG and assesses progress in the implementation of the strategic workplan towards the realization of the Commission's 10 recommendations. The report is organized by the original 10 recommendations and work areas as defined by the strategic workplan. **Annex 1** includes the recommendations and targets as per the strategic workplan.

First months at a glance

Implementation of the Commission's Recommendations

Broad-based partnerships have been formed to implement the strategic workplan to enhance information and accountability for women's and children's health. Nine working groups are in operation and contributing to the achievement of the 10 recommendations (see **Table 2**). Over 40 partner institutions are represented in the working groups, including civil society, government, parliamentarians, the private sector, multilateral agencies and bilateral donors.

TABLE 2: NINE WORKING GROUPS WITH BROAD BASED PARTNERSHIP	
The following lead organizations are taking forward the recommendations and targets:	
1.	**Monitoring of resources in countries:** WHO (lead), USAID, World Bank, Gates Foundation, International budget Partnership and others. (focal point: Tessa Edejer, WHO)
2.	**Monitoring of results in countries:** IHP+ M&E working group which has broad based participation from 15 constituencies, and is coordinated by WHO (focal point: Ties Boerma, WHO)
3.	**Civil registration and vital statistics systems:** HMN MoVE IT initiative, which should also include Plan International, in close collaboration with regional initiatives involving UNESCAP, UNECA CDC USA, academic institutions (focal point: Jane Thomason, HMN)
4.	**Innovation & eHealth:** Norad (lead), ITU, mHealth Alliance, WHO, Innovation Working Group with linkages to Grand Challenges (focal point: Frederik Kristensen, Norad)
5.	**Maternal death surveillance & response:** WHO (lead), USA Centers of Disease Control, H4+, United Nations FPA, University of Aberdeen, LSHTM, Evidence for Action. (focal point: Liz Mason, WHO)
6.	**Health reviews:** IHP+, Countdown (country events), H4+, Inter-Parliamentary Union (focal point: Finn Schleimann, WB)
7.	**Advocacy and action:** PMNCH (lead), Executive Office of the United Nations Secretary-General, United Nations Foundation, African Union Commission, Africa MNCH Coalition, Pan-African Parliament, Africa Public Health Parliamentary Network, Inter-Parliamentary Union, Countdown to 2015 and the H4+ (focal point: Carole Presern, PMNCH)
8.	**Global monitoring of results:** Countdown supported by UNICEF chairs, WHO (focal point: Jennifer Bryce, Countdown; and Tessa Wardlaw, UNICEF)
9.	**Global monitoring of resources:** OECD for resource tracking (OECD-DAC WP-Stats Informal Task Team on MNCH 6) and WHO for country statistics (focal point: Tessa Edejer, WHO)

Better information for better results

Country Accountability Frameworks[1]

Goal: Develop country plans to augment accountability that are based on a rapid assessment and address priority areas for strengthening national accountability processes.

Target: At least 50 countries have made commitments and completed Country Accountability Frameworks by 2013.

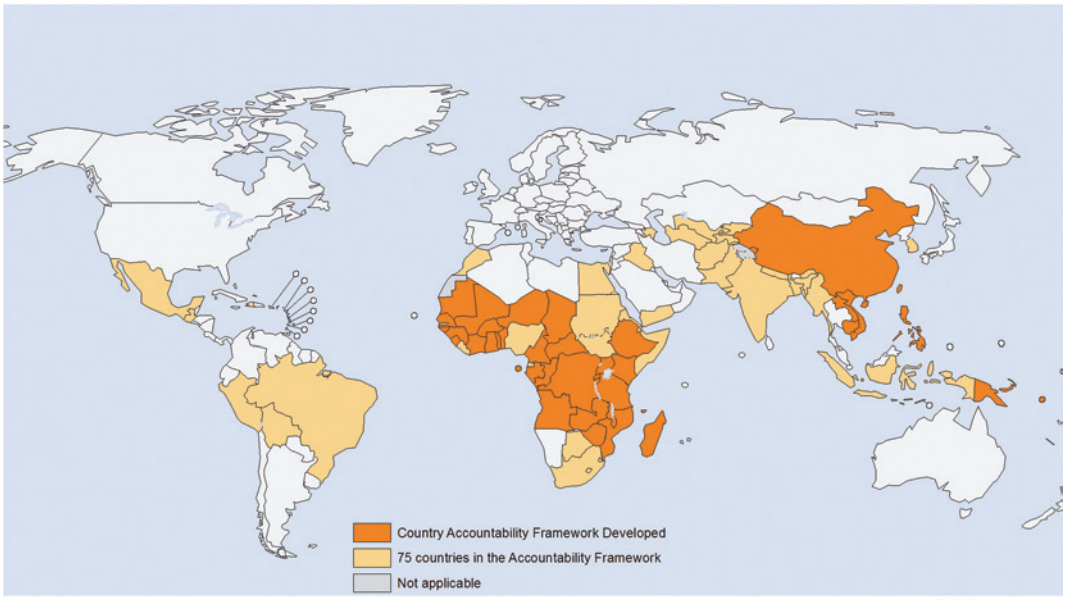
Result: 39 countries have developed CAFs; six countries with final, nationally validated CAFs.

Countries with draft CAFs include: Angola, Benin, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, China, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Gabon, Ghana, Guinea, Kenya, Lao People's Democratic Republic, Madagascar, Mali, Malawi, Mauritania, Mozambique, Niger, Papua New Guinea, Philippines, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Togo, Uganda, United Republic of Tanzania, Viet Nam, Zambia and Zimbabwe.

Countries with final CAFs include: Benin, Lao PDR, Malawi, Sierra Leone, Solomon Islands, Togo, United Republic of Tanzania and Uganda.

Status: On track

FIGURE 2. PROGRESS: COUNTRY ACCOUNTABILITY FRAMEWORK



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1 This work area is not one of the Commission's recommendations, but was established in the strategic workplan as a critical work area to support countries in implementing the recommendations.

Process

WHO defined a process for the development of Country Accountability Frameworks (CAFs), a tool which identifies strengths and weaknesses and defines priority actions for countries to reach the targets and implement recommendations.

The first step is a situation analysis of the existing national mechanisms and practices to identify gaps and weaknesses, monitor and review. The situation analysis forms the basis for the development of the CAF priority actions for strengthening national accountability. A CAF assessment and planning tool[1] was developed in order to facilitate a systematic approach to the situation analysis and framework development process, in line with the IHP+ approach. The tool can be used to assess and monitor progress towards greater accountability for women's and children's health.

In order to introduce the CAF and Accountability recommendations, a series of 11 multi-country workshops are being conducted to orient key country and regional stakeholders. Workshops have brought together over 500 stakeholders with diverse backgrounds and interests, including experts from the Ministry of Health (HIS/M&E, RMNCAH, health accounts) Planning & Finance, national parliamentarians, national statistic offices and other national institutes, leading civil society representatives, NGOS, H4 + and bilateral donors and media. At the end of the workshops, CAFs are drafted to enhance results and accountability for women's and children's health.

Following the multi-country workshops, a national consultative process (normally a two-day workshop) is conducted with a broad group of national stakeholders to build consensus on a final framework with priority actions. The final frameworks also include a detailed budget with total estimated costs, a mapping of existing domestic and partner support and funding gaps. Although much of the funding will have to come from domestic and external in-country sources, countries can request catalytic funding to spearhead activities in 2012–2013. Given the amount of additional funds made available by partners, each country can access US$ 250 000 from WHO.

Main Achievements

A CAF assessment and planning tool[1] was developed to guide the process for countries to prioritize, validate and cost action areas for women's and children's health. The process for CAFs has been met enthusiastically by countries and partners. Currently, six **multi-country workshops** have been held [Bamako (Mali), Doha (Qatar), Dar es Salaam (United Republic of Tanzania), Manila (Philippines), Ouagadougou (Burkina Faso)] to orient country teams and facilitate the development of national frameworks. CAFs have been developed for 39 countries (see **Figure 2**).

Benin, Lao PDR, Malawi, Sierra Leone, Solomon Islands, Togo, the United Republic of Tanzania (Zanzibar conducted separately) and Uganda are among the first countries to have validated and costed the CAFs through national consultative processes. Several more countries are scheduled to validate and cost CAFs in the following months (Kenya, Rwanda, Burkina Faso, Mauritania, Democratic Republic of the Congo[2]).

Key to the success of this process is **high-level political leadership**. As the case study below indicates, President Kikwete of United Republic of Tanzania, co-Chair of the Commission on Information and Accountability, ensured high-level engagement of the Minister of Health and Social Welfare, the acting Chief Medical Officer, representatives of H4+ and bilateral donors to finalize their Country Accountability Framework.

Another key to success is the synergistic effect resulting from the **gathering of various disciplines** during these workshops which bring in new ideas and perspectives on how to improve women's and children's health. Often, these partners collaborated together for the first time. As the case

1 Country Accountability Framework: a tool for assessing and planning the implementation of the country accountability framework for health with a focus on women's and children's health (http://www.who.int/woman_child_accountability/resources/acc_workshops_materials/en/index1.html).

2 Status of implementation as of 10 July 2012.

Country Accountability Frameworks bring about concrete action for improved Women's and Children's Health

A multi-country workshop was held in the United Republic of Tanzania in February 2012 with delegations from 10 sub-Saharan African countries: Ethiopia, Ghana, Kenya, Malawi, Mozambique, Rwanda, United Republic of Tanzania, Uganda, Zambia and Zimbabwe. Following the workshop, countries organized national workshops to validate and cost the draft CAF to prioritize action towards implementing the Commission's recommendations.

High-level political leadership and engagement: United Republic of Tanzania organized a national workshop bringing together more than 40 stakeholders in April 2012. Participants included the Ministry of Health and Social Welfare, Ministry of Justice, United Nations agencies, bilateral donors (CIDA, USAID, DANIDA, and the Netherlands), technical institutions and agencies (Ifakara Health Institute, University, CDC), and civil society organizations (including Sikika). The main priorities of their CAF are:

- **MDSR:** Develop MDSR guidelines and an action plan;
- **eHealth and Innovation:** Develop eHealth Strategy with support from the monitoring and evaluation strengthening plan;
- **Resource Tracking:** Strengthen the National Health Accounts system including sub-accounts;
- **Advocacy and Action:** Organize Countdown event in 2013;
- **Monitoring of results:** Use WHO data quality report card (see Cambodia report card) and build capacity for analysis of the 2012 report;
- **Reviews:** Strengthen subnational processes to contribute to the accountability framework.

Involving all levels in a dialogue on using information to create accountability: In May 2012, **Zimbabwe** held its national CAF workshop bringing together all parts of the chain of accountability – including people working in facilities, such as hospitals and clinics, and those who operate health information systems and use the information they generate to improve health services. Representation from UNICEF, USAID, the Research Triangle Institute (RTI), the Zimbabwe National Family Planning Council (ZNFPC) and the WHO all contributed with different perspectives on information and accountability for health. Among prioritized areas for immediate action are:

- **CRVS:** Conduct an assessment of current status of civil registration and vital statistics;
- **Monitoring of results:** Develop a monitoring and evaluation framework and strategy;
- **MDSR:** Improve hospital reporting and the use of International Classification of Diseases, and strengthen community reporting of births and deaths through ICT and verbal autopsy;
- **eHealth:** Develop an eHealth strategy;
- **Resource Tracking:** Develop the National Health Account and establish a reproductive, maternal, newborn and child health (RMNCAH) subaccount;
- **Advocacy and Action:** Establish a parliamentary subcommittee on RMNCAH.

Accountability – a new initiative for women's and children's health: Malawi held its national stakeholder workshop in May 2012. The new President of Malawi, her Excellency Joyce Banda, is championing women's and children's health as demonstrated by her recent launch of the initiative: *Maternal Health and Safe Motherhood*. The workshop attracted stakeholders from the National Registration Office, medical training institutions, civil society and the donor community. The following priorities were agreed upon:

- **CRVS:** Engage the National Registration Bureau in the Office of the President and Cabinet to identify existing gaps;
- **Monitoring of results:** Conduct data quality assessment focusing on RMNCAH indicators;
- **MDSR:** Capacity building for MDSR following the new WHO/CDC guidelines;
- **eHealth:** Identify best practices in e-health for potential scale-up;
- **Resource Tracking:** Build capacity of the Ministry of Health's planning unit to routinely conduct National Health Accounts (NHA);
- **Advocacy and Action:** Conduct a national Countdown exercise.

study from Malawi above relates, central- and district-level health workers worked with representatives from the Ministries of Justice and civil registry in jointly formulate priority actions.

Challenges

One of the key ingredients for a national costed CAF is the consensus of a broad range of stakeholders. Assuring full partner appropriation of the process at country level is challenging. Although MOHs are active participants for developing CAFs, accountability also depends on a broader range of stakeholders, such as Ministries of Finance, civil society, media (including social media) and youth groups. Concerted efforts are required to emphasize that accountability work is not a separate initiative, but one that builds on existing national planning, monitoring, evaluation and review processes and practices.

Another key challenge will be to ensure sustained technical support and financing for countries to implement CAF priority actions over the next three years. Although, up to US$ 250 000 are available to countries as catalytic funding, countries will not achieve the goals set forth in the CAFs if funds are not matched by domestic resources and partner investments.

Way Forward

Countries find that the multi-country workshops are an important introduction to the recommendations of the Commission on Information and Accountability and provide a platform for development of CAFs. Further multi-country workshops are planned in Asia, the Americas, Europe and the Eastern Mediterranean regions. By the end of 2012, almost all 75 countries are expected to have developed draft CAFs and action plans.

A schedule of multi-country workshops is available in **Annex 2**.

Recommendation 1: Civil Registration and Vital Statistics (CRVS) and Maternal Death Surveillance and Response (MDSR)

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.

Target:

- At least 50 countries have completed an assessment, developed a plan and have taken significant steps towards implementation by 2015 (> 20 by 2013).
- At least 50 countries have taken steps to monitor quality of care provided in health services and taken steps to make improvements.

Result:

- 29 have completed a rapid CRVS assessment;
- 29 countries have taken steps to make improvements in health systems.

Countries that have completed a rapid CRVS assessment include: Azerbaijan, Bangladesh, Burkina Faso, Burundi, Cambodia, Cameroon, China, Comoros, Democratic Republic of Congo, Egypt, Ethiopia, Gabon, Ghana, Guinea-Bissau, Iraq, Kenya, Kyrgyzstan, Madagascar, Malawi, Pakistan, Philippines, Rwanda, Senegal, Sierra Leone, Sudan, Uganda, Uzbekistan, Yemen and Zambia.

Status: On track

Process

Counting births, deaths and causes of death is a critical element of accountability. Yet, 40 million births and 40 million deaths are unrecorded each year; and, there are no reliable data on causes of death for two-thirds of the world's population. Political commitment to the importance of

CRVS is critical to strengthening the long-neglected but critical issue of registering births, deaths and causes of death.

The Commission's recommendation calls for innovative strategies to help overcome some of the traditional obstacles to CRVS. The Health Metrics Network (HMN) initiative is leading the work towards this recommendation in collaboration with the United Nations Statistical Division and regional partners. One of the key approaches is the MoVE-IT initiative which makes monitoring vital events (MoVE) a priority. HMN has been working with regional partners to develop prioritized regional programmes for CRVS strengthening and building regional capacity to support CRVS strengthening.

Main Achievements

In April 2012, the Human Rights Council adopted a resolution recognizing birth registration as a human right. This is an important step in building national political commitment to strengthening CRVS. In parallel, HMN is engaging high-level political decision-makers to support countries in setting targets for country strengthening of CRVS. For example, a Regional Plan for the Improvement of CRVS in Asia and the Pacific (including central Asia) is under preparation with targets for country strengthening and high-level political engagement. In the Africa region, an Africa Plan for Accelerated Improvement of CRVS was presented and endorsed by the African Symposium on Statistical Development and StatCOM in January 2012. An active core group is monitoring plans and progress, including targets for country strengthening and high-level political engagement.

An emerging theme for countries participating in the multi-country workshops is the increased momentum for strengthening CRVS. Countries are increasingly interested in conducting a CRVS assessment and find that the CRVS assessment is a useful means to build stakeholder engagement for essential intersectoral collaboration. To date, 29 countries have completed a rapid CRVS assessment and four more additional countries[1] plan to conduct rapid assessments. Additionally, five countries[2] plan to undertake comprehensive assessments and plans by the end of 2012. Innovative CRVS initiatives are underway in 14 countries (i.e. community registration using mobile devices) under the HMN MOVE-IT programme. HMN trained a first cadre of 20 people in Africa to provide technical assistance to help countries conduct comprehensive CRVS assessments and improve their CRVS strategies. HMN has disseminated tools for CRVS assessment planning and implementation. HMN is also undertaking a systematic review of IT innovations in CRVS to identify scalable innovations.

Challenges

The systematic strengthening of CRVS requires strong political will and cooperation among a diverse range of stakeholders. The impetus for CRVS strengthening is commonly driven from outside the health sector, and different stakeholders have different motivations for CRVS strengthening (e.g. security, human rights, identity and epidemiological statistics). This multisectoral nature of CRVS requires broad stakeholder engagement, which often is a slow and challenging process. While there tends to be broad-based demand for birth registration, interest in death registration and physician-certified cause of death tends to be a lower priority. Therefore, death registration and cause of death reporting is consistently weak, particularly in countries with poor achievements in women's and children's health. A lack of local skilled human resources to support country assessment, planning and implementation processes is a limiting factor. In addition, the lack of an interoperable and scalable IT platform for a multistakeholder national CRVS system is a limiting factor and a continuing focus on scalable IT innovation is an important adjunct to the country work.

1 Bangladesh, Indonesia, Lao PDR and Nepal.
2 Kenya, Mozambique, Egypt, Senegal and South Africa.

CRVS requires multisectoral approach

The value of CRVS is perceived differently by different constituencies. Therefore, CRVS strengthening requires active engagement with the statistical and civil registration communities and other country stakeholders in order to ensure that all perspectives are understood and incorporated into multistakeholder strengthening plans.

Country application of IT innovations for recording and reporting vital events, and changes in CRVS legislation, will take time. However, intermediate solutions can readily be found as long as political and stakeholder commitment exists. This emphasizes the need for continuing advocacy and high-level political engagement to keep CRVS on country and regional agendas.

Ghana's innovative use of technology

The Ghana MOVE-IT initiative is monitoring vital events through national multisectoral collaboration. Ghana instituted a change in policy for maternal death notification within 24 hours using text messaging. Mobile devices are used to enhance reporting on vital events and recording of events into national CRVS systems, and to support certification of vital events.

Ghana's focus is on registering pregnancies and recording births, deaths and cause-of-death. The project runs in three districts in the relatively deprived northern region of the country and uses community-based agents to report the occurrence of vital events. Additionally, the project has certified technical persons that follow up the event, confirm its occurrence, and use the information for decision making, including on improved interventions for the care of pregnant women and children.

Way Forward

HMN is pursuing three complementary work streams to accelerate country CRVS system strengthening: (i) technical support for country assessment, planning and implementation; (ii) building sustainable regional capacity through trained human resources and dissemination of tools; and (iii) driving innovation for CRVS. To support country assessment, planning and implementation, HMN will continue to engage with multisectoral regional partners and facilitate multi-country workshops. In addition, continued mobilization of political commitment through high-level and ministerial meetings and work with the Inter-Parliamentary Union will be a priority in 2012 and 2013. For example, in a recent Inter-Parliamentary Union meeting in East Africa, parliaments of the East Africa region pledged to prioritize CRVS (see section: Working with Parliaments). To support sustainable regional capacity, HMN will expand its training of regional resource persons within Africa and replicate this approach in Asia and the Eastern Mediterranean. Capacity building will be complemented by the dissemination and adaptation of technical tools. To support innovations for CRVS strengthening, HMN will undertake a systematic review of IT innovations in CRVS to identify innovations that may be scalable. In each region, HMN is also supporting countries in their resource mobilization efforts for CRVS.

Maternal deaths surveillance and response (MDSR)[1]

Process

MDSR can be a powerful process to improve the quality of care and assess the numbers and the causes of maternal and perinatal deaths. The WHO guide, *Beyond the Numbers*, was launched in 2004 to support scaling up of maternal death reviews in countries for quality improvement. This guide is being complemented by an implementation guide developed by CDC, in partnership with WHO, UNFPA and the University of Aberdeen, to support MDSR in countries.

1 The work on MDSR contributes to several recommendations, but is not one of the Commission Recommendations.

The multi-country Accountability Workshops conducted as part of the Accountability for Women's and Children's Health are an important introduction and first step to country capacity building and assessment for MDSR. In addition, a three-day multi-country workshop is organized with a focus on MDSR implementation. The main objectives include: to share experiences; to update tools for MDSR; to provide guidance on adherence to the rules of the standard the International Classification of Diseases (ICD-10) for underlying causes of death; and to share innovative strategies and tools for strengthening surveillance.

Main Achievements

Most of the priority countries are conducting maternal death reviews at facility level. Using the opportunity of the Accountability Regional Workshops, capacity building workshops are being conducted to strengthen maternal death reviews to include surveillance and response. To date, 29 countries have been reached. By the end of 2012, 50 countries will have been reached covering all regions. Findings from the workshops to date are:

- Maternal death reviews (MDR) do not always lead to a timely or adequate response;
- Maternal death notification reported by 39 countries is often NOT within 24 hours;
- MDR generally does not generate adequate data for surveillance because ICD 10 classification is not used.

Maternal death notification is a key aspect of MDSR. Global monitoring has shown that policy for maternal death notification is reported to be in place in 39 countries, but fewer have a policy stipulating notification within 24 hours. The initiative to move from MDR to MDSR is very well received by all countries, and a mapping of follow-up activities is being carried out at present.

Challenges

For many priority countries, the MDSR process is still limited to selected facilities. Only a few countries have community-level components to capture maternal deaths outside the health system.

Ethiopia: MDSR as a stand-alone programme takes greater priority

The government of Ethiopia has made MDSR its own programme within the MOH, raising the importance of MDSR within the health system. Ethiopia has also taken several steps to improve MDSR. Most recently, Ethiopia is making maternal deaths a fully notifiable event and is modifying the national PHEM software to incorporate MDSR to implement at health institutions nationwide. Ethiopia is working on legislation required for MDSR and is exploring both *e* and *m* health strategies for MDSR.

Uganda: Integrating maternal deaths into the Integrated Disease Surveillance and Response (IDSR) system

In 1998, WHO/AFRO and its Member States, along with their technical partners, adopted the Integrated Disease Surveillance (IDS) strategy for developing and implementing comprehensive public health surveillance and response systems in African countries. To highlight the essential link between surveillance and response, subsequent documents referred to IDSR. By integrating maternal deaths in the IDSR system, Uganda has integrated notification of maternal deaths in the IDSR system and, as a result, the maternal deaths notification (in 24 hours) policy has been implemented nationwide.

Rwanda: Role of Community Health Workers

Since 2010, the country has set up a nationwide network of 30 000 community health workers who were given mobile phones to communicate with the district team to notify any maternal death at the community level. The experience demonstrates the important role that community workers can play in signalling maternal deaths as an unusual event, and kick starting a response by the district health team to investigate why the death occurred and take remedial action.

Case Studies/lessons learned:

The following two case studies (Uganda & Rwanda) were shared during the first Accountability/ MDSR meeting in Tanzania (February 2012). This was a great opportunity for 10 participating countries to learn from each other about key steps, opportunities and challenges for MDSR policy implementation. The following practices were considered by specific countries for replication.

Way Forward

- Follow-up at country level to ensure MDSR plans feed into M&E roadmaps to strengthen national accountability in health with emphasis on maternal, newborn and child health;
- Finalize the guidance to help introduce MDSR in countries (MDSR technical updates);
- Provide required technical support for scaling up all MDSR components in priority countries;
- Strengthen advocacy for country MDSR implementation;
- Promote innovative tools for effective MDSR implementation.

Recommendation 2: Health Indicators

By 2012, the same 11 indicators on reproductive, maternal and 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.[1]

Target:

- By 2013, at least 50 countries use and have up-to-date accurate data on the core indicators disaggregated as part of their M&E systems;[2]
- By 2012, global partners have streamlined reporting systems around the core indicators;[3]
- At least 50 countries have timely and accurate data from core coverage indicators to inform annual reviews, with appropriate data quality controls (20 by 2013).[4]

Results:

- All 72 priority countries have accurate data on the core indicators (launched by Countdown to 2015);
- GAVI, Global Fund and UNAIDS are working to streamline reporting systems.

Status: On track

Process

In collaboration with the IHP+ M&E working group, WHO and other global, regional and country partners are working with a network of partners to provide technical assistance to countries to strengthen results monitoring. The approach builds on the IHP+ joint workplan activities and aims to strengthen country-led monitoring and evaluation platforms as the basis for assessing progress and performance in women's and children's health. This includes:

- Development of strong **monitoring and evaluation plans** within the national health strategy and harmonization of the national Reproductive, Maternal, Newborn and Child Health (RMNCAH) acceleration plans;

1 Further information related to the 11 core indicators is provided in the section on Global Monitoring.
2 See section on Global Monitoring of results for additional results for this target.
3 See section on Global Monitoring of results for additional results for this target.
4 In the workplan, this target corresponds to Recommendation 1, but the work is being carried out under the work area Monitoring of Results.

- Improving the **quality of routine facility reporting systems** (Health Management Information Systems), with annual data quality report cards on core indicators and independent data verification;
- **Addressing data gaps**, including monitoring of basic health inputs and service readiness, quality of care, strengthening cause of death reporting (ICD in hospitals);
- Strengthening **analytical reviews of progress and performance**, through building country analytical capacity, including equity analyses;
- Improving **transparency** of data through publicly accessible databases, and support country health observatories.

Main Achievements

- A guidance document for the national M&E platform for information and accountability produced under the IHP+ umbrella, with inputs from many partners and countries;
- Monitoring and evaluation plans strengthening in 10 countries.[1] Data-quality tools in advanced stage of development, including an annual data-quality report card for core indicators, a data-verification survey tool and an assessment of service readiness;
- Data-quality report cards have been introduced and completed in Cambodia (see figure below) and Uganda. Development initiated in: Nepal, Sierra Leone, in the United Republic of Tanzania and Indonesia;
- Strengthened capacity and annual analytical reports to inform health sector reviews, completed in Uganda and Kenya; ongoing in Sierra Leone and Mozambique;

FIGURE 3. DATA QUALITY REPORT CARD, CAMBODIA

Indicator		Definition	National DQ Score 2011	% of provinces with poor DQ score 2011
1	COMPLETENESS OF REPORTING		Very good	
1a	Completeness of district reporting	% of monthly district reports received	N/A	N/A[1]
1b	Completeness of facility reporting	% of expected monthly facility reports received	99.8%	0%[2]
1c	Completeness of indicator reporting (missing data for selected indicators)	% of monthly provincial/district reports that are not zero/missing values (average for 4 indicators: ANC2, measles, deliveries, OPD)	100%	0%[3]
2	INTERNAL CONSISTENCY OF REPORTED DATA		Good, but no data verification done	
2a	Accuracy of event reporting (moderate/extreme outliers)	% of monthly provincial values that are moderate/extreme outliers (2 SD/3 SD or more from mean) (average for 4 indicators)	2.7%/0.1%	4%[4]/4%[5]
2b	Consistency over time	Number of events for current year divided by mean of preceding 3 years (average for 4 indicators)	1.17	5%[6]
2c	Consistency between indicator values	Rate ratio DTP1 to ANC1: facility DTP1/ANC1 ratio divided by survey-derived DTP1/ANC1 ratio	0.92	0%[7]
2d	Consistency between DTP1 and DTP3	Number of DTP3 immunizations divided by the number of DTP1 immunizations (should be less than 1)	0.97	8%[8]
2e	Verification of reporting consistency through facility survey	% of agreement between data in sampled facility records and national records for the same facilities for 3 core indicators	Not done in 2011	N/A
3	CONSISTENCY OF POPULATION DATA		National data good, denominator problems for provinces	
3a	Consistency with UN population projection	NIS (official) population projection divided by UN population	1.01	N/A
3a.1	Availability of crude birth rates and infant mortality rates	Rates used to compute target population estimates are available and clearly documented	Partially	Partially
3a.2	Consistency of local population projection (PHD and NIS)	Provincial health department (PHD) population divided by the NIS (official) population	0.98	8%[9]
3b.1	Consistency with survey derived estimates (estimated number of pregnant women)	Number of pregnant women derived from ANC1 survey coverage (CDHS 2010) and reported number of events, divided by the official estimate	0.96	16%
3b.2	Consistency with survey derived estimates (estimated number of children under 1 year)	Number of children under 1 year derived from DTP1 survey coverage (CDHS 2010) and reported number of events, divided by the official estimate	0.85	11%
4	EXTERNAL COMPARISON OF COVERAGE RATES		Major differences for immunization with facility coverage higher than survey	
4a	External comparison: ANC2	Coverage from facility reports divided by survey for the most recent comparable year (2010)[10]	0.94	N/A
4b	External comparison: Measles immunization	Coverage from facility reports divided by survey for the most recent comparable year (2010)[10]	1.36	21%[11]
4c	External comparison: Institutional deliveries	Coverage from facility reports divided by survey for the most recent comparable year (2010)[10]	1.28	58%[12]

1 Uganda and Sierra Leone published; in process for Benin, Burkina Faso, Liberia, Lao PDR, Mozambique, Nepal, Rwanda, Togo. Requested: Sudan, Zimbabwe, Gambia.
http://www.who.int/healthinfo/publications_topic_data_quality/en/index.html

- Partnerships have been developed with regional and national institutes to support institutional capacity building at country level: Africa Population & Health Research Centre in Kenya, Ifakara Health Institute in the United Republic of Tanzania and national statistical offices;
- Global partners are showing increasing interest in alignment with single platform for information and accountability, such as GAVI, Global Fund and UNAIDS.

Challenges

- It is difficult to get buy-in from all partners at the country level to the IHP+ country-led M&E platform for information and accountability. Some partners are primarily focused on their own reporting mechanisms and investments;
- In some counties it will take a long time to strengthen weak data sources (HMIS, CRVS).

Sierra Leone: Harmonizing planning and reporting systems

In 2010, the first national health sector strategic plan (NHSSP) 2010-2015 was launched, with a major priority being the Free Health Care Initiative. The health plan aims to reduce inequalities and improve the health of the people of Sierra Leone, particularly mothers and children. With support from the highest level of government, the Ministry of Health, Ministry of Finance and Ministry of Local Government, development agencies, civil society and faith-based organizations agreed to a country compact. This compact has served as a solid foundation to get partners to support and develop a single accountability framework to monitor implementation of the health plan. This framework is the basis for the accountability work for women's and children's health and the health sector as a whole.

New ways of joint work are initiated through the Accountability work. These includes mechanisms to improve financial management systems, which are a priority under the government's Agenda for Change. Work is underway to improve the quality and completeness of the routine facility data, including a facility verification survey and an assessment of service readiness.

A comprehensive analytical report of progress and performance and a data quality report card are in preparation. Findings will be discussed at the multistakeholder annual health sector review in July 2012. Sierra Leone will hold a joint annual health sector review in December 2012.

Way Forward

The IHP+ common M&E platform approach for strengthening results monitoring is becoming more systematic and there is good buy-in from major partners including GAVI, Global Fund, World Bank and others. More countries are requesting technical support for M&E. It will be important to continue to rapidly expand the network of technical expertise at regional, sub-regional and country level to assure sustained support. In the WHO Africa Regional Office, this will involve aligning the M&E work more closely with the African Health Observatory work.

Global Monitoring of Results

The goal of global monitoring within the accountability agenda is to have up-to-date databases containing publicly accessible national data on Commission-recommended levels and other key RMNCAH indicators, disaggregated by equity variables.

A related goal would be to generate readily accessible reports and products summarizing these data in ways that promote accountability and improve RMNCAH policies, programmes and resource flows at country, regional and global levels.

Global monitoring of results contributes to the Commission's Recommendations 2 (Monitoring of Results and Health Indicators), 6 (Reaching Women and Girls) and 7 (Transparency).

Process

Population-based household surveys such as the UNICEF-supported MICS and the USAID-supported DHS play a pivotal role in global monitoring. The 11 core indicators proposed by the Commission are largely derived from these household surveys. They are the main source of data in the foreseeable future that can provide standardized information that allows for comparisons between countries and over time. Interagency MDGs Monitoring Groups play a key role in: harmonizing monitoring work across partners; developing new methodologies, standard indicators and monitoring tools; building statistical capacity at country level; and developing joint estimates. These estimates feed many of the global monitoring reports, including the annual Secretary-General's MDGs Progress Report and the Countdown to 2015 reports. Key Commission recommended indicators are closely, but not perfectly, aligned with existing indicators used for MDGs and Countdown reporting.

Main Achievements

Countdown to 2015 has revised the Country Statistical profiles to include all 11 indicators in the first page. These were launched at the April 2012 IPU Meeting in Kampala and the full profiles were launched in June 2012.

HMN, UNICEF and WHO jointly developed a document on *Monitoring MNCH: Understanding key progress indicators* that provides an introduction to the Commission's indicators. Governments and development partners found this document useful and it is being made widely available.

The Child Survival: Call to Action Child Forum held 14 and 15 June 2012 in Washington, DC, focuses on many of the same indicators and uses the same databases and sources of data (from household surveys) as Accountability for Women's and Children's Health and Countdown.

Household surveys such as the MICS and DHS will continue to provide the data for the 11 indicators. The fourth round of MICS surveys involving more than 60 countries is nearing completion and data collection for MICS 5 is scheduled to begin at the end of 2012. It is expected that around 60 countries will participate in MICS 5 which is expected to provide most of the data for final MDGs reporting in 2015. The revised and updated MICS 5 questionnaire was being field tested in Bangladesh in May 2012 in preparation for the next round of surveys. The DHS programme will continue to provide assistance to countries implementing DHS surveys. It is estimated that an additional 25–30 DHS country surveys will be completed by the end of 2013, with additional surveys to follow in the next phase of the programme.

All MICS and DHS data sets can be disaggregated by equity variables; this work is being done by Countdown, UNICEF and the WHO Global Observatory.

Interagency groups involving relevant United Nations agencies and external technical experts working on adjusted estimates compile country data, conduct data quality assessments and communicate with countries to clarify and reconcile measurement issues as needed.

Databases for most of the key 11 indicators, including disparity information, are publicly available on the UNICEF statistics website (www.childinfo.org). These databases were updated to involve rigorous data quality control.

Many groups continue to develop and release reports presenting global monitoring data, including the annual Secretary-General's MDGs progress report, Countdown reports, *The State of the World's Children*, *Progress for Children*, the *World Health Report* and *The Human Development Report*. There are also an increasing number of topical reports prepared by various groups, for example: health information systems; HIV/AIDS; malaria; pneumonia; diarrhoea; nutrition; water and sanitation; newborn health; and maternal and child mortality.

Challenges

There are well-established global monitoring mechanisms and an urgent need to ensure that there is no duplication of efforts. Many of the key steps in effective global monitoring need continued support and increased funding, including: household survey work (e.g. MICS); data and database management and quality control; and the work of interagency monitoring groups (e.g. IGME). Support is needed to ensure more-effective use of data for RMNCAH programmes and policies at country and global levels. With growth of in-country health information systems and capacity, these global monitoring mechanisms need to be better aligned, coordinated and linked with country efforts.

Way Forward

H4+ and other major global partners, coordinated by UNICEF, are leading the effort to align reporting requirements for global monitoring to focus on the Commission's recommended indicators. H4+ is expanding support for country surveys so that one survey in each country produces current estimates of intervention coverage, expands technical capacity at country level, conducts nationally representative household surveys and works to maintain and strengthen global public-access databases containing data on Commission indicators.

Existing technical reference groups will continue and expand ongoing research to improve indicator measurement, while maintaining the ability to monitor trends. Further discussion is needed on potential mechanisms for sharing the results of these efforts and ensuring they are disseminated to survey planners and implementers.

Countdown to 2015 for Maternal and Child Survival will continue to produce annual profiles for countries reporting on coverage, equity and selected indicators on health policy and health system strengthening. The Countdown will also produce complementary data presentation products on the indicators, including an equity analysis for specific target audiences and events; proactively prepare analyses and synthesis to stimulate and inform deliberations of the iERG; collaborate with UNICEF and others to maintain global databases on available coverage and equity information; and conduct cross-cutting analysis of factors affecting progress in achieving improved RMNCAH outcomes.

Recommendation 3: eHealth and Innovation

By 2015, all countries have integrated the use of information and communication technologies (ICT) in their national health information systems and health infrastructure.

Target:

- By 2015, at least 50 countries have developed and are implementing national eHealth strategies, including specifics on how this benefits information and accountability for women's and children's health.

Result: 27 countries (with available data) have a national eHealth strategy and plan in place.

Countries with a national eHealth strategy and plan in place: Azerbaijan, Botswana, Burundi, China, Democratic People's Republic of Korea, Democratic Republic of Congo, Egypt, Ethiopia, Ghana, India, Indonesia, Iraq, Kenya, Kyrgyzstan, Lao PDR, Madagascar, Mali, Morocco, Papua New Guinea, Peru, Philippines, Sudan, Turkmenistan, Uzbekistan, Viet Nam, Zambia and Zimbabwe.

Status: Making progress

Process

WHO defines eHealth as the use of ICT for health. In its broadest sense, eHealth is about improving the flow of information, through electronic means, to support the delivery of health services and the management of health systems. In the last few years, rapid expansion and upgrade of

mobile networks has enabled a flurry of innovation in this field. Increasingly, governments are recognizing that incorporating ICT is a priority for health systems development. Collaboration between the health and ICT sectors, both public and private, is central to this effort; so WHO and the International Telecommunication Union (ITU) are encouraging countries to develop national eHealth strategies.

eHealth is supporting countries to make more and better use of information and communication technologies in their national health information systems and health infrastructure. Several countries have prioritized eHealth as part of the assessment and roadmap. Through the Accountability work, countries that prioritize women and children's health as part of their eHealth strategy will be supported to develop that strategy. As a result of the multi-country workshops, countries have requested specific workshops to further develop eHealth approaches, which will be initiated in 2012.

Main Achievements

Developing a database of innovative initiatives: Technical platforms for dissemination have been identified for national and regional focal point discussions and online knowledge sharing. Links to existing resources such as the mHealth Alliance's Health UnBound database (a global online community for resource sharing and collaborative solution generation) have also been identified.

National eHealth Strategies: To facilitate the country-led processes for eHealth, a comprehensive *National eHealth Strategy Toolkit* has been jointly developed by WHO and ITU. A checklist and supporting documentation for country assessment, based on the eHealth Toolkit, has been completed and will be introduced to countries. In addition, resources and tools to support national plans are under development, which include:

- Template for developing country proposals;
- Tool to cost technical assistance for countries requiring support in the development of national eHealth strategies;
- Supporting materials for the *National eHealth Strategy Toolkit*.

Country profiles: The WHO Global Observatory for eHealth is currently preparing for its eHealth survey and country profiles in the use of ICT in maternal and child health in countries will be developed.

ICT is a cross-cutting function that is relevant to each of the working groups implementing the Accountability Framework recommendations. The working group is coordinating with other relevant working groups, such as CRVS, PMNCH and others to align their work and prevent duplication.

Challenges

Few countries have a national eHealth strategy in place to guide multistakeholder efforts. Many initiatives that would be beneficial to maternal and child health continue to take place within silos of other health programmes. Projects are mostly developed without reference to overall strategies or links to core national systems. This is particularly the case with mHealth initiatives. The field of eHealth innovations and projects is vast and rapidly expanding. The largely scattered and uncoordinated field makes it difficult for partners to keep up with developments and for them to differentiate between the proposed solutions.

Way Forward

As the participation in multi-country workshops and follow-up of individual CAFs continues, a number of parallel tracks will be pursued, including:

- **Fast tracking innovations and sharing with/between countries:** Creation of a RMNCAH Knowledge management platform (e-repository of projects, tools and best practices). Expert rosters and virtual groups will be established to share RMNCAH tools and expertise.

Bangladesh:[a] Use of ICT to Monitor and Improve Women's and Children's Health

The Bangladesh MOVE-IT initiative aims to register all pregnant mothers and their children in Bangladesh in a unified electronic information system, by leveraging a multistakeholder collaborative framework. The Bangladesh initiative will include a unique identifier, a minimum data set and a data dictionary. The operational framework will link three existing information systems: the personal health records used by various providers of maternal and child health services; the health service coverage and health outcomes reported to the Ministry of Health and Family Welfare; and the vital registration records of Bangladesh Bureau of Statistics.

Through the mHealth initiative, mobile phones are given to every district and subdistrict hospital (482 hospitals) where women can call 24 hours/7 days a week to get free medical advice from an on-duty doctor. Women can obtain care advice tailored to their pregnancies by SMS. Telemedicine for rural people, women and children is providing services through 18 000 community clinics.

These initiatives are improving maternal, newborn and child health as well as empowering women through information and services available in their communities. In addition, eHealth initiatives are minimizing the need for and cost of health survey while providing information and data in real time.

The Bangladesh initiative showcases universal registration of all pregnant women and their children by using a discrete entry point, multi-institutional engagement, development of common standards (unique ID and structure of electronic registration record) and multiagency owned and cloud-based technology that can be continuously updated.

The experience in Bangladesh demonstrates how digital health can advance MDGs 4 and 5. Despite resource constraints, Bangladesh used a model that was simple, low cost, innovative and locally appropriate.

[a] Case study presented at Ottawa meeting: http://www.slideshare.net/EveryWomanEveryChild/5-ak-azad-eng

- **Catalyzing development and dissemination of ICT tools to accelerate implementation of Accountability recommendations:** WHO, Norad and ITU will propose tools and services for RMNCAH, including a technical report on ICT tools and services for RMNCAH. Project implementation support and targeted technical assistance will be provided to countries that request support and prioritize ICT in their CAFs.
- **Facilitate development of country-led national eHealth strategies and resource mobilization for implementation:** Working group members and partners are developing tools and materials to support national strategy development. Initial situation and needs assessments will be conducted followed by support to national planning for target countries.
- **Use the Global Observatory for eHealth survey** as a basis for developing country profiles for ICT in RMNCAH for COIA countries; including, identifying projects for review and case studies for knowledge base.
- **Knowledge sharing with key audiences:** Identify, analyse, publish and share RMNCAH cases, projects and programmes through a regionally targeted Webinar series.
- **Report on progress** made in ICT for accountability for RMNCAH.

Better tracking of resources for women's and children's health

Recommendation 4: Resource Tracking

By 2015, all 74 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: (i) total health expenditure by financing source, per capita; and (ii) total reproductive, maternal, newborn and child health expenditure by financing source, per capita. 1) Total health expenditure by financing source, per capita; and 2) Total reproductive, maternal, newborn and child health expenditure by finance source, per capita.

Target:

- By 2013, at least 50 countries use and have accurate, up-to-date data on the two indicators, as part of their M&E systems.

Results: 17 countries (partially) tracking RMNCAH expenditure.

Countries tracking RMNCAH expenditure: Bolivia, Burkina Faso, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Kenya, Liberia, Malawi, Mexico, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, Uganda, United Republic of Tanzania and Zambia.

Status: Making progress

Process

- Multi-country workshops held for relevant technical staff on national expenditure tracking for RMNCAH followed by a Strengthening Health Accounts (SHA) 2011 workshop for the national health accountants with a focus on reporting RMNCAH expenditures;
- Setting up a pool of experts that can support provision of technical assistance to countries.

Main Achievements

- Capacity has been built in 30 countries to track government expenditures (from domestic and external sources) for RMNCAH;
- 18 countries have reported RMNCAH expenditure (including data from subaccounts): Benin, Burkina Faso, Burundi, Cameroon, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Kenya, Liberia, Mali, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, Senegal, United Republic of Tanzania and Uganda.

Key Challenges

- Continual turnover of trained staff weakens country capacity in health accounting;
- Institutionalization of health accounts in countries is weak. Only a few countries produce health accounts data every year;
- Institutional and IT support must be strengthened.

Case Study

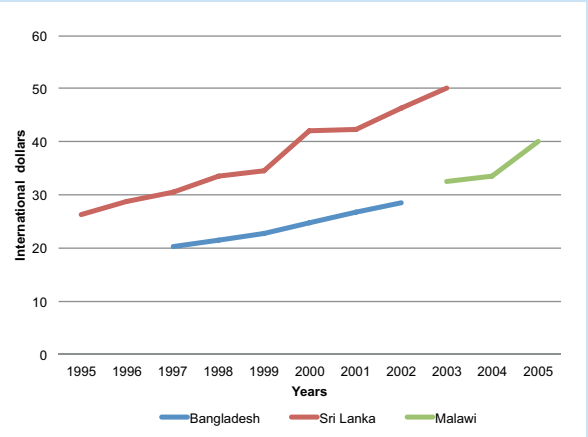
Institutionalization work in the United Republic of Tanzania has been successful at integrating health accounts in yearly strategic planning, and addressing the challenge of easing the collec-

Child and Reproductive Health Subaccounts: a tool for tracking resources in RMNCAH

National Health Accounts (NHA) offer a standardized methodology to track all health spending and investments in a country, implemented to date by over 100 countries. In recent years, the NHA framework has been further developed to track expenditures within several priority areas of health, such as HIV/AIDS, reproductive health and child health. These subaccounts are most useful when they are implemented regularly and allow for examination of trends. Countries such as Bangladesh, Malawi and Sri Lanka have used the subaccounts approach to produce estimates of child health expenditure for more than one year, with findings showing increased spending on child health over time.

To date, reproductive health subaccounts have been undertaken in at least 20 countries: Bolivia, Colombia, Democratic Republic of Congo, Dominican Republic, Egypt, Ethiopia, Georgia, Jordan, Karnataka State in India, Kenya, Liberia, Malawi, Mexico, Morocco, Namibia, Rwanda, Senegal, Sri Lanka, United Republic of Tanzania and Ukraine. Child health subaccounts or similar studies have been completed in at least five countries: Bangladesh, Ethiopia, Malawi, Sri Lanka and United Republic of Tanzania.

TOTAL HEALTH EXPENDITURE PER CHILD UNDER 5 IN INTERNATIONAL DOLLARS (I$)



Expenditure estimates from subaccounts are a policy tool. They provide stakeholders with more specific information on spending patterns for RMNCAH than do general NHA estimates, allowing governments to identify the specific challenges in their national context. Such assessments help countries to assess strategies to overcome challenges in implementation associated with inadequate funds, inefficient spending and inequitable spending. An important measure is the share of reproductive and/or child health expenditure as a percentage of total health expenditure.

Below are examples of estimates of child health expenditures.

Country	Year	Total child health expenditure (in million US$)[a]	Total child health expenditure per child under 5 (in US$)[a]	Total child health expenditure as a percentage of total health expenditure	Under-5 mortality rate in 2005[b]
Bangladesh	2000/2001	176	10.7	12.1%	64
Ethiopia	2004/2005	101	7.8	19.0%	122
Malawi	2004/2005	33	13.4	15.5%	128
Sri Lanka	2003	26	16.1	3.9%	20
Tanzania	2005/2006	198	22.4	21.9%	103

[a] Estimates are presented in year-specific US$ currency
[b] WHO Global Health Observatory Data Repository (http://www.who.int/nha/expenditure_database/en/)
A comparative analysis for maternal and reproductive health subaccounts, similar to that shown for child health above, is ongoing

tion process of good-quality data. Tracking RMNCAH expenditures is more efficient than tracking health expenditures in general, as it does not promote a parallel process of data collection. Further, tracking RMNCAH expenditures will ensure that reporting for RMNCAH expenditures will use the global standard framework for reporting health expenditures, the Strengthening Health Accounts (SHA) 2011.

Way Forward

- Technical assistance, including planning of IT support, will be provided to countries once this need has been expressed in their country accountability plans.

The financial picture: paying for RMNCAH services[a]

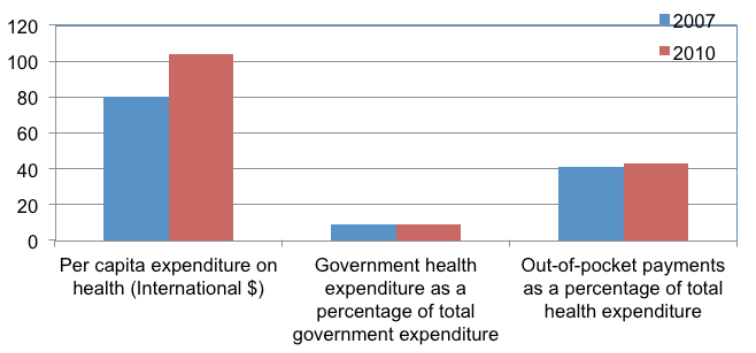
The chart below illustrates three key indicators that provide a financial picture for RMNCAH in 68 of the priority countries: per capita expenditure on health; government health expenditure as a percentage of total government expenditure; and, out-of-pocket payments as a percentage of total health expenditure.

Median per capita health expenditure in the 68 priority countries with available data is $100 (in 2010 international dollars) including expenditure funded by external sources. This is an increase from $80 for the same measure in 2007. Government health expenditure as a percentage of total government expenditure is less than 10% in more than 40 countries, and has not measurably changed since 2007. Countries in the Latin America and Caribbean and West and Central African regions have, in general, experienced decreases in this indicator. Only in 10 countries do out-of-pocket expenditures represent less than 15–20% of total health expenditure, indicating that many households in the Countdown countries are at increased risk of financial catastrophe and impoverishment due to health care costs.[b]

Governments can increase access and reduce financial barriers for RMNCAH services through the adoption of pro-poor legislation (e.g. expansion of fully or partially subsidized pre-payment schemes, removal of user fees and other financial barriers to accessing care, conditional cash transfer schemes, etc.) and through ensuring adequate levels of funding for RMNCAH, including domestic resources.[c]

Reforms and new financing mechanisms have been introduced in many countries to improve service access and financial risk protection. Ghana, for example, made maternal health services free of charge in accredited facilities in 2008.[d] Viet Nam increased access by exempting fees for services for poor mothers and children from 2003 and 2009 respectively.[e] In addition to user fee reforms, Ghana and Viet Nam introduced large-scale pre-payment schemes which emphasize cross-subsidization between different populations as a strategy to reduce the reliance on out-of-pocket payments and augment funding for increasing the quality and availability of health services, including RMNCAH services. These two country examples show how women and children can directly benefit from government commitment to move towards achieving universal coverage.

MEDIAN FINANCING INDICATORS FOR ACCOUNTABILITY PRIORITY COUNTRIES



[a] See Countdown report, June 2012
[b] World Health Organization. National Health Accounts: http://www.who.int/nha/en/
[c] World Health Organization. *The World Health Report – Health Systems Financing: The Path to Universal Coverage*. Geneva, 2010.
[d] Borghi J, et al. Mobilising Financial Resources for Maternal Health. *The Lancet*, vol 368, issue 9545, 21 October 2006, pp1457–1465.
[e] Ekman B, et al. Health insurance reform in Vietnam: A review of recent developments and future challenges. *Health Policy and Planning*. 2008;23, pp252–263.

- New work areas being developed include:
  1. Providing technical inputs and support to civil society in using resource tracking information at the country level for advocacy and greater accountability;
  2. Developing links with providers of online educational materials and courses (e.g. World Bank Institute) to tailor their courses to advocate for better use of funds for health with a focus on RMNCAH.

Recommendation 5: 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.

Target: By 2015, at least 50 countries have formal agreements with donors.

Results: 17 out of the 31 countries have a compact or equivalent partnership agreement.

Countries that have a compact or equivalent partnership agreement: Benin, Cambodia, Chad (pre-compact), Democratic Republic of the Congo, Ethiopia, Kenya, Mali, Mauritania, Mozambique, Nepal, Niger, Nigeria, Rwanda, Sierra Leone, Togo, Uganda and Zambia.

Status: On track

Process

Country compacts are written commitments made by government and development partners that describe how they will work together to improve health outcomes. Everyone who enlists in the IHP+, whether a national government, development agency or civil society organization, is committed to support a single national health strategy or plan.

Countries have various mechanisms that offer opportunities to enhance accountability for results. These include joint annual reviews of progress with implementing national health plans and priorities; the development of country compacts; parliamentary processes; civil society organizations in their watchdog function; and participation in global mechanisms for accountability.

The 31 countries in the International Health Partnership (IHP+) are encouraged to consider whether or not it would be useful to develop a local compact or equivalent partnership agreement.

Current IHP+ compact guidance emphasizes the importance of agreeing benchmarks for countries, developing partner performance and establishing mutual monitoring and reporting processes. It contains illustrative benchmarks of performance for both government and development partners.

Main Achievements

Of these 31 developing country signatories to the IHP+, 17 countries now have a compact or an equivalent partnership agreement that defines the ways in which governments and development partners will work together in support of a national health plan. Six additional countries are in the process of developing a partnership agreement: Burkina Faso, Burundi, Cote d'Ivoire, Djibouti, Senegal and Sudan. In other countries such as Malawi, whereas there is no compact per se, resource mapping takes place and there is a joint funding agreement for a sector-wide approach (SWAp).

Compact review processes are becoming more systematic. For example, Niger has started a process of regularly monitoring the progress of implementation of commitments included in the country compact. Burundi, Ethiopia, Kenya, Mozambique and Nigeria are also tracking progress on commitments, usually through sector reviews. Togo's compact includes specific commitments by both government and development partners to track financial resources. IHP+ is commissioning a synthesis of experience with compacts and other partnership agreements, which will also look at experiences with joint annual reviews the basis for national accountability mechanisms.

Challenges

- Not all compacts have specific indicators to monitor adherence to commitments.

Togo and Democratic Republic of Congo: Compact is leading to new ways of joint work across a wide range of partners

Togo has been gradually building up mechanisms for delivering health results and greater accountability for results over the last two years. During this period, the country has developed a National Health Policy, an investment case on Primary Health Care, a National Heath Strategic Plan, a Medium Term Expenditure Framework and, most recently, a National M&E Plan 2012–2015. A country Accountability Workshop in 2011 has helped shape the M&E plan. Joint working arrangements between governments, development partners and civil society and mechanisms for holding each other accountable have been gradually evolving. A 'pre-compact' signed in early 2011 has been followed by the signing of a country compact in May 2012 by government, external development partners and local NGOs and CSOs. This includes explicit commitments to track resources from both government and development partners. Joint annual health sector reviews took place in Togo as far back as the 1980s. In recent years, these have become more inclusive with development partners, NGOs and citizens groups. Poor data remains one major constraint to more evidence-based policy discussions during these reviews, a problem that Togo and partners are addressing through strengthening data collection activities and participatory data analysis. An additional route to increasing accountability is the independent monitoring of progress by IHP+ Results against commitments made by signatories to the IHP+ Global Compact.

The Democratic Republic of Congo (DRC) Ministry of Health intensified efforts to have a comprehensive approach to improve health results over the last five years. The country has a national health strategic plan (2011–2015) with an agreed monitoring and evaluation framework, including MCH indicators. This serves as the basis for joint annual reviews of progress. Annual reviews have been held for the last six years, attended by stakeholders from MOH, provinces and districts, NGOs and development partners. During the review, provinces present reports prepared according to a standard template. DRC also has a history of organizing annual district boards, with participation of local stakeholders. A recent review of progress on aid effectiveness and results in DRC by Kahindo and Kalambay noted that while substantial progress had been made in some areas, such as reducing project management costs and improving the distribution of essential medicines, progress in managing results and mutual accountability was not as great.

The Commission's focus on information and accountability, and the M&E framework it supports, provides a stimulus to strengthen the different components of the national health information system in a larger number of provinces in DRC. To increase accountability, the MOH and nine of its development partners participated in the independent monitoring of progress against commitments made by signatories to the IHP+ global compact by IHP+ Results in 2010. Findings were discussed in the 2011 joint annual review (JAR). DRC is participating in the 2012 IHP+ Results monitoring exercise.

- A review of 10 country compacts in late 2010 included a look at the scope and specificity of commitments made by government and development partners. Many commitments were ambitious and, in some cases, quite general and difficult to measure.
- Newer compacts are more likely to include specific indicators to track progress on a range of commitments, including resource tracking. Burundi, Niger and Togo are three recent examples. Countries are being systematically encouraged to include a commitment and indicators to track and report on externally funded expenditures.

Way Forward

Increasingly countries are including specific indicators to track progress on commitments. Compact review processes are becoming more systematic, and countries are looking more closely at whether the indicators being proposed to track progress are relevant and measurable. More countries now have commitment review processes, sometimes as part of the joint annual review. Ethiopia and Kenya have completed this processand it has recently been introduced in Mozambique and Nigeria.

As part of preparation for the fourth IHP+ Country Health Teams Meeting in December 2012, IHP+ is commissioning a synthesis of experience with compacts and joint annual reviews.

Recommendation 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.

Target

- Development partners will commit to strengthen capacity related to accountability processes in an additional 10 countries each year, prioritizing those with the highest burden of women's and children's ill health.

Progress towards this recommendation and target is linked to Recommendations 2 (health indicators) and 4 (resource tracking).

Better oversight of results and resources at national and global levels

Recommendation 7: National Oversight[1]

By 2012, all countries have established national accountability mechanisms that are transparent, inclusive of all stakeholders and recommend remedial action, as required.

Targets:

- At least 50 countries have regular national health sector review processes that meet basic criteria including broad stakeholder participation;
- At least 20 countries have made progress in engaging political leaders and financial decision-makers in health;
- At least 50 countries have held at least one countdown event.

Results:

- 37 countries (with available data) have conducted an annual health sector review in the last year;
- Parliamentarians from 10 countries have been engaged;
- 13 countries planning a national countdown event.

Countries that conducted an annual health sector review in the last year: Afghanistan, Angola, Benin, Burkina Faso, Burundi, Cambodia, Cameroon, China, Comoros, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Kyrgyzstan, Lao PDR, Madagascar, Malawi, Mali, Mauritania, Mozambique, Nepal, Niger, Papua New Guinea, Philippines, Rwanda, Senegal, Sierra Leone, Solomon Islands, South Sudan, Sudan, Tajikistan, Togo, Uganda, United Republic of Tanzania, Viet Nam, Zambia and Zimbabwe.

Status: Indicator 1: On track; Indicator 2: Making Progress; Indicator 3: On track

Health Sector Reviews

Process

Health sector reviews, a long-established tradition in countries with a significant number of external development partners, are mechanisms that countries can use to enhance accountability. These events are designed to jointly review implementation of national priorities and health sector performance over the last year. Reproductive, maternal, newborn and child health reviews are embedded in the well-established processes for health reviews. The Strategic Workplan for Accountability recognizes that national oversight mechanisms align with country-led review platforms such as those promoted by the IHP principles.

1 In the workplan, this recommendation includes three other targets related to engaging political leaders, Countdown events and country reporting to the iERG. Results for engaging political leaders and Countdown can be found under the Advocacy and Action sections: Working with Parliaments and Countdown to 2015.

Nepal: Aid effectiveness contribution to improved accountability for RMNCAH

Nepal's health partnership and performance review mechanisms have evolved considerably since the Ministry of Health and Population and external development partners signed the 2004 Statement of Intent to guide the Partnership for Health Sector Development. Joint annual reviews of health sector performance have been held since 2005. Partnership agreements, or compacts, have become progressively more explicit. The 2010 Joint Financing Arrangement (JFA), signed by the government and 10 development partners, emphasized the joint annual review as the single joint review mechanism for all partners to monitor progress against agreed priorities and results. Preparation for the JAR is becoming progressively more systematic and discussions during the JAR more strategic.

Improving maternal and child health is a major priority in the current National Health Sector Development Programme 2010–2015. In the 2012 JAR, the priority topics were maternal and child health, health workforce, monitoring and evaluation, financial management and medicines procurement and distribution. In the 2012 JAR, external development partners reported for the first time on progress on their commitments in partnership documents. The government of Nepal confirmed that the Ministry of Finance's new Aid Management Platform, which will contain data from external development partners and NGOs, is to be extended to sector level during 2012 and will be made publicly available. The 2012 JAR Aide Memoire stated that a holistic costed M&E plan would be ready by 2011.

An additional way to increase accountability is through the independent monitoring of progress by IHP+.

According to an IHP+ assessment of aid effectiveness and results in Nepal,[a] the aid effectiveness efforts have helped strengthen health systems by improving governance and harmonizing external development partners' priorities and aligning finances. Efforts have also facilitated the rapid scaling up of proven, successful service delivery interventions in RMNCAH, such as the scaling up of a successful intervention for increasing the number of births delivered in a health facility. Once its efficacy had been proven, the financing and coordination mechanism enabled partners to pool funds to make these services available on a national scale.

[a] Vaillancourt D, Pokhrel S. Aid Effectiveness in Nepal's Health Sector: Accomplishments to Date and Measurement Challenges. International Heath Partnership (IHP+), 1 February 2012. Available at: http://www.internationalhealthpartnership.net/en/ihp-partners/nepal/

Main Achievements

According to the national health planning cycle database other data from IHP+, 26 countries have had annual health sector review meetings in the last year. This is probably an under-estimate as information is not available for all countries.

Joint annual reviews offer an opportunity to debate key health policy questions and reflect on progress against the strategic plan with a range of health development actors. Given the range of situations in which the reviews occur, experience suggests they vary in the type of preparation, duration and participation, and in what is produced and how they are followed up. There are many examples where participation in the annual review has become broader over time, to include civil society organizations, professional associations and other non-state providers. Ghana, the United Republic of Tanzania, Togo and Uganda are four country examples. Including civil society organizations provides greater transparency to the process.

Challenges

There is relatively little systematic comparison across countries of joint annual review processes, but a wealth of operational experience exists. One common challenge is the need for more reliable data on health priorities and health system performance, framed to inform the priority themes of the review. A second concerns follow-up of agreed actions.

Way Forward

In 2012, IHP+ is commissioning a review of experience with joint annual reviews in time for the fourth IHP+ country teams meeting in December 2012, with the aim of identifying the characteristics that make annual reviews effective as a mechanism for policy dialogue and accountability.

Advocacy and action[1]

The Advocacy and Action stream of work is led by The Partnership for Maternal, Newborn & Child Health (PMNCH), in coordination with partners at global, regional and national levels and coming from different constituencies.

PMNCH's work is structured around three interconnected strategic objectives, all of which are highly pertinent to the Strategic Workplan for Accountability.[2] Advocacy and outreach activities cut across and contribute to each of the Commission's Recommendations. Annex 3 includes a list of actions taken by PMNCH to promote the implementation of the Accountability for Women's and Children's Health Framework for each of the Recommendations. This includes media advocacy for key issues, such as CRVS; partnering with the Inter-Parliamentary Union to support the development of its recent resolution on MNCH; partnering with the African MNCH Coalition to encourage greater integration between global and regional advocacy and accountability efforts; advocating for evidence produced by Countdown to 2015; and supporting the development of national CSO advocacy coalitions on reproductive, maternal, newborn and child health for greater accountability.

In addition, PMNCH is preparing its annual report on the Global Strategy commitments, which will provide further information on the progress towards implementation of these commitments.

In order to inform country stakeholders about the Global Strategy and the Commission's report (Keeping Promises, Measuring Results) PMNCH is undertaking a systematic distribution of key documents to Ministers of Health and MNCH focal points within national ministries in all 75 priority countries.

Way Forward

The next steps for advocacy and action in 2012 will further support the expansion of country partners' advocacy and outreach activities. A specific emphasis will be placed on the following activities to complement the Country Accountability Framework Assessment Tool.

Specific areas for future work include:

- Comprehensive and systematic distribution of updates, information, reports and materials to Ministers of Health, government policy-makers and senior parliamentarians, especially in the 75 Countdown countries and to a wider audience of stakeholders and policy-makers at global, regional and country level. This includes communication platforms such as PMNCH monthly e-blasts, relevant regional publications, and dedicated quarterly newsletters sent in hard and soft copy to regional and national workshop participants.
- Supporting robust and cohesive RMNCAH CSO advocacy through the development of national CSO advocacy coalitions to promote greater action and accountability at national and subnational levels. These coalitions can also take forward the evidence produced by Countdown to 2015 at a national level, including analysis on national health accounts, and link to efforts by parliamentarians and media for greater accountability.
- Through Countdown to 2015 and aligned efforts, such as the H4+ High Burden Country Initiative and the Open Health Initiative of the East African Community of states (Rwanda, Kenya, Uganda, United Republic of Tanzania and Burundi), support the development of consolidated national RMNCAH reports that compile data to assess progress in RMNCAH, including subnational data that are made widely available, online and in hard copy to parliamentarians, media, and citizen watchdog and accountability groups.

1 The work under Advocacy and Action corresponds to Recommendation 7 on national oversight.

2 These strategic objectives are cross-cut by operational principles: (1) a partner-centric organization; (2) playing a convening and brokering role for Partners; (3) guided by country demand and regional priorities; and (4) promoting the Continuum of Care.

Countdown to 2015

Countdown to 2015 is a global movement made up of academics, governments, international agencies, health-care professional organizations, donors and non-governmental organizations, with *The Lancet* as a key partner. Countdown is contributing significantly to the global accountability agenda through the preparation of Countdown profiles focused on the Commission indicators, which are updated annually. Countdown also supports country-level countdown processes that include national consultations, workshops or publications and utilize Countdown data and methodological approaches. PMNCH acts as the secretariat for Countdown.

Countdown has produced the accountability report with country profiles for 75 countries reporting on the 11 core indicators, launched at the IPU meeting in Kampala in March 2012.

Coverage data is disaggregated by key equity considerations.

A full Countdown report was released during the Child Survival Forum that the governments of USA, Ethiopia and India hosted on 14 and 15 June 2012 in Washington, DC. In addition to the main Countdown to 2015 report, related policy briefs and scholarly papers were developed, such as the 2009–2010 ODA analysis scheduled to be released in September 2012 at the time of the United Nations General Assembly.

Country Countdown is an important strategy to improve monitoring and follow-up action for Accountability at the country level. Incorporating a country Countdown initiative into the national planning process facilitates country partners to work together to measure progress and identify ways to increase coverage and improve outcomes for women's and children's health. Countries like Senegal, Zambia and Nigeria have conducted national Countdown events and, based on those experiences, a Countdown tool kit and guidance notes were developed to assist countries in undertaking national and subnational Countdowns to 2015 events. The tool kit includes indicator definitions, power points describing the findings of the global Countdown, and draft presentations that can be adapted for use at country level.

The multi-country workshops and the guidance notes are increasing momentum for conducting Country Countdown events. Thirteen countries have indicated that they will conduct a national Countdown event, many of which were motivated by the multi-country workshops. These countries include: Bangladesh, China, Ghana, India, Kenya, Malawi, Nepal, Niger, Pakistan, Rwanda, Senegal, Viet Nam and Zambia.

- Undertake media mapping work to identify further scope for strengthening national media partnerships in key high-burden countries, enabling frequent and robust reporting on a wide range of RMNCAH-related topics, including policy and budget action.

Working with Parliaments to engage political leaders and financial decision-makers

In 2011, the Inter-Parliamentary Union[1] (IPU) announced its commitment to the Global Strategy, pledging to mobilize support among parliaments to enhance access to and accountability for improved health for women and children. This commitment is implemented through a three-year workplan on MNCH (2011–2013), coordinated by the IPU secretariat and supported by a number of donors and other partners. Key objectives include: creating knowledge on parliamentary practices relating to MDGs 4 and 5; raising the profile of MNCH in national parliaments; facilitating specific parliamentary interventions on MNCH; and strengthening links between parliaments and other networks/stakeholders for improved MNCH outcomes.

Main Achievements

- *Global level:* Unanimous adoption of a resolution, by all member-parliaments of the IPU, entitled *Access to Health as a Basic Right: The Role of Parliaments in Addressing Key Challenges to Securing the Health of Women and Children* (March 2012, IPU Assembly, Kampala). The resolution represents consensus among parliamentarians as to their role in improving the health of women and children. Parliamentarians represent citizens, they shape policies, make laws, approve budgets and hold the executive branch of government to account – all vital compo-

1 The IPU is an international organization made up of more than 170 national and regional parliaments, and acts as a focal point for worldwide parliamentary dialogue and coordination in support of democracy and development.

nents of the concerted action needed to improve accountability for women's and children's health.

- *Regional level:* The development of a joint statement by the IPU and the East African Legislative Assembly on *Improving Information to Secure Women's and Children's Health and Health-Related MDGs* (May 2012, Arusha, United Republic of Tanzania), focuses on the importance of continuous, accurate, up-to-date and timely data for public health interventions, policy and planning and the importance of parliamentary support for improving civil registration and vital statistics (CRVS) in the East Africa region.
- *National level:* To date, **the IPU has worked with 10 countries**[1] to improve legislation and oversight relating to increased access of women and children to health services, including increased allocation of funds and improved monitoring and transparency of resource flows. The IPU will also support the development of national accountability frameworks and national Countdown to 2015 processes, aligning with efforts by partners for greater action and accountability.
- Forthcoming opportunities to continue global dialogue on the implementation of the IPU resolution will include a meeting of Women Speakers of Parliament in New Delhi in October 2012, and at the assembly of the IPU in Quebec City in October 2012, where a preliminary report on the implementation of the Kampala resolution will be presented in a session dedicated to MNCH issues.

Challenges

The role of ministries and parliaments in promoting accountability for women's and children's health requires that policy-makers and technical advisers have access to current, reliable and user-friendly information. This continues to be a significant challenge in many situations, where information about the Commission recommendations is not widely shared in local languages. This requires redoubling efforts to identify effective communication channels. Similarly, in order to contribute effectively to accountability for women's and children's health, it is important that processes and platforms for women's and children's health are inclusive of parliamentarians. Finally, it is also important that the work of regional, national and global parliamentary forums on MNCH issues is well-coordinated to ensure complementary action.

Recently adopted Inter-Parliamentary Union Resolution Galvanizing Momentum on Women's and Children's Health in East Africa

"*The IPU resolution has placed the issue on the radar of EALA for urgent action and provides EALA with a renewed mandate to tackle the issue of accountability for maternal, new born and child health.*"

Rt. Hon Abdirahin Abdi, Speaker of East Africa Legislative Assembly (EALA) at the East African Legislative Assembly, May 2012.

Way Forward

To ensure progress, it is essential that national parliaments are active on maternal, newborn and child health issues by supporting the expansion of the IPU's MNCH Workplan to more countries in support of the implementation of the recent IPU resolution on MNCH. Speakers of parliaments in the 75 priority countries will receive a package of information, including a covering letter from the IPU Secretary-General, urging the close review of documentation in support of the implementation of the resolution on women's and children's health passed in Kampala in March 2012.

1 Burundi, Ethiopia, Ghana, India, Kenya, Malawi, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

Recommendation 8: Transparency

By 2013, all stakeholders are publicly sharing information on commitments, resources provided and results achieved annually, at both national and international levels.

Targets:

- At least 50 countries have effective data sharing and dissemination mechanisms;
- Global partners have up-to-date databases on women's and children's health and effective dissemination of country-level and global data on the core indicators;
- In 2011, governments and partners (were expected to) clarify their announced financial commitments (up to US$ 40 billion) to the Global Strategy for Women's and Children's Health to enable these commitments to be tracked at global and country levels.

As of June 2012, 220 stakeholders across a range of constituencies had made commitments to advance the Global Strategy.[1] The Partnership for Maternal, Newborn & Child Health is developing a report to review the implementation of stakeholder commitments to the Global Strategy and the extent to which those commitments support and align with national strategies and investment to improve women's and children's health. The report is informed by an online survey, country case studies and in-depth analyses of topics, such as financial commitments, human resources for health and accountability mechanisms.

Recommendation 9: Reporting aid for women's and children's health: OECD-DAC

By 2012, development partners request the OECD-DAC to agree on how to improve the Creditor Reporting System so that it can record, 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.

Targets:

- By 2012, development partners agree on the method;
- By 2013, OECD has developed the guidance and instructions to support the new scoring system for RMNCAH in the Creditor Reporting System and donors begin reporting using the new method.

Results: Method approved during June 2012 meeting

Status: On track

Process

Tracking financial resources provides critical information that helps increase accountability. Details of expenditure by development partners on RMNCAH cannot easily be obtained from the OECD-DAC's Creditor Reporting System (CRS), because the coding system does not flag expenditures by types of intended beneficiaries.

A task team of the Working Party on Development Finance Statistics (WP-STAT) of the OECD-DAC convened in October 2011 to prepare a technical proposal on tracking RMNCAH commitments and disbursements. Two options were presented by the task team to an informal meeting of WP-STAT in February 2012. Based on feedback received, a third option consisting of a quartile approach with a scoring system of five values associated with percentages (4 = 100%; 3 = 75%; 2 = 50%; 1 = 25%; 0 = 0%), was developed. The technical options differ on the precision of the quantification of the amount of ODA towards RMNCAH. All three options were presented in the official annual meeting of WP-STAT in Paris on 6 and 7 June 2012.

1 All commitments are available at http://everywomaneverychild.org/commitments.

Main Achievements

At its 6 and 7 June meeting, WP-STAT members agreed to use the scoring system of five values to tag RMNCAH investments in the Creditor Reporting System. Reporting would be on new commitments only, starting with 2014 reporting on 2013 flows.

Challenges

Several WP-STAT members noted that they would not be able to implement the quartile approach internally; three reserved their positions.

Lessons Learned

CIDA piloted the three proposed options for tagging RMNCAH in ODA within its own statistical system, which proved empirically that the quartile approach was the most feasible.

Way Forward

Building on draft definitions submitted by Germany, further work will be done to refine instructions and guidance for the use of this new scoring system. WP-STAT members agreed that this work, when completed, should be approved through the use of the OECD's written procedure, in order not to delay further consideration until the next annual meeting of WP-STAT. Data collection is scheduled to start in 2013.

Recommendation 10: Global Oversight

Starting in 2012 and ending in 2015, an independent Expert Review Group iERG is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission's recommendations.

Targets:

- By September 2011, the members have been appointed;
- From September 2011, iERG members with support of the WHO secretariat will start preparing for a first meeting of the ERG in the second quarter of 2012.

Results:

- Seven iERG members appointed;
- iERG held Stakeholder Consultation in May 2012.

Status: On track

The Commission requested WHO to lead a transparent process to establish the iERG. A call for nominations was opened in July 2011 and a selection committee unanimously chose seven members (see Table 3), four of whom represent low- and middle-income countries. The individuals do not represent their respective organizations, institutions or governments but serve in an independent, personal and individual capacity. The functions of the iERG are to:

- Assess the extent to which all stakeholders honour their commitments to the Global Strategy and the Commission; including the US$ 40 billion of commitments made in September 2010;
- Review progress in implementation of the recommendations of the Commission;
- Assess progress towards greater transparency in the flow of resources and achieving results;
- Identify obstacles to implementing both the Global Strategy and the Commission's recommendations;
- Identify good practice, including in policy and service delivery, accountability arrangements and value-for-money approaches relating to the health of women and children;

- Make recommendations to improve the effectiveness of the accountability framework developed by the Commission.

TABLE 3: INDEPENDENT EXPERT REVIEW GROUP MEMBERSHIP
The Committee proposed Dr Horton and Mrs Phumaphi as co-chairs of the iERG.
Dr Carmen Barroso of Brazil – Director, International Planned Parenthood Federation (IPPF) Western Hemisphere Region
Dr Zulfiqar Bhutta of Pakistan – Professor and Founding Chair of the Division of Women and Child Health, Aga Khan University, Karachi
Dr Richard Horton of the United Kingdom of Great Britain and Northern Ireland – Editor of *The Lancet*
Dr Dean Jamison of the United States of America – Professor, School of Public Health, University of Washington
Mrs Joy Phumaphi of Botswana – Executive-Secretary of the African Leaders Malaria Alliance – ALMA
Dr Marleen Temmerman of Belgium – Senator and Professor, University of Ghent
Dr Miriam Were of Kenya – Global Health Workforce Alliance

The iERG has a website which reports on its work and current activities. The iERG held a Stakeholder Consultation in May 2012 where partners spoke about their experiences and concerns around the Accountability Framework. Inputs from the meeting as well as the content from this report will feed into the report that the iERG will submit to the United Nations Secretary-General.

Discussion and Conclusions

The strategic workplan to implement the Commission for Information and Accountability for Women's and Children's Health recommendations has been in place for just over six months. During this time, the initiative has brought people together, forging partnership between technical health experts, health programme managers, information, communication and technology experts, advocates and politicians. There is renewed energy for women's and children's health.

The initial months focused on the development of Country Accountability Frameworks (CAFs), which are the foundation for the priority action that countries undertake to fulfil the Commission's recommendations. To date there are 39 draft CAFs available, six of which are finalized, costed and ready for funding. By the end of the year all 75 priority countries will have completed draft CAFs, paving the way for country-level implementation towards the Commission's 10 recommendations. High-level political leadership has been a key convening factor for a broad stakeholder representation as well as decision-making for priority action. In the last six months, three important resolutions related to the Accountability work were passed: First, the World Health Assembly resolution (A65/15) urging Member States to honour their commitments to the Global Strategy and to strengthen efforts to improve women's and children's health by implementing the Commission's 10 recommendations. Second, the Inter-Parliamentary Union unanimously passed a resolution which articulates the role of parliaments in addressing key challenges to improve the health of women and children; and the Human Rights Council passed a resolution on recognizing birth registration as a human right. These resolutions provide a political platform for improvements to women's and children's health.

Aside from high-level political leadership, another success has been the gathering of partners representing different disciplines and sectors for the first time to discuss women's and children's health – something that served to bring in new ideas and perspectives on how to deliver for women and children's health. The mix of priority actions included in the CAFs is a reflection of the different disciplines coming together. For example, actions in the innovation area are being used to strengthen civil registration, maternal death surveillance and response and quality of care.

The Accountability Framework proposed by the Commission on Information and Accountability for Women's and Children's Health in itself is also an element contributing to success. The fact

that there is an accountability framework with time-bound deliverables and targets monitored by the United Nations Secretary-General through an independent and transparent group is keeping up the momentum among partners and is a catalyst for results. The OECD working group members deciding on a method to track financial commitments and disbursements for RMNCAH is an example of how accountability is harmonizing donor funding mechanisms. The Global Vaccine Plan, a new initiative recently endorsed by the World Health Assembly has been asked to use an accountability framework to guide its actions. Similarly, the Commission on Life-Saving Commodities for Women and Children is likely to request an accountability framework for the implementation of its recommendations. Therefore, the accountability framework is increasingly seen as a potential model for strengthening deliverables among partners around new health initiatives.

Of the working group areas, five are on track (or even exceeding targets), and five are "making progress" and one recommendation has mixed progress.[1] Much of the work requires systems strengthening and the first six months have been used to lay the foundations for strengthening health systems, an investment that takes time before witnessing tangible returns. The CAFs are now at the phase of implementation. Although countries set ambitious targets and goals, it seems probable many of these plans will produce long-term sustainable results that will improve women's and children's health. In order for this to happen, we need sustained inputs from all stakeholders to ensure the commitments are met.

Global leaders and partners are rallying to implement different aspects of the Global Strategy, resulting in new declarations, initiatives and commitments. This is a reflection of the renewed energy for women's and children's health and achieving MDGs 4 and 5. Each of the initiatives comes with financial commitments and promises, and in this constrained financial environment it is not yet clear whether the actual funding will match the promises made. This makes harmonization even more important. Moving forward, global partners will need to continue the spirit of collaboration and ensure harmonization across the various processes to ensure efficiencies. At the country level, efforts are required to ensure that the various initiatives link to national processes and do not over burden human or financial resources or other systems. The accountability framework is a catalyst for the required harmonization.

Way Forward

By the end of 2012, the 75 priority countries will have a draft CAF. The initial months of implementation and the review of progress has shed light on work areas that are moving fast and others where it is more difficult to progress. The next phase of implementation is critical and requires a stock-taking exercise to review the original strategic work plan (attachment 1) and explore how to fast-track certain areas where progress has been slower. In order to keep momentum and facilitate timely and coordinated follow-up, the working groups and WHO secretariat propose the following actions for the upcoming year:

Advocacy: High-level political influence will be solicited to maintain partner engagement and facilitate continued political commitment, particularly at the country level. Civil society and the private sector are also critical partners to stimulate country-level action.

Expanded Partnerships: New partners will be engaged in order to support countries to deliver on various aspects of the CAF. A promising approach is to strengthen regional institutions to assist countries in the implementation of their CAFs.

Resource mobilization: Resources will need to be mobilized to ensure that the 75 countries have the necessary funds to implement their CAFs; the resources are not yet available for each of the countries to deliver on their plans. Partners and donors at global and country level will need to be approached to try to match financial commitments to country demands.

1 Based on working group self-assessment against targets.

Communicating results: As countries implement their CAFs, an active mechanism for exchanging information and sharing results, lessons and strategies will be established. The ability to articulate results and identify gaps will be a critical approach to mobilize resources.

Strong links to Global Initiatives: The last six months have seen new initiatives contributing to the Global Strategy, such as the Commission on Life-Saving Commodities for Women and Children, the Family Planning Summit and the Child Survival Call for Action. All contribute to the United Nations Secretary-General's Global Strategy and strong links will be forged at the operational level to capitalize on and maximize synergies.

Annexes

Annex 1

Original Strategic Workplan with recommendations, indicators and targets

ACTION ITEM	INDICATOR / TARGETS	LEAD PARTNER	COMMENTS
0. General			
Develop country plans to augment accountability that are based on a rapid assessment and address priority areas for strengthening national accountability processes	At least 50 countries have made commitments and completed COPAAs by 2013	Countries: governments, other institutions With TA from UN, bilaterals, academic institutions Partnerships, CSO	(workplan 1.2.3)
1. By 2015, all countries have well-functioning health information systems, including surveys, facility and administrative sources, and have taken significant steps to establish a system for registration of births, deaths and causes of death			
Strengthening of country civil registration and vital statistics systems (CRVS), to better count maternal, newborn and child deaths	At least 50 countries have completed an assessment and developed a plan, and have taken significant steps towards implementation by 2015 (>20 by 2013)	Countries, multiple sectors involved HMN/WHO and United Nations Statistical Division	Strong country commitment to CRVS strengthening critical; Expanding the HMN MOVE-IT initiative (Workplan 1.2.2)
Strengthening of country health information systems to support timely and accurate monitoring of national health strategies accurate	At least 50 countries have timely and accurate core coverage indicators data to inform annual reviews, with appropriate data quality controls (20 by 2013)	Countries, health and statistical sectors UN HMN, PMNCH	Involves well-functioning HMIS (see also rec.3), combined with regular household surveys (workplan 1.2.1)
2. By 2012, a core set of 11 indicators on reproductive, maternal 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.			
The core indicators included in monitoring systems in countries Monitoring incorporates equity, including main stratifiers (gender, socio-economic position, sub-national data) to track and target disadvantaged populations	At least 50 countries use and have up to date accurate data on the core indicators, disaggregated, as part of their M&E systems by 2013 Global partners have streamlined reporting systems around the core indicators by 2012	Countries, health and statistical sectors Partnerships (GAVI, Global Fund, HMN, PMNCH) UN	Comprehensive plans developed and implemented for countries with highest burden for monitoring progress towards the core indicators Additional information and new resources required to institutionalize quality of care assessments in countries. (workplan 1.2.1)

ACTION ITEM	INDICATOR / TARGETS	LEAD PARTNER	COMMENTS
3. By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.			
Innovation through ICT is used to improve the performance of the health information system, including surveillance of maternal death), facility reports, and administrative data, and data sharing, supported by national e-health strategies involving all relevant stakeholders Accelerate the consultation process to develop required standards for increased interconnectivity and common standards	At least 50 countries have developed and are implementing national eHealth strategies, including specifics on how this benefits information and accountability for women's and children's health, by 2015	Countries Private sector, CSO/NGO ITU, WHO, other United Nations agencies Improved coordination between existing initiatives and bodies to support such as Broadband Commission, Digital Health Initiative, the World Bank, the Innovation Working group, UN-DESA, etc.	(workplan 1.2.1)
4. By 2015, all 74 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.			
Increase country capacity to routinely track health expenditures in ways consistent with the national health accounts framework Build capacity for RMNCAH specific expenditure tracking at global, regional and country levels	At least 50 countries use and have up to date and accurate data on the two indicators, as part of their M&E systems by 2013	WHO, World Bank, USAID with technical experts (academia, regional networks, other organizations)	Tracking private sources would be difficult on annual basis, but government and donor expenditures could be tracked annually. (workplan 1.2.3)
5. 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.			
H4 and United Nations support countries in developing country agreements with external partners, and external partners encouraged to comply.	At least 50 countries have formal agreements with donors by 2015.	H4 and United Nations support countries. IHP+ playing a role in several countries. Bilaterals and CSO/NGOs encouraged to support the process through their country representatives.	
6. 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.			
	Development partners will commit to strengthen capacity related to accountability processes in an additional 10 countries each year, prioritizing those with the highest burden of women's and children's ill health.	All development partners, linking recommendations 2 and 4 above.	(workplan 1.2.3)

ACTION ITEM	INDICATOR / TARGETS	LEAD PARTNER	COMMENTS
7. 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.			
Plans for national accountability mechanisms established all countries building on existing initiatives and inclusive of all stakeholders All countries will report on the chosen mechanism to the iERG From 2011, countries with support of development partners will obtain their own baseline data for the indicators recommended in the Commission report.	At least 50 countries have regular national health sector review processes that meet basic criteria including broad stake holder participation At least 20 countries have made progress in engaging political leaders and financial decision makers in health At least 50 countries have held at least one Countdown event All countries provide relevant information to the iERG for review on an annual basis starting 2012.	Countries CSOs, UN	(workplan 1.2.3)
8. By 2013, all stakeholders are publicly sharing information on commitments, resources provided and results achieved annually, at both national and international levels.			
H4 will work with other United Nations partners to further develop current databases on key indicators and disseminate effectively From 2011, monitoring of adherence to the IHP+ principles will also be an integral part of accountability for the Global Strategy and IHP+ reports will be made public on the global website Every Women, Every Child	At least 50 countries have effective data sharing and dissemination mechanisms Global partners have up to date databases on women's and children's health and effective dissemination of country level and global data on the core indicators In 2011, governments and partners should further clarify their announced financial commitments (up to US$40 billion) to the Global Strategy for Women's and Children's Health to enable these commitments to be tracked at global and country	H4+ Academic and research institutions Countries Donors CSOs	(workplan 2.1)
9. 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.			
Development of improved Creditor Reporting System	By 2012, development partners agree on the method By 2013, OECD has developed the technology to support the new Creditor Reporting system and donors begin reporting using the new methods.	Global level: OECD DAC for the data base, with inputs from EC, WHO, World Bank, USAID on methods. PMNCH in the short run estimating donor commitments and disbursements for women's and children's health until DAC data base revised and relatively complete	(workplan 2.2)

ACTION ITEM	INDICATOR / TARGETS	LEAD PARTNER	COMMENTS
10. 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 this Commission's recommendations.			
WHO will facilitate an open and transparent process to solicit nominations for an expert review group to review progress against the Global Strategy and the implementation of the Commission's recommendations.	By September 2011 the members have been appointed From September 2011, iERG members with support of the WHO secretariat will start preparing for a first meeting of the iERG in the second quarter 2012	WHO	(workplan 2.3)

Annex 2

Country Accountability Framework

Schedule of multi-country and national workshops, 2011–20121[1]

November 14–16, 2011	Bamako, Mali	Benin,* Mali, Niger, Senegal, Togo* (5 countries)
February 13–15, 2012	Dar es Salaam, Tanzania	Ethiopia, Ghana, Kenya,* Malawi,* Mozambique, Rwanda,* Uganda,* United Republic of Tanzania,* Zambia,* Zimbabwe* (10 countries)
March 19–21, 2012	Manila, Philippines	Cambodia, China, Lao People's Democratic Republic,* Papua New Guinea,* Philippines, Viet Nam* (6 countries)
June 18–20, 2012	Ouagadougou, Burkina Faso	Angola, Burkina Faso,* Comoros, Côte d'Ivoire, Guinea, Mauritania,* Democratic Republic of Congo* (7 countries)
June 21–23, 2012	Ouagadougou, Burkina Faso	Burundi, Cameroon, Central African Republic, Chad, Congo, Gabon, Guinea Bissau, Madagascar, Sao Tome and Principe (9 countries)
September 2–4, 2012	Cairo, Egypt	Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, Somalia, South Sudan, Sudan, Yemen (10 countries)
September 24–26, 2012	Bangkok, Thailand	Bangladesh, Democratic People's Republic of Korea, India, Indonesia, Myanmar, Nepal (6 countries)
October 1–3, 2012	Harare, Zimbabwe	Botswana, Eritrea, Gambia, Lesotho, Liberia, Nigeria, South Africa, Swaziland (8 countries)
October 8–10, 2012	Bishkek, Kyrgyzstan	Azerbaijan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan (5 countries)
October 22–24, 2012	Antigua, Guatemala	Bolivia, Brazil, Guatemala, Haiti, Mexico, Peru (6 countries)

* National Accountability Workshop conducted or to be completed by end September 2012 (17 countries).This includes Sierra Leone and Solomon Islands that completed the Country Accountability Framework through national consultative processes/workshops.

Note: Equatorial Guinea is expected to join one of the multi-country workshops scheduled in 2012.

1 Schedule as of August 09, 2012. For updated information, please see: http://www.who.int/woman_child_accountability/accountability_workshops/en/index.html

Annex 3

Overview of Current Activities: Advocacy and Action

PMNCH, in collaboration with partners, is acting as a platform for a series of strategic actions to ensure the effective promotion and implementation of the Commission's recommendations. These take account of resources and results and continued prioritization of women's and children's health in global, regional and national policy making. Deliverables are outlined below:

COIA RECOMMENDATION	ADVOCACY ACTIVITIES	LEAD PARTNER
1. Vital events	Disseminate the findings from the 7th African Symposium on Statistical Development (ASSD) at key African Union (AU) and Pan-African Parliament events and in technical sessions with stakeholders	PMNCH, Health Metrics Network (HMN)
	Promote the AU February 2009 Heads of State Summit Decision On African Charter On Statistics and 2010 Declaration Of African Ministers Responsible For Civil Registration through the Integrated RMNCAH Advocacy Strategy 2011–2015	Africa MNCH Coalition
	Production and dissemination of media and knowledge products in support of Civic Registration and Vital Statistics (CRVS), including January 2011 press release on outcomes of ASSD meeting in Capetown, and PMNCH knowledge summary on CRVS	PMNCH, HMN, WHO
2. Health Indicators	Develop and disseminate consensus document *Essential Interventions for RMNCAH*, supporting policy implementation via regional workshops, eg, forthcoming Asia-Pacific Leadership Dialogue and Technical Workshop (October–November 2012)	PMNCH and key partners, including Government of India, Asian Development Bank, RMN Alliance partners (BMGF, DFID, AusAid), WHO WPRO
	Incorporate into knowledge tools for tackling RMNCAH for parliamentarians	IPU
	Disseminate the Integrated Africa MNCH Advocacy Strategy at the AU and PAP	APHA/ Africa MNCH Coalition activities
	Advocacy and media outreach in support of the Countdown to 2015 evidence and policy reports, including a new accountability report using CoIA indicators, produced for dissemination at the Inter-Parliamentary Union meeting in Kampala, April 2012	PMNCH, FCI on behalf of Countdown to 2015
3. Innovation	Organize innovation break-out sessions during PMNCH advocacy strategy workshops, held in conjunction with the Women Deliver Regional Consultations (e.g., Kampala, March 2012)	PMNCH, Women Deliver, African MNCH Coalition, UNFPA and partners
	Act as secretariat for the Innovation Working Group, supporting its m-health catalytic grants for mobile technology to share knowledge, improve management and improve evaluation design to advance maternal and newborn health	PMNCH, Norad, in support of Every Woman Every Child joint workplan

COIA RECOMMENDATION	ADVOCACY ACTIVITIES	LEAD PARTNER
4. Tracking Resources	Advocacy for new evidence on resource allocations and trends generated by the finance working group of the Countdown to 2015, e.g., through the RH finance policy brief to be developed in conjunction with the Family Planning Summit in July 2012 and the 2009–2010 ODA analysis to be shared at the assembly of the Inter-Parliamentary Union in October 2012	PMNCH, FCI for Countdown to 2015
	Implementation of Africa Regional Integrated RMNCAH Advocacy Strategy, with strong focus on resource tracking	Africa MNCH Coalition
	Research and publication of PMNCH 2012 report on the implementation of the 2010–11 Global Strategy commitments, with key evidence and messages to be considered by the independent iERG for publication in its report (September 2012)	PMNCH and supporting partners involved in this product
5. Country Compacts	Facilitate consensus and "compacts" in high-burden Asia-Pacific countries to optimize investment of government and multilateral partners, to be discussed at the Asia-Pacific Leadership Dialogue and Technical Workshop, October–November 2012, Manila	PMNCH and key partners, including Government of India, Asian Development Bank, RMN Alliance partners (BMGF, DFID, AusAid), WHO WPRO
	Work with national parliamentarians to support and promote accountability activities related to commitments, actions and results of both country governments and development partners	IPU, Pan-African Parliament, UNFPA
	Activities to align national and global policies will feed into mechanisms such as the High-Level Forum on Aid Effectiveness	IPU
6. Reaching Women and Children	Develop national investment cases for health and through advocacy to parliaments for the prioritization of health in national budgets, and produce evidence and templates for country-specific RMNCAH investment and implementation scenarios and options	PMNCH
	Produce evidence on the economic case for investing in RMNCAH to support advocacy for increased resources, engagement and investment in women's and children's health aimed at public sector	PMNCH with support of lead partners, including Norad
	Implement activities to ensure continental, sub-regional and country-level integrated policy and budget actions across sectors that impact on MNCH through the AU Integrated MNCH Advocacy Strategy 2011–2015 and via preparatory papers for regional events, including Ministers of Finance and Health meeting in Tunis, July 2012, supported by Harmonization for Health in Africa partners	Africa MNCH Coalition, HHA
7. National Oversight	Provide information on obstacles and best practices in PMNCH's 2012 Report on Global Strategy commitments	PMNCH
	Strengthen national level parliamentary action through case studies of effective parliamentary engagement, providing knowledge tools for tackling RMNCAH and supporting national level parliamentary action, eg, in Kenya and Uganda	IPU
	Support implementation of IPU MNCH Workplan relating to national follow-up on the 2012 IPU Resolution on the role of parliamentarians in realizing women's and children's health	IPU, PMNCH and NGO partners, including World Vision
	Organize coordination workshops and advocacy material development to build African civil society capacity for successful RMNCAH advocacy, strengthening skills in accountability, tracking commitments, and monitoring of MNCH with small grants for joint workplanning and implementation of value-added activities in support of national and regional plans and frameworks	Africa MNCH/ PMNCH

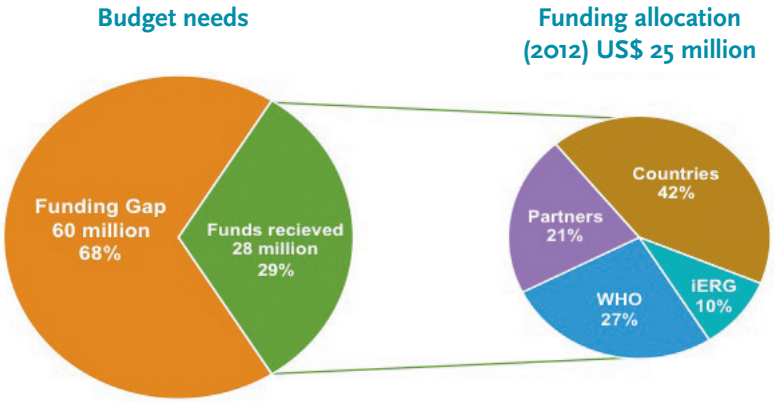
COIA RECOMMENDATION	ADVOCACY ACTIVITIES	LEAD PARTNER
	Implement media advocacy strategy that concentrates on selecting, framing, packaging and promoting evidence with potential to influence news agendas and raise public awareness and pressure (e.g., press campaigns on CRVS, G8/G20 asks on accountability and food security/nutrition, launch of Countdown to 2015 new report, launch of *Born Too Soon: The Global Action report on Preterm Birth*, etc.)	PMNCH
	Develop action and accountability component of the Country Accountability Framework, supporting the advocacy component of regional accountability workshops hosted by WHO (e.g., Dar es Salaam, February 2012; Manila, March 2012)	FCI, IPPF, and other NGO and health professional partners of PMNCH
8. Transparency	Produce and disseminate PMNCH 2012 Report on Global Strategy commitments analysing progress and bottlenecks in implementing the commitments (policy, financial and service delivery)	PMNCH
	Send copies of the Commission recommendation report to all PMNCH members and promote via website and e-blast, and disseminate iERG-related information via the PMNCH website and e-blast	PMNCH
	Host www.pmnch.org and www.everywomaneverychild.org to promote common information, evidence and as catalysts to joint action on accountability, as well as supporting active Twitter, e-blast and social media efforts to promote key messages and evidence	PMNCH/United Nations Foundation
	Implement 2012 PMNCH Media Plan to actively facilitate the flow of information to key policy actors, expand public engagement and foster accountability at the highest levels for political decisions	PMNCH
	Support Every Woman Every Child communications strategy to increase overall awareness and dissemination of information related to the Global Strategy, the CoIA recommendations and the iERG	EWEC
9. Reporting Aid	Produce and disseminate 2012 PMNCH Report on the progress of implementing the 2010–11 commitments;	PMNCH
	Produce and disseminate the Countdown to 2015 accountability report and policy briefs	Countdown to 2015 and partners, incl H4+
	Improve coordination of regional and global advocacy by facilitating the alignment of Global Strategy commitments and resources in existing intersectoral Africa MNCH continental, subregional and country policies through the AU's Integrated RMNCAH Advocacy Strategy 2011–2015	Africa MNCH Coalition
10. Global Oversight	Promote and build capacity to review progress on implementation of the recommendations of CoIA through the Country Accountability Framework Assessment Tool	PMNCH and partners

Annex 4

Funding

In order to implement the Commission's recommendations, the Accountability Strategic Workplan included a budget, costed at US$ 88 million. To date, US$ 28 million have been received in catalytic funding from the governments of Canada and Norway. The funds have been allocated as follows: Countries: 42%; Partner-led working groups: 21%; WHO headquarters-led working groups: 27%; iERG: 10%.

To date, US$ 11.7 million have been disbursed. Projections suggest that by the end of 2012, most of the priority 75 countries will have completed their Country Accountability Frameworks and may request catalytic funding, amounting to approximately US$ 19 million. The catalytic funding provided through the Accountability Framework is meant to be a support to countries to trigger action and accelerate progress towards implementing the Commission's 10 recommendations. Countries will need to mobilize additional resources in order to fill the funding gap for full implementation of the Country Accountability Framework. There is as yet no mechanism to track additional national resources committed to this effort at national level. Similarly, there is need for additional resources at global level to provide continued support to countries to fulfill their commitments in implementing their Country Accountability Frameworks.



WE SUPPORT
EVERY WOMAN
EVERY CHILD