Every Woman, Every Child: from commitments to action

The First Report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health

iERG

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iERG

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PREFACE

Welcome to the first report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health. This is the first of four annual reviews we will complete up to and including the Millennium Development Goal target date of 2015. Here, we summarise progress on the UN Secretary-General's Global Strategy on Women's and Children's Health and the recommendations of the Commission on Information and Accountability for Women's and Children's Health. As the first report of the iERG, we provide the foundation for our subsequent reviews.

Our shared view is that independent accountability is, and will increasingly become, a powerful force to accelerate progress towards both national and international health and development targets. The now rather cliched phrase "More money for health and more health for the money" implies a mechanism to measure the effectiveness of aid commitments. As a result, accountability has become a compelling idea in global health. But accountability needs to be based on certain core principles—clarity as to stakeholder responsibility for action; accurate measurement; independent verification; impartial, transparent, and participatory review; and clear recommendations for future action.

Women and children have enjoyed spectacular gains in their health status in recent years. These successes have been supplemented by unprecedented opportunities to go further—to end, once and for all, preventable maternal, newborn, and child mortality. But the iERG is also conscious of the urgent actions needed now to assist countries that have so far been unable to implement known effective interventions to save the lives of women and children. We hope that our report, and the renewed debate and advocacy we believe it can generate, will accelerate these urgent actions. We want to see independent accountability not only become a new norm in global health, but also demonstrably improve the lives of women and children worldwide. Ultimately, that is the goal we are accountable for supporting—through monitoring, reviewing, and proposing remedies—and which the global community is responsible for delivering.

Richard Horton
Co-Chair

Joy Phumaphi
Co-Chair

independent Expert Review Group
on Information and Accountability for Women's and Children's Health

ABBREVIATIONS

ANC	Antenatal care
CDC	Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIDA	Canadian International Development Agency
CoIA	Commission on Information and Accountability for Women's and Children's Health
CRVS	Civil Registration and Vital Statistics
FLHE	Family Life and HIV Education
FP	Family planning
GAVI Alliance	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund to Fight AIDS, TB, and Malaria
H4+	WHO, UNFPA, UNICEF, UNAIDS, UN Women, and the World Bank
ICPD	International Conference on Population and Development
ICT	Information and communication technologies
iERG	independent Expert Review Group
IHME	Institute for Health Metrics and Evaluation
IHP+	International Health Partnership
IPT	Intermittent preventive therapy
ITU	International Telecommunications Union
NORAD	Norwegian Agency for Development Cooperation
OECD-DAC	Organisation for Economic Co-operation and Development – Development Assistance Committee
PMNCH	Partnership for Maternal, Newborn, and Child Health
PMTCT	Preventing Mother-to-Child Transmission of HIV
PNC	Postnatal care
RMNCH	Reproductive, maternal, newborn, and child health
STI	Sexually transmitted infections
U5MR	Under-five mortality rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCHR	Office of the United Nations High Commissioner for Human Rights
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Contents

Case Studies

EXECUTIVE SUMMARY

The UN Secretary-General's Global Strategy for Women's and Children's Health, *Every Woman, Every Child,* was launched in September, 2010. Its goal is "scaling up and prioritising a package of high-impact interventions, strengthening health systems, and integrating efforts across diseases and sectors such as health, education, water, sanitation, and nutrition. It also means promoting human rights, gender equality, and poverty reduction." With the target date of the Millennium Development Goals (MDGs) now in sight, *Every Woman, Every Child* represents the global community's commitment to accelerate progress towards MDGs 4 (child survival) and 5 (maternal and reproductive health).

A critical part of this strategy was the creation of a global oversight mechanism to ensure that commitments to women's and children's health were being delivered on time and with impact. The Commission on Information and Accountability for Women's and Children's Health reported in 2011. One of the Commission's 10 recommendations was the creation of an independent Expert Review Group (iERG) to report regularly to the UN Secretary-General on the results and resources related to the Global Strategy, and on progress in implementing the Commission's recommendations. This is the first of 4 annual reports up to and including 2015.

The focus of the iERG is on 75 countries where 98% of maternal, newborn, and child deaths take place. The accountability framework we use has its origins in human rights bodies—namely, monitoring (based on a small number of health status and coverage indicators), transparent and participatory review, and remedy and action.

EVERY WOMAN, EVERY CHILD: AN EARLY PROGRESS REPORT

- Headline maternal and child mortality reductions during the past decade have been impressive. In 1990, there were an estimated 11.6 million under-5 child deaths. That figure had fallen to 7.2 million deaths by 2011. Estimated maternal deaths in 1990 were 409 053. That number had fallen to 273 465 by 2011.

- According to one set of estimates, 13 of our 75 priority countries are "on-track" to reach MDG-4: Bangladesh, Brazil, China, Egypt, Guatemala, Liberia, Madagascar, Morocco, Nepal, Peru, Tajikistan, Turkmenistan, and Viet Nam. Only 4 countries are "on-track" to reach MDG-5: China, Egypt, Morocco, and Peru.

- Despite these successes, headline mortality reductions mask areas of major concern. The annual rates of decline in maternal and child mortality mean that most countries identified by the Global Strategy will not reach their MDG targets by 2015.

- Although some countries do seem to be accelerating their progress—for example, for MDG-4: Afghanistan, Angola, Burundi, Cambodia, Congo, Iraq, DPR Korea, Liberia, Madagascar, Swaziland, and Zambia—others have fallen back (also for MDG-4): Azerbaijan, Botswana, Burkina Faso, Haiti, Lesotho, and Turkmenistan.

- Priorities for action are coming into ever sharper focus. Among children, 3.07 million deaths annually take place in the newborn period, 1.08 million from pre-term birth complications and 0.72 million from intra-partum complications. The major preventable causes of post-neonatal deaths among children are pneumonia (1.07 million deaths annually), diarrhoea (0.75 million deaths), and malaria (0.56 million deaths).

- Among women, to achieve MDG-5, the annual rate of maternal mortality decline must be 5.5%. But worldwide, the decline has been only 1.9% since 1990. The predicament for adolescent girls is especially acute: one in 8 births in low-income settings is in girls aged 15-19 years old; in sub-Saharan Africa, girls aged 15-19 years account for a quarter of unsafe abortions.

- The region that suffers the highest rates of maternal, newborn, and child deaths, as well as the least progress, is sub-Saharan Africa. By any standard, Africa must be a greater global policy priority for all partners concerned with achieving the highest levels of health for women and children. A key reason for lack of progress in Africa remains persistent health-system weaknesses.

- We have noted differences in judgement between different groups about which countries are on-track to reach the MDGs for reproductive, maternal, newborn, and child health. While differences in estimates are to be expected, differences in judgements about country progress are confusing and unhelpful. We urge those responsible for these different estimates to agree on the broad progress countries are making towards internationally agreed goals.

- *Every Woman, Every Child* has brought enormous energy to advocacy for women and children. High-level political support for, and financial commitments

to, MDGs 4 and 5 have increased. The Partnership for Maternal, Newborn, and Child Health estimates that the Global Strategy has delivered US$ 18.2–20.6 billion of new and additional funding to women's and children's health. But there are signs that donor and country financial commitments are declining because of the global financial crisis.

- The distribution of commitments made to the Global Strategy is disturbingly uneven. 15 countries have received 3 or fewer commitments from donors, while 20 countries have received 15 or more commitments.

- One disappointment is that it has not proven possible to document precisely the progress made on each of the 220 commitments to the Global Strategy. This absence of evidence is a major gap in the Global Strategy, one that may undermine the credibility of *Every Woman, Every Child*. Although it may be true that implementation of the Global Strategy has advanced the health of women and children, the exact nature of those advances—the tangible results that have been achieved for women and children—is, as yet, impossible to determine.

- The health of women and children does not exist on a static landscape. Non-communicable diseases are now a growing concern. And the policy environment has moved considerably during the past 2 years. New initiatives on vaccines, child survival, and family planning have been launched. Universal health coverage is now a central concern of global health policymakers. Meanwhile, the post-2015 development agenda is in the early stages of planning. A mechanism is needed to continuously update the Global Strategy—to take account of the shifting burden of disease and disability facing women and children, as well as to integrate new policies shaping the global and country responses to those burdens.

IMPLEMENTING ACCOUNTABILITY: DELIVERING THE CoIA's RECOMMENDATIONS

- The Commission on Information and Accountability made 10 recommendations: on better information for better results, on better tracking of resources, and on better oversight of results and resources, nationally and globally. Five of these recommendations were to have been fulfilled in 2012.

- On health indicators (recommendation 2), the goal has not been met. Only 11 out of 75 countries have data on all 8 coverage indicators selected by the Commission. In many countries, no data are available for key indicators, such as met need for contraception, post-natal care, antiretroviral prophylaxis for PMTCT, and antibiotic treatment of pneumonia. The Commission also asked that indicator data should be disaggregated for equity consideration. By wealth quintile, the available evidence shows that the poorest groups are largely excluded from any benefits being brought by efforts to deliver the Global Strategy. On age, the available evidence shows that young women have much lower met need for contraception.

- On country compacts (recommendation 5), the goal has not been met. A "compact" is a written commitment between a government and its development partners, which describes how they will work together to improve outcomes. Only 36 of 75 countries have signed compacts to date. Even when compacts have been agreed, there are no data as to how those compacts have led to different actions on behalf of women and children.

- On national oversight (recommendation 7), this goal has not, as far as we can tell, been met. The Commission asked that all countries establish national accountability mechanisms that are transparent, inclusive of all stakeholders, and that recommend remedial action to address gaps and obstacles to achieving better health for women and children. But for the majority of our 75 priority countries, there is no reliable information about the presence or nature of annual health sector review.

- On reporting aid for women's and children's health (recommendation 9), this goal has been met. Agreement has been reached that a new marker for reproductive, maternal, newborn, and child health tracking will be introduced in 2014, reporting on 2013 financial flows. The recommendation also asked that, in the interim, development partners and the OECD implement a simple method for reporting such expenditure. This has not been done.

- On global oversight (recommendation 10), this goal has been met. The iERG has been established and is working according to its terms of reference.

- The Commission's remaining recommendations—on vital events reporting (recommendation 1), innovation (recommendation 3), resource tracking (recommendation 4), reaching women and children (recommendation 6), and transparency (recommendation 8) will be reviewed more fully in subsequent reports. As of now, we have serious concerns that progress towards these goals is insufficient. There is very little evidence of progress towards reliable civil registration and vital statistics systems in countries where the greatest burdens of morbidity and mortality among women and children

occur. Only 22 of 75 countries have national eHealth or telemedicine strategies in operation. Only 18 countries are reporting expenditure on reproductive, maternal, newborn, and child health. We have no reliable data to judge progress on including women's and children's health as part of health spending reviews, or whether those reviews are linking spending to commitments, human rights, gender, and other equity goals and results. Finally, only 16 countries have data available on public reporting of performance; only 4 have a publicly accessible performance report from the preceding year.

- At present, there is a severe shortfall in available resources to deliver the Commission's recommendations for 75 priority countries where the greatest burdens of women's and children's ill-health are to be found. We estimate that funding gap to be at least US$ 64 million.

IDENTIFYING SUCCESSES, OVERCOMING OBSTACLES

- While many successes can be documented—some of which we highlight in a series of case studies—there are many gaps in our assessment. We hope to bring more precise and quantitative measures to our analysis in future years to understand better how countries are performing relative to themselves and to one another. What we can be sure of are the many threats that exist to the aspirations set out in *Every Woman, Every Child,* threats that are either receiving too little attention or being almost wholly ignored in countries and globally.

- There are pervasive and troubling weaknesses throughout the health systems of countries with the greatest burdens of mortality and disease among women and children. These weaknesses encompass inadequate high-level political leadership, insufficient financing, weak national governance and parliamentary oversight, lack of skilled health workers, unacceptable variations in coverage of specific interventions, and steep inequities in the availability, accessibility, and quality of healthcare.

- In addition to these systemic failures, we have also identified specific but neglected areas that are critical to future success—undernutrition, lack of attention to adolescent girls, gender discrimination, pervasive neglect of safe abortion services, inattention to conflict-affected and displaced populations, insufficient intersectorality, weak information technology platforms, overburdened national oversight capacity, and threats to sustained advocacy for women and children.

RECOMMENDATIONS FOR STRENGTHENING ACCOUNTABILITY

- We make 6 recommendations for improving the effectiveness of the accountability framework developed by the Commission.

- ***Strengthen the global governance framework for women's and children's health.*** To maximise the impact of multiple initiatives in women's and children's health, and to ensure coordination and coherence in their implementation, we recommend that a more formal global governance (or guidance) framework for women's and children's health be established. At present, there is a governance gap that must be filled by a mechanism inclusive of partner countries, multilateral agencies, donors, non-governmental organisations, health professionals, researchers, foundations, and the private sector. We advocate a renewed effort to promote effective interaction and cooperation between all partners dedicated to improving women's and children's health.

- ***Devise a global investment framework for women's and children's health.*** The case for stronger accountability mechanisms to track resources for women's and children's health was one of the main conclusions of the Commission on Information and Accountability. But how will the needs for priority countries be fully costed and met? The likelihood is that a financing facility for women's and children's health will be established in the near future. The creation of a financing facility without a clearer idea of country needs and priorities would be a mistake. We recommend the creation of a global investment framework, taking account of national investments and allocations, to guide a more targeted and strategic approach to supporting women's and children's health. The success of the investment framework that exists for AIDS provides one possible model for doing so.

- ***Set clearer country-specific strategic priorities for implementing the Global Strategy and test innovative mechanisms for delivering those priorities.*** Priorities across the continuum of care need to be sharpened during the 3 years remaining until the MDG target date of 2015. We make recommendations for reproductive health (contraceptive information and services, sexual health, and safe abortion services); maternal health (skilled birth attendants, facility-based delivery, emergency obstetric care, and postpartum care); stillbirths (addressing the complications of childbirth, maternal infections and diseases, and maternal undernutrition); newborn health (addressing the

complications of preterm birth); child health (targeting pneumonia, diarrhoea, and malaria); and adolescent health (sexuality education and universal access to reproductive health services). We also recommend innovative approaches to scaling up coverage through equity-focused initiatives, community mobilisation, integration of services (especially with AIDS programmes), using the mass media, and poverty alleviation (such as conditional cash transfer schemes).

- ***Accelerate the uptake and evaluation of eHealth and mHealth technologies.*** The potential for digital technology to accelerate improvements in women's and children's health is great—notably, in supporting country civil registration and vital statistics systems. Although eHealth and mHealth have generated much attention, the evidence on which to base decisions about implementation and scale up are weak or non-existent. We urge partners to assist countries with the development and implementation of national eHealth plans, to focus on sustainable long-term investments in eHealth, to encourage coordination between providers, and to support evaluation.

- ***Strengthen human rights tools and frameworks to achieve better health and accountability for women and children.*** Human-rights based approaches have a crucial, but neglected, part to play in the delivery of the Global Strategy. A human-rights based approach provides not only a goal but also a process to reach that goal. In 2011, the Committee on the Elimination of Discrimination against Women became the first UN human rights body to state that countries have an obligation to guarantee, and take responsibility for, women's timely and non-discriminatory access to maternal health services. They wrote: "The right to health means the availability, accessibility, acceptability, and quality of health care, as well as tackling the underlying determinants of health. Women and children have the right to hold States accountable for the health care they provide". This decision was an important turning point in strengthening accountability for women's health. We recommend that human rights treaty bodies that interface with health routinely incorporate the health of women and children into their work.

- ***Expand the commitment and capacity to evaluate initiatives for women's and children's health.*** Evaluation is a key component of accountability. We recommend that partners accelerate their work to establish a global research network to support the Global Strategy. Without reliable evidence, openly and freely accessible, to inform what works for women and children (and what does not), results will fall short of expectations and resources will be wasted. We also urge research funders to invest more in women's and children's health. Research itself can be a powerful accountability tool. We see evaluation—the relentless pursuit of results—becoming one of the foundations of effective independent accountability.

CONCLUSION

- The Global Strategy has triggered remarkable energy and commitment. But the test of the Global Strategy's impact lies not in promises, but in results. As yet, it is too early to say whether the Global Strategy has accelerated progress in improving women's and children's health in the 75 countries where most maternal and child deaths take place.

- An impartial review of existing commitments to the Global Strategy shows considerable weaknesses in the enabling environment needed to turn promises into results—in health systems, around more specific but still neglected issues, and in those MDGs that influence women's and children's health (such as poverty, education, gender inequality, water and sanitation, urban environments, and access to affordable, essential medicines). Unless these broader issues are addressed urgently, not only will the MDGs for women and children not be met, but also the gains that have been made so far will not be protected and secured for the future.

- The grounds for moving fast to implement our recommendations are strong. Evidence is gradually growing to show that investing in adolescent, women's, and children's health has important economic as well as health returns. This emerging evidence should give confidence to Ministries of Finance to invest in adolescents, women, and children for long-term economic prosperity.

- The past 12 months have seen many new and welcome initiatives launched to accelerate progress towards improving women's and children's health—for example, on child survival, family planning, and life-saving commodities. While welcome, these projects, and the accountability mechanisms that go with them, need an effective means of coordination to avoid unnecessary duplication and inefficiency.

- Financial donors need to be clearer about the extent to which their stated financial commitments are being met. We have not found this core element of donor accountability to be consistently in place. There are disturbing suggestions that at least some donors are falling behind in their financial commitments.

- We are also concerned about the future environment for women's and children's health. The resistance that some sectors of society have shown to women's health and reproductive rights and justice has to be addressed. Although awareness of *Every Woman, Every Child* is strong in countries, there has been far less attention paid to the Commission on Information and Accountability. Yet the Commission's recommendations are crucial to accelerate progress towards meeting the objectives of the Global Strategy. All partners need to do more to make policymakers, parliamentarians, and political leaders better aware of the Commission's work. Accountability is only a practical means to a larger end: better health for adolescents, women, and children.

- Finally, we are fully conscious that mechanisms are already underway to plan the post-MDG period. The Secretary-General's High-Level Panel of Eminent Persons on the Post-2015 Development Agenda is beginning its work. The lives—and health—of women and children must be central to any future vision of sustainable development. The predicaments facing women and children are truly global problems requiring global solutions. Women have an indispensable role as agents of sustainable development. We will only make further progress for adolescents, women, and children if we understand a core truth: the interdependence of all human beings, one with another, the literal and correct meaning of *Every Woman, Every Child*.

INTRODUCTION

1. A decade ago, and despite the priority given to maternal and child health in the Millennium Development Goals (MDGs), a widespread view among programme managers and public health scientists was that UN agencies, donors, and countries had failed to make the health of women and children a serious strategic priority (1,2). Today, that era of relative neglect has been replaced by a period of renewed political commitment and societal action. Thanks, in part, to the work of a dedicated coalition of global and national stakeholders in health—organised as the Countdown to 2015 initiative—evidence has been gathered not only to show the size of the health challenge afflicting women and children, but also the opportunity available if proven interventions to reduce mortality were to be fully implemented, scaled up, and sustained (3).

2. In addition to the accumulation of ever more compelling science, multilateral agencies, civil society organisations and initiatives (such as the White Ribbon Alliance and Women Deliver), donors, foundations, healthcare professionals, partner countries, and the private sector identified an increased need for better accountability. The result was a series of initiatives culminating in the creation of the Partnership for Maternal, Newborn, and Child Health (PMNCH) in 2005. The Partnership is the only platform that exists to bring together all constituencies focused on improving the health of women and children. PMNCH is also the main advocate for the continuum of care. The political confidence these initiatives fostered—that investments in reproductive, maternal, newborn, and child health (RMNCH) would not be wasted but, on the contrary, would yield rapidly measurable results—triggered an upsurge in political action, resource mobilisation, and programmatic activity in countries and among donors (4). African nations became more vocal advocates for women's and children's health (5). Influential donors made the lives of women and children a Head of State and Government priority, rather than merely a priority for their Ministries of International Development (6). And non-governmental organisations joined forces to begin a new social movement for women and children.

3. These renewed commitments reached a turning point with the UN Secretary-General's Global Strategy for Women's and Children's Health, *Every Woman, Every Child*, launched in September, 2010 (7). The strategy set out six key elements: country-led health plans; a comprehensive, integrated package of essential interventions and services; integrated care; health-systems strengthening; health workforce capacity building; and coordinated research and innovation. The Secretary-General argued for greater investment in women's and children's health and for improved efficiency in the way resources were deployed.

4. He also urged all partners to hold themselves accountable: "Accountability is essential. It ensures that all partners deliver on their commitments, demonstrates how actions and investment translate into tangible results and better long-term outcomes, and tells us what works, what needs to be improved, and what requires more attention" (7). In 2010, the Secretary-General requested that WHO facilitate a process "to determine the most effective international institutional arrangements for global reporting, oversight, and accountability on women's and children's health, including through the UN system." The Commission on Information and Accountability for Women's and Children's Health, co-hosted by WHO and the International Telecommunications Union (ITU) and co-chaired by Tanzania's President Jakaya Kikwete and Canada's Prime Minister Stephen Harper, was the result.

5. The Commission's final report was published in 2011 (8) and made 10 recommendations (see panel 1) grouped under three objectives—better information for better results, better tracking of resources for women's and children's health, and better oversight of results and resources (nationally and globally). Recommendation 10 established the independent Expert Review Group (iERG), whose first report is presented here. The iERG's functions are shown in panel 2. The Group is the global review mechanism for the Commission's recommendations. We are hosted by WHO (with a lean and efficient secretariat) and we will report annually to the UN Secretary-General through WHO's Director-General. Our principles are those of the Commission—to focus on national leadership and national ownership of results; to strengthen country capacity to monitor, review, and remedy progress on women's and children's health; to reduce reporting burdens by aligning efforts with country systems to monitor and review national health strategies; and to strengthen and harmonise existing international mechanisms to track progress on all commitments made.

6. A crucial aspect of our work is the accountability framework adopted by the Commission. Our framework is based on three separate but interlocking activities. First, monitoring. Monitoring means acquiring data to find out what is happening, where, and to whom. Monitoring alone is not accountability. A second crucial activity is analysis and review: have pledges, promises, and commitments been kept by countries, donors, and other actors? In other words, did we deliver? The third element of accountability is remedy and action: what must be done to put things right? This cyclical process of monitoring, review, and remedy publicly recognises success, draws attention to good practice, identifies shortcomings, and offers corrective actions. Our framework applies in countries and globally, and emphasises human rights principles, including equality

and non-discrimination, transparency, and partnership. The iERG is an example of independent accountability.

7. Our report is divided into five sections. First, a review of the early progress of *Every Woman, Every Child.* Second, a report on progress towards implementing the Commission's 10 recommendations. Third, a review of good practices and obstacles to implementing both the Global Strategy and the Commission's recommendations. Fourth, our own recommendations to improve the effectiveness of the accountability framework developed by the Commission. And finally, our concluding observations. Our report is based on an open call for submissions of evidence (Annex 1), evidence commissioned by the iERG itself (Annex 2), an open consultation with stakeholders (conducted on May 24, 2012, during the 65th World Health Assembly), a review of published evidence relevant to women's and children's health, and interviews with key informants during the course of the past 12 months. Throughout our report we have included case studies to provide examples of how improved accountability can produce progress in the health and wellbeing of women and children.

Panel 1: The recommendations of the Commission on Information and Accountability for Women's and Children's Health

Better information for better results

Recommendation 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.

Recommendation 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.

Recommendation 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 for women's and children's health

Recommendation 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.

Recommendation 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.

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.

Better oversight of results and resources: nationally and globally

Recommendation 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.

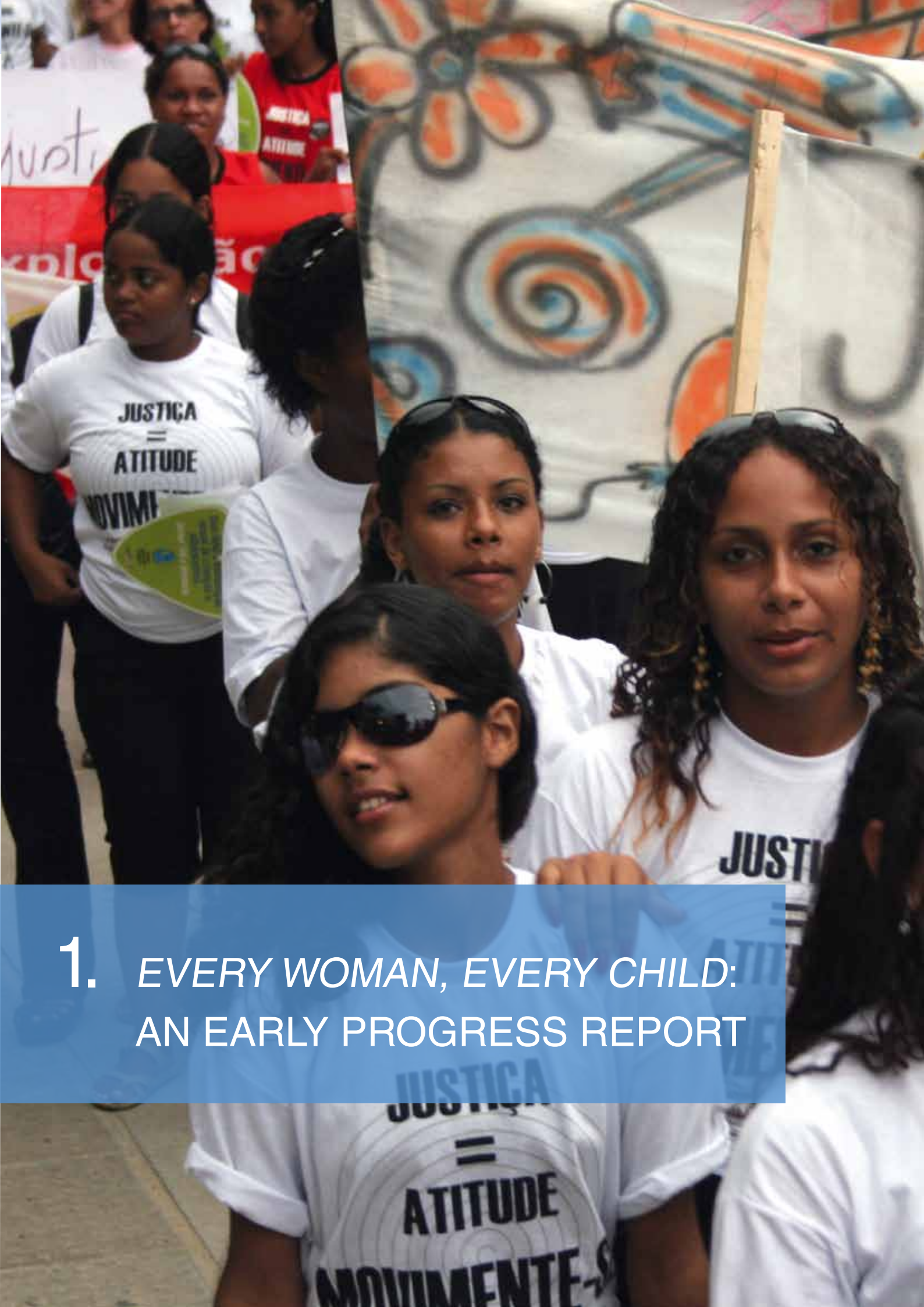
Recommendation 8 - Transparency: By 2013, all stakeholders are publicly sharing information on commitments, resources provided and results achieved annually, at both national and international levels.

Recommendation 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.

Recommendation 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 this Commission's recommendations.

Panel 2: The functions of the independent Expert Review Group

- 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
- To review progress in implementation of the recommendations of the Commission
- To assess progress towards greater transparency in the flow of resources and achieving results
- To identify obstacles to implementing both the Global Strategy and the Commission's recommendations
- To identify good practice, including in policy and service delivery, accountability arrangements and value-for-money approaches relating to the health of women and children
- To make recommendations to improve the effectiveness of the accountability framework developed by the Commission

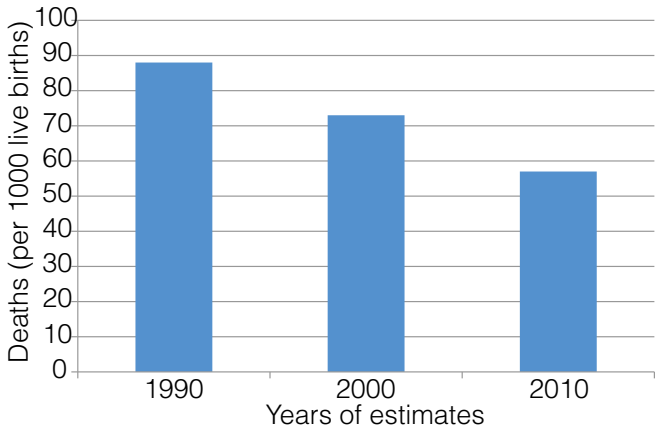


1. *EVERY WOMAN, EVERY CHILD*: AN EARLY PROGRESS REPORT

8. The central objective of the Global Strategy is to accelerate progress towards MDG-4 (a two-thirds reduction in under-5 mortality) and MDG-5 (a three-quarters reduction in maternal mortality and universal access to reproductive health). The Global Strategy identified 49 low-income countries where, if the MDGs were achieved, nearly 16 million lives could be saved between 2011 and 2015. The Countdown to 2015 initiative has broadened these countries of concern to include an additional 26 nations that, together with the Global Strategy's 49, account for 98% of all maternal and child deaths. These 75 countries are listed in Annex 3 and, because they cover such a large proportion of deaths among women and children, are the subject of our report.

9. Headline mortality reductions during the past decade have been impressive (figure 1). In 1990, there were an estimated 11.6 million under-5 child deaths. That figure had fallen by 38% to 7.2 million deaths by 2011 (9). Although numbers vary slightly because of methodological differences in the way estimates are calculated, these trends show strong concordance (10). The reductions show convergence of countries towards lower levels of child mortality. Especially encouraging is the observation that 39 of 48 countries in sub-Saharan Africa have achieved faster declines during 2000-2011 than during 1990-2000. For maternal mortality, there have been similarly substantial declines. Estimated total maternal deaths in 1990 were 409 053. That figure had fallen by 33% to 273 465 by 2011 (9). Again, these trends have subsequently been independently verified (11).

Figure 1: Estimates for under-5 mortality rate per 1000 live births



Source: World Health Statistics, 2012

10. Despite such successes, headline mortality reductions mask areas of major concern. To achieve the MDG-4 target in 2015 requires annual rates of mortality decline of 4.4%. From 1990 to 2011, the decline has been only 2.2%. According to one set of estimates (from the Institute of Health Metrics and Evaluation in Seattle, Washington, USA), only 13 of our 75 priority countries will achieve MDG-4 by 2015—Bangladesh, Brazil, China, Egypt, Guatemala, Liberia, Madagascar, Morocco, Nepal, Peru, Tajikistan, Turkmenistan, and Viet Nam. We note, however, that different groups calculating estimates arrive at substantially different judgments about country progress towards the MDGs. The Countdown to 2015 initiative, for example, reports that 23 countries are "on track" for MDG-4: Bangladesh, Bolivia, Brazil, Cambodia, China, Egypt, Eritrea, Guatemala, Indonesia, Iraq, the Democratic People's Republic of Korea (DPR Korea), Kyrgyzstan, Lao PDR, Liberia, Madagascar, Malawi, Mexico, Morocco, Nepal, Peru, Philippines, Solomon Islands, and Viet Nam. By contrast with IHME's calculations, Turkmenistan was not listed as on-track by Countdown to 2015.

11. We have explored these differences in judgments about country progress further. The reasons for these differences partly depend on the different criteria used for judging progress. Countdown's definition of on-track for MDG-4 is that the U5MR in 2010 is either less than 40 deaths per 1000 live births or, if it is 40 or greater, there is an annual rate of reduction of 4% or higher for the period 1990-2010. An example illustrates the difference in approach. For Iraq, Countdown reports a 2010 U5MR of 39 deaths per 1000 live births with an annual rate of reduction of 0.8%. Based on its threshold figure of 40 deaths per 1000 live births, Countdown judges Iraq to be on-track even though the annual rate of reduction is well below that needed to reach MDG-4. By contrast, IHME calculates an U5MR for Iraq of 35.8 deaths per 1000 live births with an annual rate of reduction of 2.3%. Applying stricter criteria than Countdown, IHME judges that Iraq is not on-track to meet MDG-4.

12. These differences are confusing for those judging the progress and effectiveness of national programmes, including country programme managers (see Table 1 for a direct comparison). We urge that those responsible for these different estimates meet to agree, if not on the precise detail of their methods or even their figures, then certainly on the broad progress of countries towards internationally agreed goals.

1. Malawi: advancing newborn survival

According to Countdown to 2015, Malawi is currently on track to meet MDG-4, achieving major progress in lowering under-5 mortality and also reducing neonatal mortality by 29% over the past decade. In the same period, seven countries worldwide have halved neonatal mortality but none are in sub-Saharan Africa which has had, on average, no significant change in neonatal mortality rates *(1)*.

Between 2000 and 2010, Malawi reduced under-5 mortality after the first month of life by 7.1% per year and maternal mortality by 6.0% per year, almost doubling progress made in the 1990s. The reduction of neonatal mortality was slower (3.5% per year), but still faster than averages for sub-Saharan Africa (1.5% per year) and globally (2.1% per year) *(2)*. Yet Malawi has one of the lowest gross national incomes worldwide, high HIV prevalence (11%), ongoing high fertility (TFR of 6), and extremely low health worker density (3 per 10 000 population).

These data prompted an analysis to better understand and accelerate progress, undertaken by over 20 Malawian experts *(1)*, as part of a multi-country analysis of a decade of change for newborn survival *(3)*. This research identified several factors contributing to Malawi's achievement. First, consistent high-level political commitment to maternal health provided a programmatic and policy platform for a small network of newborn survival technical experts to advocate for the addition of high-impact newborn care interventions, despite very limited newborn-specific funding *(1)*. Second, increased facility births, from 54% to 73%, improved the reach of newborn care interventions, including neonatal resuscitation and Kangaroo Mother Care (KMC).

National scale up of KMC may have played a critical part in neonatal mortality reduction as Malawi has the highest preterm birth rate globally (18%), and roughly one third of Malawian newborn deaths are due to complications of preterm birth *(4-6)*. Associated with reducing the risk of mortality for babies <2500g by over 50%, KMC involves tying the baby skin-to-skin with the mother to provide warmth, promote breastfeeding, and reduce infections *(4)*. Malawi now has over 121 KMC units and is recognised regionally as a learning site for KMC scaling-up *(1)*.

Health system investments, including a 30% increase in numbers of midwives *(7)*, improved transport schemes and, together with more maternity waiting homes, probably contributed to increased facility births and reductions in newborn mortality, as did demand strategies, such as community empowerment and redefining the roles of traditional birth attendants *(1)*. To strengthen community as well as facility care, the Government has initiated the Community-Based Maternal and Newborn Care package, which integrates maternal, newborn, and child health, HIV/AIDS, and malaria care. This package uses existing frontline health workers, Health Surveillance Assistants, to undertake home visits during pregnancy and after birth and is currently being implemented in 17 of Malawi's 28 districts.

Malawi is making remarkable progress towards reducing neonatal mortality despite only recent attention to newborn survival and few specific funds for newborn survival. Improving quality of care will be critical for accelerating progress, especially given the rapid increase in facility deliveries, and this is also important for maternal health outcomes. Using data and evidence to include specific newborn care interventions within maternal and child investments is feasible even in challenging contexts and gives added value in lives saved.

Sources

1. Zimba E, Kinney MV, Kachale F, et al. Newborn survival in Malawi: a decade of change and future implications. *Health Policy and Planning 2012; 27(Suppl. 3): iii88–iii103.*
2. Lawn JE, Kinney MV, Black RE, et al. Newborn survival: a multi-country analysis of a decade of change. *Health Policy and Planning 2012; 27(Suppl. 3): iii6–iii28.*
3. Lawn JE et al. A decade of change for newborn survival, policy and programmes (2000–2010): A multi-country evaluation of progress towards scale. *Health Policy and Planning 2012; 27(Suppl. 3).*
4. Lawn JE, Mwansa-Kambafwile J, Horta BL, et al. 'Kangaroo mother care' to prevent neonatal deaths due to preterm birth complications. *International Journal of Epidemiology* 2010; 39(Suppl. 1): i144–54.
5. Blencowe H, Cousens S, Oestergaard M, et al. National, regional and worldwide estimates of preterm birth rates in the year 2010 with time trends for selected countries since 1990: a systematic analysis. *Lancet 2012; 379: 2162–72.*
6. Liu L, Johnson H, Cousens S, et al. Global, regional and national causes of child mortality: an updated systematic analysis. *Lancet* 2012; 379(9832): 2151-61.
7. DFID, Management Sciences for Health. Evaluation of Malawi's Emergency Human Resource Programme. Cambridge, MA: Management Sciences for Health, 2010.

Table 1. Measuring country progress in MDG-4: comparison between Countdown and IHME

	IHME				COUNTDOWN TO 2015		
Countries	**U5M Rate***	**UI** 95%**	**Annual decline**	**Progress**	**U5M Rate***	**Annual decline**	**Progress**
Bangladesh	56.4	(49.4-64.1)	4.4	On track	48	5.5	On track
Bolivia	55.6	(47.8-64.4)	3.5	-	54	4.0	On track
Brazil	21.8	(18.9-24.9)	4.4	On track	19	5.7	On track
Cambodia	53.9	(43.5-66.0)	3.7	-	51	4.3	On track
China	14.6	(12.7-16.9)	5.1	On track	18	4.9	On track
Egypt	24.1	(19.7-29.1)	6.2	On track	22	7.3	On track
Eritrea	72.2	(56.7-88.9)	3.5	-	61	4.2	On track
Guatemala	34.3	(29.8-39.7)	4.0	On track	32	4.5	On track
Indonesia	38.8	(32.2-46.2)	3.3	-	35	4.4	On track
Iraq	35.8	(25.2-49.4)	2.3	-	39	0.8	On track
Korea, Dem. People's Rep.	23.7	(23.1-24.3)	2.4	-	33	1.6	On track
Kyrgyzstan	45.7	(35.2-58.5)	2.1	-	38	3.2	On track
Lao People's Dem. Rep.	71.4	(49.0-99.9)	3.4	-	54	4.9	On track
Liberia	104.8	(92.0-118.2)	4.4	On track	103	4	On track
Madagascar	61.0	(55.1-67.0)	4.6	On track	62	4.7	On track
Malawi	101.8	(89.8-116.2)	3.6	-	92	4.4	On track
Mexico	18.7	(16.3-21.5)	3.8	-	17	5.3	On track
Morocco	34.6	(23.7-49.1)	4.0	On track	36	4.4	On track
Nepal	52.1	(45.2-59.8)	4.9	On track	50	5.2	On track
Peru	25.3	(21.8-29.2)	5.2	On track	19	7.1	On track
Philippines	27.6	(22.9-32.6)	3.4	-	29	3.6	On track
Solomon Islands	28.0	(20.0-38.0)	1.5	-	27	2.6	On track
Tajikistan	45.6	(34.5-59.2)	4.2	On track	63	3.1	-
Turkmenistan	30.9	(24.7-38.6)	6.2	On track	56	2.8	-
Viet Nam	11.0	(9.0-13.5)	6.7	On track	23	4.0	On track

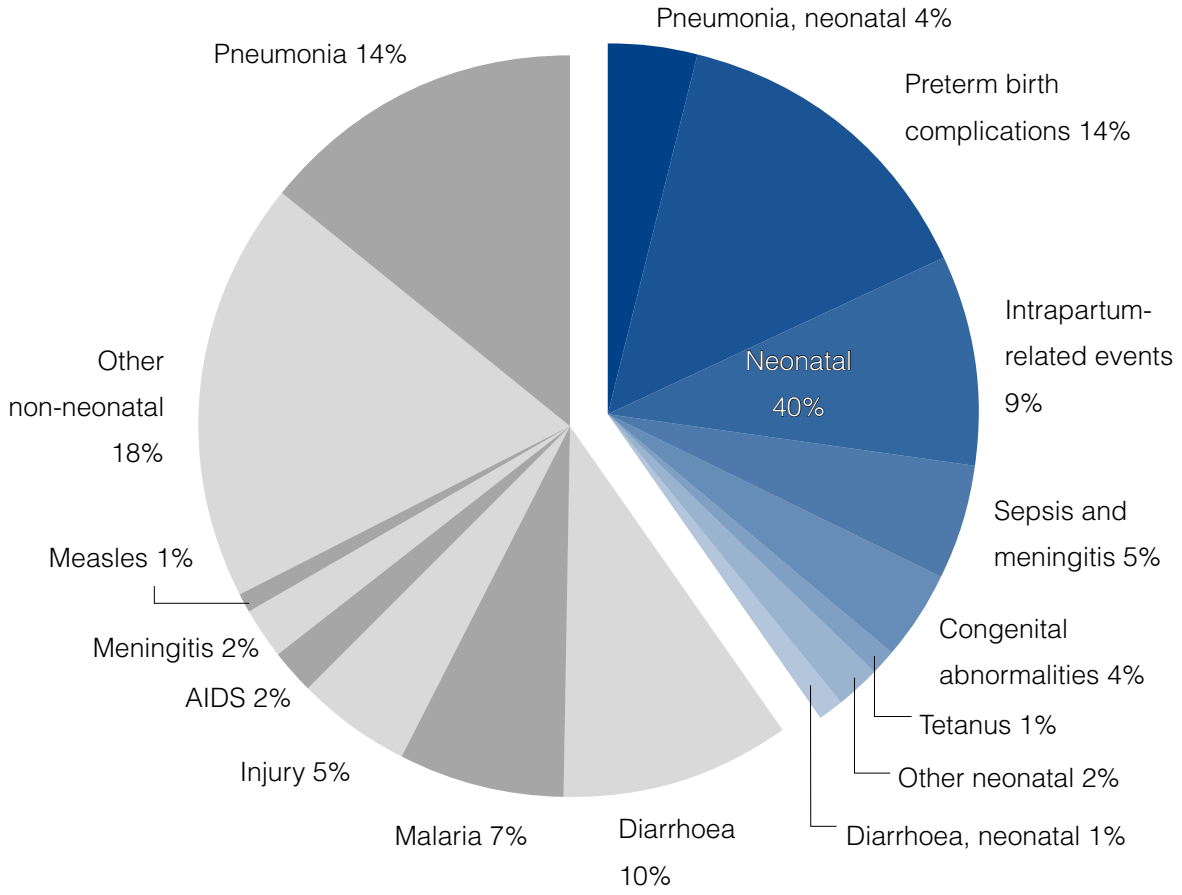
* U5M Rate: Under Five Mortality Rate per 1 000 live births
** Uncertainty interval
Note: "On track" for Countdown indicates that the under-five mortality rate for 2010 is less than 40 deaths per 1 000 live births or that it is 40 or more with an average annual rate of reduction of 4% or higher for 1990–2010; for IHME, "On track" indicates that the under-five mortality rate for 2010 has an average annual rate of reduction of 4.4% or higher for 1990–2010

Sources: Lozano R, Wang H, Foreman KJ, et. al Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis *Lancet* 2011; 378: 1139-65; WHO and UNICEF. Countdown to 2015. Maternal, Newborn and Child mortality. Washington DC 2012

13. The Countdown to 2015 initiative also reports the type of progress countries not "on track" are making (see Annex 5). Of great concern, 13 countries are making "no progress" towards MDG-4—Burkina Faso, Cameroon, Central African Republic, Chad, the Democratic Republic of the Congo (DRC), Haiti, Kenya, Lesotho, Mauritania, Sao Tome and Principe, Somalia, South Africa, and Zimbabwe. We can also compare the progress of countries from the Countdown 2010 report to the latest, 2012, data. That comparison shows that 11 countries have moved forward from a lower to a higher category of progress: Afghanistan, Angola, Burundi, Cambodia, Congo, Iraq, DPR Korea, Liberia, Madagascar, Swaziland, and Zambia. 6 countries have fallen back, from a higher to a lower category of progress: Azerbaijan, Botswana, Burkina Faso, Haiti, Lesotho, and Turkmenistan.

14. According to research published in 2012, there are two particularly neglected groups where most under-5 deaths occur: among children with infectious diseases and among newborns (figure 2) (12). In 2010, an estimated 4.88 million children under-5 died of infectious causes—the biggest killers being pneumonia (1.07 million deaths), diarrhoea (0.75 million deaths), and malaria (0.56 million deaths). 3.07 million children died in the newborn period—most commonly from pre-term birth complications (1.08 million deaths), intrapartum-related complications (0.72 million deaths), and sepsis or meningitis (0.39 million deaths).

Figure 2: Global causes of childhood deaths in 2010

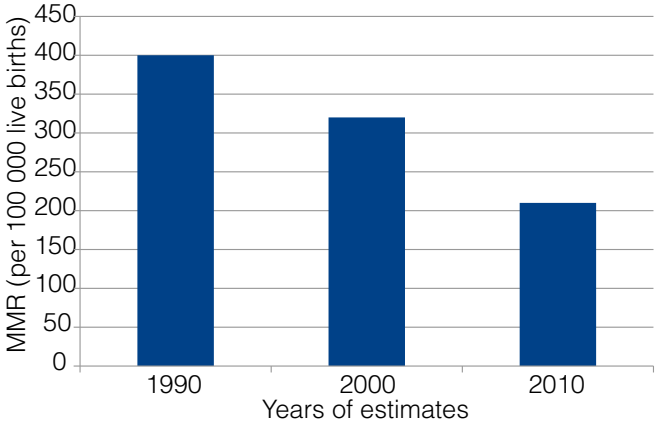


Note: causes that led to less than 1% of deaths are not shown.
Sources: Liu L, Johnson HL, Cousens S et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. *Lancet* 2012; 379: 2151-61.

15. To achieve MDG-5, the annual rate of maternal mortality decline needs to be 5.5%. But worldwide declines have been only 1.9% since 1990 (figure 3). Of the 75 highest burden countries, only four—China, Egypt, Morocco, and Peru—are projected to reach their MDG-5 target by 2015. Only three (China, Egypt, and Peru) will achieve both MDG-4 and MDG-5 by 2015. Again, different estimates have the potential to confuse rather than enlighten judgements about progress. The above estimates come from IHME. But the Countdown to 2015 initiative identifies 9, not 4, countries on-track to achieve MDG-5: Bangladesh, Cambodia, China, Egypt, Equatorial Guinea, Eritrea, Lao PDR, Nepal, and Viet Nam (see Table 2 for a direct comparison). Countdown does not include Morocco or Peru in its list of on-track countries.

16. Despite these differences, what is clear is that the region where there remains the highest rates of maternal and child deaths, and where there has been the slowest progress, is sub-Saharan Africa. In sub-Saharan Africa, 1 in 8 children still die before the age of 5. Countdown identifies 9 countries making "no progress": Botswana, Cameroon, Chad, Congo, Lesotho, Somalia, South Africa, Swaziland, and Zimbabwe. By any standard, Africa must be a greater global policy priority for all partners concerned with achieving the highest level of health for women and children.

Figure 3: Estimates of maternal mortality ratio (maternal mortality ratio per 100 000 live births)



Source: World Health Statistics, 2012

Table 2. Measuring country progress in MDG-5: comparison between Countdown and IHME

	IHME				COUNTDOWN		
Countries	**MMR***	**UI 95%****	**Annual decline**	**Progress**	**MMR***	**Annual decline**	**Progress**
Bangladesh	244.0	(195.7-301.4)	4.4	-	240	5.9	On track
Cambodia	337.4	(261.5-421.7)	1.0	-	250	5.8	On track
China	28.9	(22.6-36.8)	5.5	On track	37	5.9	On track
Egypt	69.9	(58.3-85.2)	6.0	On track	66	6	On track
Equatorial Guinea	213.9	(137.9-323.2)	5.2	-	240	7.9	On track
Eritrea	1,098.5	(844.9-1367.7)	0.5	-	240	6.3	On track
Lao People's Dem. Rep.	293.5	(187.9-400.4)	2.3	-	470	5.9	On track
Morocco	75.8	(58.2-97.0)	8.3	On track	100	5.1	-
Nepal	319.2	(244.2-404.5)	1.8	-	170	7.3	On track
Peru	54.5	(40.9-69.3)	5.8	On track	67	5.2	-
Viet Nam	57.2	(39.5-81.4)	4.1	-	59	6.9	On track

* MMR: Maternal Mortality Ratio per 100 000 live births
** Uncertainty interval
Note: "On track" indicates for IHME and Countdown that the MMR for 2010 has an average annual rate of reduction of 5.5% or higher for 1990–2010

Sources: Lozano R, Wang H, Foreman KJ, et. al Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis Lancet 2011; 378: 1139-65
WHO and UNICEF. Countdown to 2015. Maternal, Newborn and Child mortality. Washington DC 2012

17. Despite differences in headline estimates, the most comprehensive assessments of progress towards women's and children's health have come from Countdown to 2015 (13-15). Progress across core indicators identified by the Commission on Information and Accountability will be reported in the next chapter. The key findings of the 2012 Countdown analyses present a mixed picture of success. Some countries—such as Ethiopia, Rwanda, Bangladesh, and Cambodia—have performed exceptionally well, increasing coverage of key interventions across the continuum of care. The scale-up of vaccine and insecticide-treated bednet coverage has been a particular success. But where strong and functioning health systems are needed—eg, for skilled birth attendance—progress has often been poor. In addition, most countries have little or no mechanism for financial risk protection should a woman or child fall ill. 53 countries also suffer a severe shortage of health workers, exacerbated by population growth.

18. Evidence submitted to the iERG by the Office of the UN Secretary-General describes how over 200 partners are now supporting his Global Strategy. The commitment of billions of dollars to *Every Woman, Every Child* "is set to fast-track the achievement of the health-related MDGs", according to the Secretary-General's Office. In many ways, this statement is indeed true. Political visibility for women's and children's health has never been higher. The breadth of the partnership of stakeholders committed to accelerating progress is almost unprecedented. Implementation, as the Secretary-General's Office points out, is taking place in most countries. Collaboration across the UN system through the H4+ (UNFPA, UNICEF, WHO, World Bank, UNAIDS, and UN Women) is strong. The *Every Woman, Every Child* Innovation Working Group is mobilising the support of the business community. And the commitment and engagement of the Secretary-General himself has continued to build remarkable momentum around his Global Strategy.

19. Parts of this positive assessment are supported by PMNCH's review of commitments to the Global Strategy. Their annual analysis of commitments to advance the Global Strategy in 49 (not 75) countries has become an important piece of the accountability framework for women's and children's health (16). In their submission to the iERG, PMNCH concludes that much of the news is "encouraging". The Global Strategy is, according to PMNCH, delivering added value to advance women's and children's health. This value is expressed through high-level political support, stronger national, regional, and global linkages, and the creation of innovative public-private partnerships (eg, the MDG Health Alliance, Merck for Mothers). A substantial number of the 220 commitments made to the Global Strategy are being implemented (or are soon to be implemented). Financial commitments for women's and children's health superficially seem good, with previously neglected dimensions (such as reproductive health and family planning) now becoming new areas of interest. In total, PMNCH's surveys show that financial commitments to the Global Strategy have grown to US$ 57.6 billion. But further analysis revealed considerable double-counting: US$ 14.8-17.2 billion, or between 26%-30% of total commitments. Of the remaining financial promises, only US$ 18.2-20.6 billion

2. Rwanda: prioritising family planning

It is widely acknowledged that family planning is key to improving maternal and child health and to reducing poverty. In 2005, as part of its framework for development, Vision 2020, the Government of Rwanda prioritised improving the availability of family planning commodities and services and set an ambitious target of achieving a 70% contraceptive prevalence rate by 2012 *(1)*. The latest available data show significant progress: modern contraceptive use increased from 10% in 2005 to 45% in 2010. However, in 2010, unmet need for contraception remained high with nearly 20% of women who wished to prevent pregnancy still in need of family planning services *(2)*. Two factors have played a critical part in the increased use of contraceptives in Rwanda. First, modern contraceptives and community-based family planning services are included in the Mutuelles Community-based Insurance Scheme, which covers over 90% of the population *(2,3)*. This means there are no financial barriers to access. Second, the provision of long-acting family planning methods was shifted from doctors at the district level to nurses at the health centre level and then to community health workers (CHW). Thirty thousand CHWs were progressively trained to provide family planning at the community level *(4)*. Given that every village in Rwanda has CHWs, this training has increased women's access to both short-acting and long-term contraceptive options. A three-fold increase in implant users and ten-fold increase in intrauterine device (IUD) users per month was observed following provider training *(4)*. These gains are largely due to the ability of CHWs and health providers at health centres and posts to articulate the needs of the communities they serve. Further, the task shifting approach is sustainable because it uses existing health infrastructure.

Community-based provision of contraception is scheduled to be expanded to all districts by mid-2012 and scaled up nationwide. In addition, the Government has recently reaffirmed its commitment to providing high-quality integrated family planning services in every hospital and health centre *(5)*. Other challenges are also being addressed.

Difficult physical terrain and a poor transportation infrastructure limit the ability to access "non-emergency" services and may contribute to low rates of health seeking behaviour. In addition, there is an on-going need to ensure contraceptive security. A large proportion of contraceptive costs are donor-funded, and up to 50% of the health sector budget is provided by development partners *(4)*. The National Family Planning Policy aims to double the projected share of national resources in contraceptive commodity costs from 25% in 2006 to 51.8% in 2020 *(6)*.

It seems almost certain that overcoming barriers in access to family planning will remain a national priority. In a keynote speech at the London Summit on Family Planning in July, 2012, President Paul Kagame said: "Rwanda considers it a basic right to be able to properly manage one's own family size..." *(5)*.

Sources

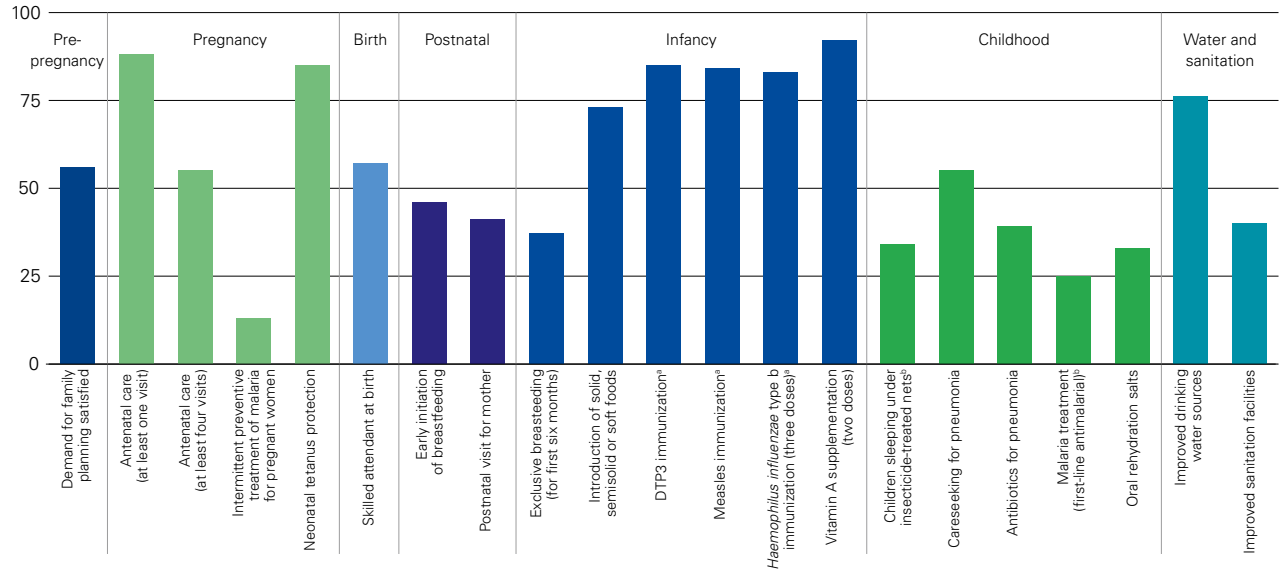
1. Rwanda Ministry of Health, Application to Resolve Award: service delivery. Kigali, Rwanda, 2012. http://www.aspeninstitute.org/policy-work/global-health-development/what-we-do/glc/resolve
2. *Rwanda Interim Demographic and Health Survey 2010, preliminary.* Kigali: Rwanda National Statistical Institute, and Ministry of Health, and Calverton, MD, USA, ORC Macro, 2011.
3. Saksena P, et al. Mutual health insurance in Rwanda: evidence on access to care and financial risk protection. *Health Policy*, 2011, 99(3):203-209.
4. Rwanda Women Network, Application to Resolve Award: service delivery. Kigali, Rwanda, 2012. http://www.aspeninstitute.org/policy-work/global-health-development/what-we-do/glc/resolve
5. Speech by H.E. Paul Kagame, President of the Republic of Rwanda, at the London Summit on Family Planning. http://www.presidency.gov.rw/speeches/669-speech-by-he-paul-kagame-president-of-the-republic-of-rwanda-at-the-london-summit-on-family-planning
6. Pandit-Rajani T, Sharma S, Muramutsa F. Fostering *Public–Private Partnerships to Improve Access to Family Planning in Rwanda.* Washington, DC: Futures Group, Health Policy Initiative, Task Order 1, 2010.

is estimated to be new and additional funding. This figure comprises US$ 6.9 billion from commitments made at the Muskoka 2010 G8 Summit, together with an additional US$ 5.7-8.1 billion from low-income countries, US$ 2.5 billion from the UK, US$ 1.6 billion from GAVI, US$ 0.5 billion from Australia, US$ 0.4 billion from Norway, and US$ 0.6 billion from the Global Fund.

Alarmingly, recipient countries describe reduced donor funding following the global financial crisis. These nations—the main concern of *Every Woman, Every Child*—report jeopardised domestic financial flows because of global economic conditions. Only 20 of 49 countries have made financial commitments to the Global Strategy.

Figure 4: Coverage across the Continuum of Care

Median national coverage of selected *Countdown* interventions, most recent year since 2006 (%)



a. Data are for 2010.
b. Analysis is based on countries with 75% or more of the population at risk of P. falciparum transmission.
Source: Immunization rates, WHO and UNICEF; postnatal visit for mother, Saving Newborn Lives analysis of Demographic and Health Surveys; improved water and sanitation, WHO and UNICEF Joint Monitoring Programme 2012; all other indicators, UNICEF global databases, April 2012, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other national surveys.

20. One disappointment is that it has not proven possible to document precisely the progress made on each of the commitments pledged towards the Global Strategy—financial, policy, services, product, and health systems. PMNCH sets out the limitations to its analysis very clearly: difficulty in avoiding double-counting; a lack of a precise definition for "commitment"; and the fact that none of these data are objectively or independently measured (they all rely on self-reports). Instead, only general statements can be made about overall progress, and even those have a very subjective and qualitative feel to them. The iERG has no reliable data that provide an objective and quantitative assessment of the precise monies or promises committed and delivered, or the returns on and impact of those commitments and promises. This absence of evidence is a major gap in the Global Strategy, a gap that may undermine the impact and long-term credibility of *Every Woman, Every Child*. While it may be true that progress is being made, the exact nature of that progress—what tangible results have actually been achieved for women and children—is, as yet, impossible to determine.

21. What we hope to see in the future is an assessment of what each commitment to or within a particular country has achieved for women and children. As part of the causal chain from commitment to end result, we need to know what the commitment is, how much resource has been allocated and delivered, what has been done with that resource, and finally what has been achieved by that commitment. Complete accountability cannot take place without this information being made fully and transparently available.

22. From what we do know, we can say that low and middle income countries have increased their commitments to the Global Strategy. Of the 49 countries identified, 23 made commitments in September, 2010: 15 in May, 2011; and a further 6 in September, 2011. These commitments include finance, policy, services, and products.

23. But the PMNCH report also points to critical weaknesses in the implementation of the Global Strategy, weaknesses that have so far been largely neglected by partners.

24. First, implementation is being constrained by several factors. The most important is a financing shortfall. The estimated total cost of delivering the Global Strategy to 49 countries was US$ 88 billion *(7)*. But as the PMNCH report points out, additional resources are still needed to meet this US$ 88 billion financing gap, especially since new funding only amounts to US$ 18.2-20.6 billion. As of July, 2012, only US$ 9.9 billion had been disbursed – US$ 5.3 billion from high-income countries, US$ 2.5 billion from GAVI/GFATM, US$ 1.4 billion from non-governmental organisations, US$ 0.65 billion from foundations, and only US$ 7.1 million from the private sector. A lack of skilled health workers, weak health systems, unstable governance, and socio-cultural and religious barriers (such as gender discrimination) are further constraints.

Particular bottlenecks remain a lack of qualified birth attendants, absence of any infrastructure for emergency obstetric care, lack of 24/7 health services, and inadequate access to contraceptive information and services.

25. Second, commitments are not evenly spread. Of our priority countries, 15 have received 3 or fewer commitments—Comoros, The Gambia, Guinea-Bissau, Morocco, Uzbekistan, Congo, Eritrea, Gabon, DPR Korea, Sao Tome and Principe, Solomon Islands, Turkmenistan, Azerbaijan, Equatorial Guinea, and Iraq. Equatorial Guinea and Iraq have received no commitments at all. Contrast this pervasive lack of commitment with the large number of promises made to India (31), Ethiopia (27), and Bangladesh (25). The distribution of commitments is not closely linked to progress on the MDGs. There is a danger of an inverse-care law: the availability of donor support varies inversely with the needs of women and children.

26. Third, there are vital service intervention gaps in countries, most notably around pneumonia and diarrhoea. This finding is as puzzling as it is worrying—under-5 deaths from pneumonia and diarrhoea are the highest priority of all for non-newborn childhood interventions (figure 4) (12). There is also a serious omission around provision of safe abortion services.

27. Fourth, important aspects of the continuum of care continue to be neglected—nutrition (especially nutrition for children and young adults), adolescent health, pregnancy (eg, the prevention of hypertension), and newborn health (neonatal infection and resuscitation). There has also been little progress in reducing low-birth weight—eg, intra-uterine growth restriction and stunting—which remain major concerns in South Asia.

28. These shortfalls are some of the main obstacles to achieving MDGs 4 and 5 (they will be considered in greater detail in Chapter 4). That said, the H4+—UNFPA, UNICEF, WHO, UNAIDS, UN Women, and the World Bank—seems to have had some success in building national commitments to the Global Strategy, which includes providing support to accelerate implementation of initiatives for women's and children's health within national health plans. But we were disappointed by the H4+'s own assessment of its work. In its report to the iERG, *Mapping of Progress and Needs in Implementation of Country Commitments to UN Global Strategy to Improve Women's and Children's Health*, the H4+ concludes that "progress was considerable" in countries: improved health-worker training, better infrastructure, integrated management of common conditions, increased health spending, and improved family planning services. Yet their analysis—the sum total of the monitoring and evaluation capacity of 5 UN agencies and the World Bank—is superficial and incomplete. Statements such as "training of health workers carried out" (Afghanistan), "free preventive care to pregnant women and children under 5 years" (Burkina Faso), "free MNCH services at primary care level" (Ethiopia), "access to FP is national" (Ghana), and "FP, ANC, PNC, PMTCT, STI services and IPT-Malaria integrated" (Mozambique) are common, but unsupported by evidence and presented without further discussion. Numbers of countries are cited for their achievements. But there is no detailed evaluation of the claims of progress made. There is no qualitative, let alone quantitative, analysis to support the conclusions drawn. The H4+ claims that "the work of the H4+ is aligned to support implementation of the Global Strategy at the country level within three main work streams: strengthening the provision of harmonised technical support to countries for RMNCH; accelerating actions in selected countries; strengthening activities on crosscutting issues." But on the basis of the H4+'s own analysis, we cannot conclude that considerable country progress has been made. Indeed, several key countries are omitted from the H4+ report (which focuses only on the 49 countries cited in *Every Woman, Every Child*): for example, Nigeria, DRC, Pakistan, Mali, Uganda, and Tanzania are not included in its summary of progress on implementation of essential interventions. The best we can say is that the H4+ describes activity in countries. But what that activity has achieved in measurable terms for women and children is unknown.

29. The landscape for women and children is even more complex than that reported by PMNCH and the H4+. Across the MDGs, the health and wellbeing of adolescent girls, women, and children are touched on at multiple points, underlining the multisectoral nature of the Global Strategy. Any consideration of the health of women and children cannot be completed without, in addition to MDGs 4 and 5, taking account of:

- The proportion of women and children living in poverty (MDG-1a)
- The proportion of women and children suffering from hunger (MDG-1c)
- The literacy rates of young women (MDG-2)
- The prevalence of gender inequality (MDG-3)
- The prevalence of HIV, condom use, and comprehensive knowledge about AIDS (MDG-6a)
- Access to antiretroviral drugs (MDG-6b)
- The proportion of children sleeping under insecticide-treated bednets and receiving appropriate treatment with anti-malarial drugs (MDG-6c)
- Access to safe drinking water and basic sanitation (MDG-7c)
- The proportion of women and children living in slums (MDG-7d)
- Sustainable access to affordable essential drugs (MDG-8e)

These aspects of women's and children's health are not explicitly within the remit of the iERG. But we wish to underline their importance here, nevertheless, and we will return to them in more detail in subsequent reports. A full appraisal of accountability towards women and children needs to take account of these additional dimensions of their health.

30. Beyond the MDGs, old and new health predicaments are adding further layers of complexity to the way in which the Global Strategy must be conceived and implemented. Non-communicable diseases can no longer be ignored as a growing contributor to women's ill-health. Over recent years, the importance of cancer (17), obesity (18), and mental health (19) have all been recognised as neglected dimensions of women's and children's wellbeing. The UN General Assembly's Political Declaration to address non-communicable disease, passed in September, 2011, was a crucial milestone for integrating chronic diseases into human development programmes (20). The goal following the High-Level Meeting is now to implement the Political Declaration, with appropriate monitoring and accountability mechanisms in place to ensure that political leadership is converted into progress for those most affected by non-communicable diseases. The Secretary-General's Global Strategy, together with the work of the iERG, provides an excellent means to bridge these sometimes separate and mutually exclusive fields of work.

31. At the 2012 World Health Assembly, the Director-General of WHO, Dr Margaret Chan, inaugurated her second term of office by saying that "Universal health coverage is the single most powerful concept that public health has to offer." Universal health coverage has the potential to be a dominant theme shaping and framing the next 5 years of global health, taking us beyond the MDG target date of 2015 (21). Universal health coverage is an important goal for adolescents, women, and children. Wealth-related inequalities in coverage play a significant part in preventing the equitable distribution of maternal and child health services (22). The iERG will monitor the evolution and implementation of WHO's newly stated priority strategic initiative. We hope that the words expressed by the Director-General will translate into real organisational and strategic reform at WHO. The effects of this important commitment by the agency on the health of women and children will be closely followed in future reports from the iERG.

32. But other initiatives must be added to this important foundation stone of global health policymaking. Vaccine coverage is a vital part of women's and children's health. The GAVI Alliance, for example, aims to save children's lives and protect the health of women by increasing access to immunisation in low-income countries. Vaccines alone could prevent 4 million future deaths if 243 million children were immunised between 2011 and 2015. A global strategy for vaccines is embodied in the Decade of Vaccines (2011-20) initiative. The vision of the Decade of Vaccines is for a world in which all individuals and communities enjoy lives free from vaccine-preventable diseases. The unmet need for vaccines remains a major impediment to a sustainable future for the health of women and children. To take just one example, 98% of children in low-income settings do not have pneumococcal conjugate vaccines in their immunisation schedules, despite the fact that the importance of invasive pneumococcal pneumonia as a cause of preventable child death is well known and understood. The goal of the Decade of Vaccines fully aligns with *Every Woman, Every Child*—namely, to exceed the MDG-4 target for reducing child mortality. But how the Decade of Vaccines fully integrates with *Every Woman, Every Child* remains elusive. We return to the issue of governance in Chapter 4.

33. The UN Commission on Life-Saving Commodities for Women and Children (23) goes beyond vaccines to identify critically important drugs and technologies across the continuum of care—maternal (oxytocin, misoprostol, magnesium sulphate), newborn (injectable antibiotics, antenatal steroids, chlorhexidine, resuscitation devices), child (amoxicillin, oral rehydration salts), and reproductive (female condoms, contraceptive implants, emergency contraception) health technologies. The Commission's findings are a welcome addition to the Global Strategy. But it will be important to ensure that the supply of commodities does not, on its own, determine programmes. Commodity supply must also be needs and demand led. New coalitions of donors, countries, foundations, and multilateral agencies came together in 2012 to promote renewed commitments to child survival (24) and family planning (25). If these commitments are honoured, we should see demand increase substantially.

34. Yet even as partners refocus their efforts to achieve the MDGs, a new era looms—that of sustainable development and the post-2015 development architecture. This new frame for health is deeply challenging. Health was a dominant presence across the MDGs. But the agenda of sustainable development is far broader, integrating economic, social, and environmental dimensions of development. It includes population, energy, biodiversity, employment, climate change, environment, forests, oceans, water, agriculture, disasters, and cities, among many other issues. What is the place of women and children in this new phase of global development? In the early period of thinking about the meaning of sustainable development,

3. Bangladesh: female education and child survival

A child born today in Bangladesh is almost two-thirds less likely to die before his or her fifth birthday than a child born 20 years ago. The country is well on its way to achieve the primary target for MDG-4 by 2015. The under-5 mortality rate has been declining rapidly for two decades, falling on average by 5.5% annually between 1990 and 2010 *(1)*. What has contributed to this success? Bangladesh has been quite successful in achieving high coverage of certain critical interventions that directly impact on child survival. For example, in 2010, 86% of children received all basic vaccines, 71% of children with possible pneumonia received an antibiotic, 78% of children with diarrhoea were given oral rehydration therapy, and 87% of children in the second year of life were being breastfed.

While these gains are impressive, perhaps equally important has been the progress made in female education. From 1981 to 2009, the literacy rate[1] among young women between the ages of 15 and 24 years almost tripled from 27% to 77% *(2)*. During this time several programmes have played a major role in increasing female enrolment in schools and in narrowing the education gender gap. Bangladesh initiated its landmark Female Secondary School Stipend Programme (FSP) in the early 1990s. Hugely successful, FSP was a conditional cash-transfer programme that paid parents if they allowed their daughters to stay in school. An assessment of the programme estimated that every additional year of the stipend programme's duration increased female secondary enrolment by 8% *(2)*. Other programmes included targeted scholarships for the poor and female quotas for scholarships.

Progress in the realm of education undoubtedly has played a key role in the improvements made in children's health, as about 50% of all births in Bangladesh are among young mothers who have most benefited from the investments in education (15-24 years). A large body of evidence from Bangladesh and elsewhere confirms the strong association between maternal education and child survival *(3,4)*. Globally, it has been estimated that for every one-year increase in the educational attainment of women of reproductive age, child mortality is reduced by 9.5% *(5)*. Indeed, investments in female education have had a higher pay-off in child survival than increased wealth *(6)*.

[1] Define as being able to both read and while with understanding a short simple statement on everyday life

Sources

1. Liu L, Johnson HL, Cousens S, Perin J, Scott S, Lawn J, Rudan I, Campbell H, Cibulskis R, Li M, Mathers C, Black RE. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. *Lancet* 2012; 379: 2151– 2161.
2. Schurmann AT. Review of the Bangladesh Female Secondary School Stipend Project using a social exclusion framework. *Journal of Health, Population, and Nutrition* 2009; 27(4): 505.
3. Hobcraft J. Women's education, child welfare and child survival: a review of the evidence. *Health Transition Review* 1993: 159–75.
4. Bicego GT, Boerma TJ. Maternal education and child survival: a comparative study of survey data from 17 countries. *Social Science & Medicine* 1993; 36(9): 1207–27.
5. Gakidou E, Cowling K, Lozano R, Murray CJL. Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis. *Lancet* 2010; 376: 959–74.
6. Fuchs R, Pamuk E, Lutz W. Education or wealth: which matters more for reducing child mortality in developing countries? *Vienna Yearbook of Population Research* 2010; 8: 175–99.

health was not identified as a "critical issue". But women's and children's health is clearly critical—people must be at the centre of sustainable development, and especially, we argue, women and children—eg, through the social pillar of sustainable development, where issues such as women's empowerment, girls' education, and reproductive health, including family planning, are vital elements.

35. The UN Conference on Sustainable Development (Rio+20), held in June, 2012, adopted *The Future We Want*, a 49-page document that includes 56 references to women and 16 to gender equality (26). The statement reaffirmed governments' commitment to full implementation of the ICPD Programme of Action, the Beijing Platform for Action, and the promotion and protection of all human rights. Rio+20 acknowledged that progress on gender equity had not been fully realised because of persistent and deeply rooted discrimination against women. While the conference made important commitments that will affect women and children—on energy services, urban planning,

water, sanitation, nutrition, and employment, among others—it concluded that health was "a precondition for and an outcome and indicator of all three dimensions of sustainable development." The strongest commitments to women are perhaps to be found in the Health and Population section. Here, commitments and pledges were made specifically:

- "to promote the equal access of women and girls to education, basic services, economic opportunities, and health-care services, including addressing women's sexual and reproductive health, and ensuring universal access to safe, effective, affordable, and acceptable modern methods of family planning."

- "to promote gender equality and to protect the right of women's, men's, and young people's rights to have control over and decide on their sexuality free of coercion, discrimination, and violence, and a commitment to work actively to ensure that health systems provide the information and sexual and reproductive health services women need."

- "to strengthen health systems through increased health financing, recruitment, development, training, and retention of the health workforce, improved access to affordable and quality medicines."

- "to strengthen health systems to provide equitable universal health coverage."

- "to consider population trends and projections in national, urban, and development strategies and policies."

Additionally, the outcome document includes positive references to the rights of young people to have control over their sexuality, though the reference to adolescents was ultimately deleted. It further recognises youth employment needs, and their rights to participate in decision-making.

36. However, the reception of the Rio+20 outcome—*The Future We Want*—has been mixed. Critics have argued that Rio+20 was only a small and insufficient step in the right direction. There were few concrete targets and timelines to signal the kind of bold action necessary to accelerate progress for women's and children's health. References to reproductive rights were not maintained in the concluding document. Indeed, the lack of supportive voices for these rights in negotiations over the final statement led to removal of a commitment to ensuring equal access to reproductive rights (several governments questioned the relation between sustainable development and reproductive rights). The Rio+20 concluding document also failed to recognise the nexus between reproductive rights and population dynamics as an important component of sustainable development. This extremely disappointing result may have adverse implications for securing reproductive rights in the post-2015 framework.

37. Advancing women's health, and the health of their children, is essential if the vision of a sustainable and prosperous future is to be realised. So far, partners who work together for women's and children's health have been too slow in assembling evidence to show the importance of women and children for truly sustainable development. They have been too quiet in using that evidence to advocate for women and children in the post-2015 period. The case must be argued much more strenuously—women have an indispensable role as agents of sustainable development. The gains made in women's and children's health during the past two decades need to be protected and augmented. The reproductive health community has worked in isolation and has sometimes failed to link effectively with other movements, such as environmentalists. In many ways, Rio+20 exemplified this gap. Negotiators who for the most part were environmentalists and economists were largely unaware (or uninterested) in women's and children's health. The neglect and resistance that some sectors of society have shown to women's health and reproductive rights and justice has to be more directly addressed. This priority must become a foundation for the next decade of development.

2. IMPLEMENTING ACCOUNTABILITY: DELIVERING THE CoIA'S RECOMMENDATIONS

38. The Commission on Information and Accountability made 10 recommendations (see Panel 1 and Annex 4). The iERG's task is to review progress in implementing these recommendations, notably around achieving results and improving transparency for resource flows. This, our first report, is in many ways a baseline measure by which to make comparisons in future years. The Commission's recommendations gave phased priorities. It recommended that the following objectives were immediate goals to be achieved in 2012 (in Annex 6, we show the availability of data for these 2012 recommendations):

- *Health indicators:* By 2012, the same 11 indicators on reproductive, maternal, newborn, and child health, disaggregated for gender and other equity considerations, are being used for the purpose of monitoring progress towards the goals of the Global Strategy (Recommendation 2)

- *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 (Recommendation 5)

- *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 (Recommendation 7)

- *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 (Recommendation 9)

39. We will report on progress towards these 2012 objectives first, and then return to the Commission's remaining 5 recommendations. The Commission's recommendations were finalised in May, 2011. The intention was that these recommendations would be implemented by a wide range of stakeholders, with WHO playing a coordinating role. Subsequently, WHO led the development of a multistakeholder strategic workplan and budget, which was in place by November, 2011. That workplan established 10 work areas, the majority of which were focused on country actions: development of roadmaps to strengthen country accountability frameworks; monitoring of results (using the 11 core indicators, health management information systems, and surveys); strengthening civil registration and vital statistics; improving quality assessment through maternal and perinatal death surveillance; using eHealth and innovation in health information systems; tracking financial resources (through national health expenditures and RMNCH sub-accounts); concluding compacts between governments and all major partners; annual review and action with all relevant stakeholders, including human rights bodies; and advocacy (national Countdown conferences, parliamentarians, media, and civil society engagement). Multiple institutions partnered together to deliver the workplan—the Executive Office of the UN Secretary-General, national and international non-governmental organizations, WHO, UNFPA, UNICEF, H4+, ITU, OECD, African Union, PMNCH, UN Foundation, World Bank, Countdown to 2015, Health Metrics Network, Inter-Parliamentary Union, CDC, Norad, USAID, IHP+, mHealth Alliance, University of Aberdeen, London School of Hygiene and Tropical Medicine, and the Bill and Melinda Gates Foundation, among others. A set of core indicators for this workplan was developed within WHO (by consensus among technical experts and with external expert input) for monitoring country progress towards implementing the Commission's recommendations (Annex 4).

40. The Country Accountability Framework developed by WHO and its partners is a standard tool for assessing a country's situation and its priority actions. The method builds on existing country plans and also uses the framework adopted by IHP+. 7 multi-country workshops for 53 countries have taken place, 17 of which have completed in-country consultations to further disseminate the accountability framework. There has been high-level national endorsement of this process through national accountability workshops. Further assessment of progress will be completed annually.

41. *Health indicators.* The 11 indicators agreed by the Commission include:

- maternal mortality ratio (deaths per 100 000 live births)

- under-5 child mortality, with the proportion of newborn deaths (deaths per 1000 live births)

- children under 5 who are stunted (percentage of children under 5 years of age whose height-for-age is below minus two standard deviations from the median of the WHO Child Growth Standards).

These three health status indicators are essential for monitoring MDGs. Stunting, a nutrition indicator, is important for understanding not only outcomes,

but also determinants of maternal and child health. Nutrition is also a useful proxy indicator for human development more broadly. These indicators are relatively insensitive to change and do not measure progress over short periods (in the absence of birth and death registration systems they can only be measured with substantial time lags). More sensitive and timely data that can monitor almost real-time changes in a set of key interventions to improve women's and children's health are needed. This objective can be achieved by monitoring a tracer set of 8 coverage indicators:

- met need for contraception (proportion of women aged 15-49 years who are married or in union and who have met their need for family planning—ie, who do not want any more children or want to wait at least two years before having a baby, and are using contraception)
- antenatal care coverage (percentage of women aged 15–49 years with a live birth who received antenatal care by a skilled health provider at least four times during pregnancy)
- antiretroviral prophylaxis among HIV-positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment-eligible
- skilled attendant at birth (percentage of live births attended by skilled health personnel)
- postnatal care for mothers and babies (percentage of mothers and babies who received a postnatal care visit within two days of childbirth)
- exclusive breastfeeding for six months (percentage of infants aged 0–5 months who are exclusively breastfed)
- three doses of the combined diphtheria, pertussis and tetanus vaccine (percentage of infants aged 12–23 months who received three doses of diphtheria/pertussis/tetanus vaccine)
- antibiotic treatment for pneumonia (percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics).

These 8 coverage indicators have been selected because they are strategic and significant: each one represents a part of the continuum of care and each one is connected with other dimensions of health and health systems. We caution that this set of indicators is a minimum. It should not be taken as a comprehensive mechanism for assessing delivery of the continuum of care. A measure of contraception is needed as a tracer for reproductive health. Antenatal care provides a measure of access to the health system and is critical for ensuring proper coverage of care, to identify maternal risks, and to improve health outcomes for the mother and newborn. HIV-related indicators are included to emphasise the need to move towards a more holistic approach to health care, and to encourage further integration of health services. Skilled birth attendance, postnatal care, and breastfeeding are critical elements of the continuum of care. The recommended vaccines are delivered routinely and so helpfully measure a child's ongoing interaction with the health system. Finally, case management of childhood pneumonia is an indicator of access to treatment. Although a vaccine will have a long-term impact on pneumonia, case management will remain an important measure of success.

42. According to WHO's criteria for judging progress in the use of health indicators—at least 50 countries should use and have accurate data on core indicators, together with streamlined reporting systems and the use of core indicator data to inform annual reviews—priority countries for women's and children's health are "on-track". There are challenges—notably, obtaining "buy-in" from partners at the country level (some of whom are more concerned about their own reporting mechanisms) and strengthening weak data sources. WHO identifies the way forward as being to expand the network of technical expertise at both regional and country level. However, an objective review of available data (see Annex 6) suggests serious obstacles to achieving this objective. Only 11 out of 75 countries have data for all 8 coverage indicators. In many countries, no data are available at all, especially for post-natal care, anti-retroviral prophylaxis for PMTCT, and antibiotic treatment of pneumonia. In too many countries, where data are available, these indicators are not being used—especially for skilled birth attendance, exclusive breastfeeding, antenatal care, met need for contraception, and antibiotic treatment for pneumonia. We recognise that use of indicators is not a static situation. WHO's judgments from multi-country workshops held in 2012 may be more up-to-date than objectively available national data. However, the verifiable baseline country-specific data available to the iERG indicate that this recommendation will not be met in 2012, as requested by the Commission.

43. A key aspect of our accountability framework is the degree to which the principle of equity is being respected. According to Countdown to 2015, 59 countries have data on equity by wealth quintile (13). These data show substantial variations in coverage levels between interventions and between countries (figure 4) (14). What is abundantly clear is that not all social groups are being reached. The poorest people

are largely excluded from the benefits being brought by the Global Strategy. Skilled birth attendance was the least equitably distributed intervention. The most equitably distributed intervention was early initiation of breastfeeding. The most equitable countries, where there were data, were Uzbekistan and Kyrgyzstan. The least equitable countries were Chad, Nigeria, Somalia, Ethiopia, Lao PDR, and Niger. The Commission asked that equity should also be considered beyond wealth quintiles. They suggested equity analyses by sex, age, urban/rural residence, geographic location, ethnicity, education, marital status, number of children, and HIV status. Data are not available for many of these equity variables. We only have preliminary data for sex, education, area of residence, and geographical region. So far, we can say there are some examples of wide geographic gaps between urban and rural residence. Countdown to 2015, for example, has highlighted Ethiopia as being the country with the widest urban-rural gap using a composite measure of coverage, followed by Niger, Chad, Nigeria, and Yemen. We plan a deeper analysis of equity in subsequent reports. Disaggregation by sex and age is especially important because poor young women have the largest unmet needs.

44. *Country compacts.* According to WHO's assessment, countries are "making progress" towards the creation of "compacts" between country governments and development partners to facilitate resource tracking. A country compact is a written commitment made between a government and its development partners, which describes how they will work together to improve health outcomes. WHO's target is to have 50 countries with formal agreements with donors by 2015 (we note a substantial slippage from the Commission recommendation, which originally made 2012 the target date for all 75 countries). To date, only 36 countries have signed compacts. And based on country data available to the iERG, fewer than half of priority countries (31) have a reporting system in place for externally funded expenditure. Even when compacts are agreed, what matters will be how these compacts lead to different actions. On that question, we do not yet have data. The failure to meet this Commission recommendation by the originally specified time is a source of great regret given the need to urgently improve tracking of resources for women's and children's health.

45. *National oversight.* WHO's target for achieving this recommendation was to have at least 50 countries implement regular national health sector review processes that meet specified criteria, such as broad stakeholder participation. WHO judges that countries are "on target" in achieving this recommendation. However, again, an objective appraisal of available data indicates lack of reliable information about annual health sector review during the past year in 39 of 75 countries. WHO recognises that there is little systematic comparison of annual health sector reviews between countries. Worse, there are concerns about how to ensure agreed actions are followed up. An opportunity does exist to strengthen our understanding of annual health sector reviews. Later in 2012, the International Health Partnership will complete a review of its experiences with joint annual reviews (27 countries cited in our report are in the IHP+ framework) with the goal of identifying what makes such a review successful or not.

46. *Reporting aid for women's and children's health.* In October, 2011, a task team of the Working Party on Development Finance Statistics of OECD-DAC met to prepare a technical proposal on tracking RMNCH financial flows. Options were presented in February, 2012, to the Working Party, and these were discussed at its annual meeting in June. Most OECD members favoured a new marker for RMNCH resource tracking. Reporting will be on new commitments only, starting with 2014 and reporting on 2013 financial flows. This new mechanism will be reviewed after 12 months. We strongly endorse the progress made towards achieving this goal.

47. We will now turn to the remainder of the Commission's recommendations, whose deadlines lie beyond 2012.

48. *Vital events.* WHO's assessment is that the 75 priority countries for women's and children's health are "on-track" to meet the 2015 deadline for this recommendation. There have, indeed, been several notable achievements. First, the UN Human Rights Council adopted a resolution on birth registration as a human right in April, 2012. Second, 29 countries have completed rapid Civil Registration and Vital Statistics (CRVS) assessments (8 countries have completed a full assessment). Third, innovative (eg, using mobile devices for community registration) CRVS initiatives are ongoing in 18 countries. Fourth, the Africa Symposium on Statistical Development adopted a resolution to strengthen CRVS in all 54 African countries during the next 5 years. And finally, an Asia regional CRVS plan is being prepared, with targets for country health information system strengthening and high-level political engagement. These developments are welcome. They highlight the increased momentum for strengthening CRVS. Several partners—notably the Health Metrics Network—have had, and continue to have, a critical part to play in mobilising political commitment for this neglected aspect of accountability. The challenge is the multisectoral nature of action to strengthen CRVS, which demands patient and sometimes lengthy stakeholder engagement that can take time. Moreover, although

4. Peru: engaging citizens to promote the right to health

At the beginning of this decade, 25% of the population of Peru (close to 6.5 million people) lacked access to health care when it was needed. While progress is being made in the country towards MDG-5 (the reduction of maternal mortality to 66 deaths per 100 000 live births), maternal mortality rates remain high, especially in poor, rural areas. Access to quality care for women living in these areas, especially non-Spanish-speaking indigenous women, is also affected by their perceived or actual mistreatment at healthcare facilities.

There has been increased international consensus in recent years on the vital importance of citizen participation to ensure the legitimacy and sustainability of social policies. Participatory Voices, a citizen healthcare monitoring project that began in 2008, is aimed at improving the responsiveness of healthcare institutions to the rights and needs of the Peruvian people, especially the poor. The work of Participatory Voices is led by indigenous female community representatives who are trained to monitor the quality and acceptability of health services and to promote health service users' rights. After attending a series of capacity-building workshops, these "citizen monitors" visit health facilities two to three times per week. During stays of approximately six hours they make direct observations and talk with female patients in their native languages.

On the basis of their findings, the monitors produce regular reports and analyse them monthly with representatives from the regional Ombudsman's office, CARE Peru, and ForoSalud, the main civil society network dedicated to health. The findings—both good and bad—are then prioritised, shared, and discussed with healthcare facility staff and health teams. Through negotiation with health authorities, an action plan is developed. After implementation, changes and improvements are monitored and assessed for success.

Evaluations of the citizen surveillance initiative have found numerous positive impacts particularly on women's empowerment. These include increased knowledge of women's rights among health providers, Ombudsman officers, and local authorities, and greater knowledge among rural women of their own healthcare rights, needs and entitlements. Healthcare providers who have interacted with monitors from Participatory Voices demonstrate better attitudes and greater responsiveness to the needs and expectations of indigenous women, which include culturally appropriate health care. Rural women have greater satisfaction with healthcare services and there has been an increase in demand for maternal health services. Moreover, the initiative has generated new spaces and methods for a sustained, systematic dialogue on what women expect from the healthcare system and on the achievements and failures of healthcare delivery.

The success of Participatory Voices demonstrates the intersection between international human rights frameworks and quality and accessibility of healthcare services. It also highlights the contribution of rights-based approaches (with their core principles of citizen participation, non-discrimination, and the promotion of accountability) to maternal and child health improvements. The development of mutual understanding and productive relationships has led to the integration of citizen surveillance in Peru's national health policy and the launch in 2010 of national policy guidelines to promote this approach throughout the country.

Sources

Frisancho A, National Coordinator of Social Rights Programs, CARE Peru. Citizen monitoring to promote the right to health care and accountability. Chapter 4 in: *Maternal Mortality, Human Rights and Accountability* (Hunt P and Gray T, eds). In press: Routledge, Taylor & Francis Group, 2012.

there is a country demand for birth registration, there seems to be less interest in death registration and cause of death data.

49. However, a careful appraisal of the available country data suggests there are reasons for concern. The Health Metrics Network itself reports concern about progress in some countries, making an overall assessment for all 75 countries largely meaningless *(27)*. The 17 countries the Health Metrics Network singles out for needing more "focused support" are: Angola, Azerbaijan, Bangladesh, Burundi, Cameroon, Comoros, Congo, Eritrea, Ethiopia, The Gambia, Kenya, Lao PDR, Mauritania, Mozambique, Sudan, Swaziland, and Yemen. The Commission workplan identified four indicators for monitoring progress on vital events: at least 75% of births registered; at least 60% of deaths registered; at least 90% of maternal deaths notified and

reviewed; and a CRVS improvement plan approved by the government and in place (Annex 4). Of 70 countries with data, only 26 have coverage of birth registration that exceeds 75%. Countries in sub-Saharan Africa have the lowest coverage rates for birth registration. Of 69 countries with data, only 11 have more than 60% death registration. For maternal deaths notified or reviewed, no data are publicly available or accessible. And only 8 of 71 countries have a CRVS improvement plan approved by the government. Although there are still 3 years to go until this recommendation should be met, the iERG is concerned that the actions needed to meet the goal are too few and too slow.

50. *Innovation.* WHO judges countries to be "making progress" towards the goal of integrating ICT into their national health information systems by 2015. Multiple initiatives in eHealth are currently ongoing, although few countries (27 of 75) have national eHealth or telemedicine strategies in place. But, as yet, it has proven hard to gather systematically the best available evidence from these pilot projects to draw generalisable conclusions. Too often, eHealth and mHealth projects are developed without any substantive connection to overall national health priorities or plans, or links with district health systems. They may be driven more by the demands of the supplier than the needs of the country. WHO's Global Observatory for eHealth should be able to fill this important gap in understanding how largely uncoordinated eHealth and mHealth initiatives are evolving. The Observatory will be responsible for developing country profiles for ICT in MNCH for all 75 priority countries. WHO also proposes an MNCH Knowledge Management Platform—an e-repository of projects, tools, and best practices—to enable the sharing of innovations between countries. An additional concern is that often donor funding is small and short-term, with no opportunity for reliable evaluation. WHO and ITU will be submitting a full report of progress, including the results of their global eHealth survey, to the iERG in 2013.

51. *Resource tracking:* WHO's assessment is that countries are "making progress". Specifically, capacity has been built in 30 countries to track government expenditures for RMNCH. 18 countries have reported RMNCH expenditure at least once: Benin, Burkina Faso, Burundi, Cameroon, Cote d'Ivoire, DRC, Ethiopia, Kenya, Liberia, Mali, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, Senegal, Tanzania, and Uganda. Progress is hampered both by high staff turnover in countries and by weak institutional and IT systems for supporting and sustaining national health accounts. These will be areas of intense focus by partners during further implementation of the workplan.

52. *Reaching women and children:* WHO judges countries to be "making progress" towards this recommendation. Development partners have committed themselves to strengthen capacity to review spending on RMNCH and to link that spending to commitments in an additional 10 countries each year, prioritising those with the highest burden of women's and children's ill-health. According to WHO, however, no data are yet publicly available or accessible on the inclusion of RMNCH spending as part of annual reviews of health spending.

53. *Transparency:* WHO judges that countries are "making progress" to meet this recommendation by 2013. Transparency—which means public accessibility—applies to all partners. Global partners are expected to have up-to-date databases on women's and children's health and effective means to disseminate country and global data on core indicators. Countries should have effective data sharing and dissemination mechanisms. And all partners should have clarified their announced financial commitments to *Every Woman, Every Child.* The reality, however, according to WHO's findings, is that only 16 countries have data available on public reporting of performance. And of those 16, only 4 have a publicly accessible performance report from the preceding year—Cambodia, Lao PDR, Sierra Leone, and Uganda. The target date for Recommendation 8 is 2013. We see little hope, based on these data, for this recommendation to be fulfilled at present rates of progress.

54. The total budget needed to deliver the Commission on Information and Accountability's recommendations has been estimated to be US$ 88 million for the period 2011-15. As of July, 2012, US$ 28.2 million of that figure had been made available—US$ 19.8 million from CIDA and US$ 8.4 million from NORAD. From January to May, 2012, according to figures provided to the iERG by WHO, US$ 25.1 million had been disbursed on post-Commission activities within WHO (including US$ 2.2 million to the iERG). The income in 2012 is expected to be supplemented with US$ 3 million from NORAD (as part of a signed agreement) and US$ 3.2 million from DFID (based on a drafted but as yet unsigned memorandum of understanding). 2013 income is expected to be a further US$ 3 million from NORAD (as part of a signed agreement) and US$ 1.6 million from DFID (again, based on an unsigned memorandum of understanding). In sum, the total expected income for 2012-13 is US$ 39 million, compared with a budget of US$ 44 million. The iERG therefore registers concern about a looming shortfall in the available resources needed to deliver the Commission's recommendations for the 75 priority countries enduring the greatest burden of women's and children's ill-health. Plans need to be put in place urgently not only to fill this gap, but also to secure the additional US$ 44 million needed for 2014-15.

55. A final comment should be made about the process partners have adopted in implementing the workplans. In 2012, the multi-country workshops seem to have been, in many cases, catalytic. They have brought together, often for the first time, country representatives from diverse communities who are critical to the improvement of accountability for women's and children's health—health information, maternal and child health, finance, civil society, parliament, national statistical offices, bilaterals, WHO, the H4+, and Ministries of Health, Interior, and Planning. The process of convening these parties has taken existing and mostly technical monitoring and evaluation discussions to a higher political level. The political momentum these workshops have triggered—multi-country workshops are usually followed by national consultative processes—seems to have brought new determination to address unacceptable and preventable burdens of maternal and child mortality. In April, 2012, in Tanzania, for example, over 40 stakeholders gathered for 3 days to finalise their Country Accountability Framework—to strengthen resource tracking, birth and death registration, and maternal death surveillance and response. The workshop ended with a high-level meeting with the Minister of Health and Social Welfare. Funding to support this accountability plan was available through the support of the Global Fund, CDC, and the Netherlands government. These dividends of the Global Strategy and Commission on Information and Accountability should encourage further commitments to the process of enhancing country mechanisms for monitoring, review, and remedy. The key challenge for the future will be sustainability, which will require continued investment from partners and countries alike.

3. IDENTIFYING SUCCESSES, OVERCOMING OBSTACLES

56. We have encountered many success stories during our first year of work. Some of these successes are reported in the case studies published throughout this report. They cover the whole spectrum of the continuum of care. These successes are described qualitatively. We hope to bring more quantitative measures to our analysis in future years to understand better how countries are performing relative to themselves and to one another. For example, there is a strong suggestion that donors have increased their funding for reproductive health and family planning. We would like to quantify those commitments further, a crucial part of tracking resources for accountability, especially since there are concerns and signals that donor funding may have fallen more recently. We believe that a more precise report card will foster opportunities to accelerate the sharing of innovations and best practices, including in policy and service delivery, and more quickly identify obstacles to implementing both the Global Strategy and the Commission's recommendations.

57. Despite these successes, there are clearly obstacles to further progress. We have drawn our assessment of these obstacles from several sources. First, from the evidence we have commissioned (principally from WHO, PMNCH, and the H4+). Second, from existing accountability mechanisms (notably the Countdown to 2015 initiative). And third, from a large array of reports and peer-reviewed research studies. Several issues consistently emerge.

58. ***Insufficient high-level political leadership.*** Support for the Global Strategy and for accountability cannot rest with Ministers of Health alone. A repeated message to us is that without ministerial support across several sectors—eg, Finance, Planning, Interior, Social Welfare, Education—together with active participation by, and advocacy from, the President's or Prime Minister's office, progress will falter or even fail. These commitments do not only apply to individuals. Political parties of all persuasions need to align themselves with women and children if societies are to make progress on health. The great lesson of scaling up action to address AIDS was that it was only when the highest level of political leadership within a country was fully engaged that real progress was made. However, we have received evidence from PMNCH to suggest that awareness of the Commission on Information and Accountability's recommendations is poor in low and middle income countries. Intensified efforts are needed to raise the profile of the Commission's work and its ongoing implementation. Donors have also expressed strong support for the Global Strategy. But that support has sometimes been tempered by actions that send mixed signals to countries and those working on behalf of women and children. For example, we signalled our concern in May, 2012, on the eve of a Child Survival Call to Action, held in Washington, DC, on June 14-15. This meeting was convened by the governments of the US, India, and Ethiopia, in partnership with UNICEF. It is commendable that increased global attention was given to child survival during this meeting. However, the conference triggered concerns among many parties, including other UN agencies, advocates, and experts in women's and children's health. The new goals being proposed for child mortality were not devised through a consultative, multilateral process and were not incorporated into the evolving framework of *Every Woman, Every Child*. The continuum of care was insufficiently emphasised. The political and practical feasibility of the child survival goal, as well as the 2035 target date, were also called into question. The danger of events such as the Child Survival Call to Action is that while they focus welcome attention to one aspect of the continuum of care, they risk taking us back to a time when strategies for women's and children's health were fragmented, uncoordinated, and even competitive. We urge all partners who have committed to the Global Strategy to consider carefully opportunities for aligning and harmonising their own programmes with *Every Woman, Every Child*.

59. ***Inadequate financing for women's and children's health.*** Lack of investment is one of the most important limiting factors for the delivery of both the Global Strategy and the Commission's recommendations, especially in the context of the present global financial crisis. Not all priority countries depend upon international financing. But for those that do—countries often with the highest rates of maternal and child mortality—these financial shortfalls (together with slow disbursement of funds by donors) are a serious threat to the health of women and children (through, for example, preventing investments in midwifery services). To be fair, official development assistance for women's and children's health has been rising in recent years. But the rate of growth of these increases is now diminishing. The conclusion we draw is that without increased external funding, countries are unlikely to be able to meet their commitments in full. Nor should national funding for women's and children's health be neglected. In Africa, for example, the 2001 Abuja commitment called for African nations to dedicate at least 15% of their domestic budgets to health. Over a decade later, only 6 of 55 African Union member states have done so. But to understand fully the nature of these shortfalls, we need better information about how the financial commitments made by all parties to *Every Woman, Every Child* have been spent. This information is not available to us, and it is a major limitation in our efforts to strengthen accountability around women's and children's health.

60. *Lack of skilled health workers.* Although there is good general awareness of the human resource crisis in health generally—and strong commitments have been made to expand the number of health workers for women's and children's health, as shown by PMNCH's surveys of country commitments—specific barriers remain—eg, the lack of qualified health workers at birth, a difficulty in attracting health workers to rural settings, and slow country-level implementation of commitments. In total, 53 of 75 priority countries suffer a severe shortage of health workers. In one analysis, between 130 and 180 million non-skilled-birth-attendant births are predicted for sub-Saharan Africa and South Asia between 2011 and 2015 (28). 90% of these births will be in rural areas. The immense urgency of strengthening human resources for women's and children's health is therefore hard to overemphasise. But one example is telling. Midwifery services are about delivering health, saving lives, and preventing disability across the whole continuum of care. Midwives have crucial roles not only in preventing maternal mortality and morbidity, but also in providing family planning services and preventing 2.2 million early newborn deaths and 2.6 million stillbirths annually. UNFPA has calculated that with just 112 000 more midwives globally, 3.6 million maternal and newborn deaths could be prevented in 2015 (29). The correct investments and incentives therefore need to be put in place now to ensure the equitable distribution of health workers where need is greatest. In part, task shifting may represent one innovative solution to the human resources crisis. It has been used successfully in Ghana, Lao PDR, Malawi, and Tanzania to scale up provision of services. But task shifting should not lessen the focus on the quality of care being provided to women and children. Nigeria's Midwives Service Scheme, for example, aims to expand the reach of high-quality midwifery services in underserved rural areas. Launched in 2009, this initiative is still in its early years of development (30). We hope that innovative policies, such as the Midwives Service Scheme, can attract sustainable funding and political commitment from countries and donors alike. Overall, the shortage of human resources remains one of the most important obstacles to delivering the goals of the Global Strategy and Commission.

61. *Weak health systems.* Again, there is no shortage of awareness about the importance of a strong health system to advance women's and children's health. The challenges are political leadership to make health system strengthening a national priority, together with implementation of sound policies. Health-system weaknesses worsen inequalities for those interventions that depend on strong systems for their delivery—eg, skilled birth attendance and the treatment of pneumonia and diarrhoea. A sign that health-system strengthening is being taken more seriously is a 2011-16 H4+/CIDA initiative to strengthen health systems through joint support of the continuum of care. Five high-burden countries are being targeted: Burkina Faso, DRC, Sierra Leone, Zambia, and Zimbabwe. The programme is aiming to scale up coverage of interventions; strengthen health system stewardship, implementation and monitoring; and collect evidence that might apply to other high-burden countries. Results of this initiative remain to be reported. Financial risk protection is another key element of a strong and well-functioning health system. In 70 of 75 priority countries, out-of-pocket payments account for 15% or more of total health expenditure (in some countries, that figure may rise to as high as 80%). Reducing financial barriers to care and service uptake so as not to exclude any mother or child in need is a vital part of achieving universal health coverage for women and children (21). Overall, however, our impression, based on the evidence available to us, is that there is insufficient technical support to countries to help governments strengthen beleaguered health systems.

62. *Variations in coverage and coverage gaps.* Some countries achieve high coverage with specific interventions (see Figure 4). They show that successful implementation of life-saving interventions can be achieved. For example, access to contraceptive information and services is over 90% in China, Brazil, and Viet Nam (although even in these countries young women often lack access to family planning). But elsewhere coverage may be extremely low—eg, access to contraceptive information and services in Sierra Leone. These inequalities between (and within) countries are unacceptable. Overall, some parts of the continuum of care still show persistent coverage deficiencies. Intermittent preventive treatment of malaria during pregnancy, early and exclusive breastfeeding during the first 6 months of life, a postnatal visit to the mother, provision of insecticide-treated bednets to children, treatment of pneumonia and malaria, and availability of oral rehydration salts all fall below 50% coverage. A particular challenge will be to address inequalities in countries with rapidly rising populations. Surprisingly too, and despite strong advocacy and the availability of reliable evidence, some dimensions of women's and children's health have received insufficient attention. Three areas have been especially highlighted this past year—namely, intrapartum stillbirths and interventions to prevent and treat diarrhoea and pneumonia (12). There are also others—for example, non-communicable diseases among women and the health of newborns. As we have alluded to, one cross-cutting issue is frequently neglected—namely, quality. Attention to continuous quality improvement of services for women and children can yield dramatic health improvements (31).

63. *Weak national governance.* Not all of the 75 priority countries we are reviewing have stable governance arrangements. Some countries are in civil conflict, while others have or are experiencing destabilising humanitarian crises and natural disasters, as well as systemic corruption. The World Bank has identified countries in what it calls "fragile situations"—defined as "periods when states or institutions lack the capacity, accountability, or legitimacy to mediate relations between citizen groups and between citizens and the state, making them vulnerable to violence" (32). 24 of our priority countries for women's and children's health—almost a third—are classified by the Bank as fragile: Afghanistan, Angola, Burundi, Central African Republic, Chad, Comoros, DRC, Congo, Cote d'Ivoire, Eritrea, Guinea, Guinea-Bissau, Haiti, Liberia, Myanmar, Nepal, Sierra Leone, Solomon Islands, Somalia, Sudan, Togo, Yemen, Zimbabwe, and Iraq. There are no special efforts, as yet, to address countries that suffer these severe governance challenges. Yet these countries demand special and highly tailored initiatives to match their perilous political situations. In addition, many RMNCH projects are not well aligned to national plans, working in parallel rather than being fully integrated with government efforts. This fragmentation leads to duplication and inefficiency that further disables governments from fulfilling their health system stewardship role.

64. *Working with Parliaments.* Parliaments have a critical part to play in supporting the Global Strategy. They represent a powerful accountability tool in their own right to drive progress towards improved women's and children's health. Parliamentarians have a role in allocating resources, passing legislation, and overseeing programme implementation. Globally, the Inter-Parliamentary Union has been a strong partner of *Every Woman, Every Child*. It has pledged to mobilise support among parliaments to enhance access to and accountability for improved women's and children's health. For example, in April, 2012, in Kampala, the IPU unanimously adopted a resolution on the role of parliaments in addressing key challenges to secure the health of women and children. Their resolution called on parliamentarians to take all possible measures to generate and sustain political will, build partnerships, and closely monitor their domestic policies in the service of women and children. Raising the political profile of RMNCH in regional and national parliaments remains a major objective of the Global Strategy. Some successes have been achieved. In May, 2012, in Arusha, the East Africa Legislative Assembly committed its members to hold their governments to account for the provision of maternal, newborn, and child health, including delivering on the Global Strategy. Individual parliamentarians must therefore have access to current, reliable, and user-friendly information, a need that remains a substantial challenge in many settings. Parliamentarians must also be routinely included in decision-making processes and platforms about women's and children's health.

65. *Inequalities in commitments.* As discussed in Chapter 2, some countries have few or no commitments made through the Global Strategy. Several of these countries are most off-track to reach their MDG targets. Efforts need to be strengthened to ensure that these countries do not assume a permanently "orphan" status.

66. *Nutrition.* Most of the 75 priority countries for women's and children's health face a severe nutrition crisis. A third of women of reproductive age have iron-deficiency anaemia. Maternal anaemia is associated with maternal mortality and reduced birth weight. Each year, about 13 million children are born with intrauterine growth restriction and about 20 million children with low birth weight. Undernutrition contributes to at least a third of child deaths and a fifth of maternal deaths. In most countries, over a third of children are stunted. Although the prevalence of children who are underweight is falling, it is not doing so at a fast enough rate to reach the MDG-1c target. Most countries recognise the urgency of revitalising efforts to address undernutrition (33). And advocacy around nutrition is now impressively high (34,35). Yet a disconnect exists between words and deeds. Nutrition is an urgent priority for women and children. All partners to the Global Strategy have to do more. At the 65th World Health Assembly in 2012, countries recommitted themselves to put into practice comprehensive implementation plans on maternal, infant, and young child nutrition (WHA65.6). That recommitment includes new targets on childhood stunting, anaemia among women of reproductive age, low birth weight, exclusive breastfeeding, and childhood wasting. The iERG will monitor progress on nutrition closely in its subsequent reports.

67. *Inequity.* Women in Afghanistan have a lifetime risk of maternal death of 1 in 8. A woman in Ireland has a risk of death of 1 in 47 600. In Mali, 1 in 5 children dies before the age of 5. In Japan, the under-5 mortality rate is 3 per 1000 livebirths. In 2008, the Commission on Social Determinants of Health (36) recommended that WHO adopt a new target, together with other partners, to address inequities in maternal and child health: to "reduce by 90%, between 2000 and 2040, the under-5 mortality rate in all countries and all social groups within countries, and reduce by 95%, between 2000 and 2040, the maternal mortality rate in all countries and all social groups within countries." We have no data available to us to know whether progress is being made on this proposed target, a target that, regrettably, was not subsequently endorsed by the member states

5. Brazil: tackling child malnutrition to reduce health disparities

Child nutrition is a strong determinant of mortality and the prevalence of stunting (low height for age) is the best indicator of a population group's nutritional status. In 2005, about one in three children in low- and middle-income countries around the world were stunted *(1)*. Stunting is a complex indicator of inadequacies in the healthcare system and in the policies and interventions aimed at addressing the social determinants of health. High levels of food insecurity, unhealthy diets, low parental education, lack of access to quality health care, unhealthy living environments, recurrent infections, intestinal parasites, poor sanitation, and low birth weights can all contribute to the prevalence of stunting.

Brazil has seen a dramatic decrease in stunting from 37.1% in 1974-75 to 7.1% in 2006-07. The annual rates of reduction have accelerated over time from 4.2% to 6.0% *(2)*. Stunting affects poor children more than well-off children. In 1989, when the overall national rate of stunting was 19.9%, 39.1% of children in the lowest income quintile were stunted; by 2006-07, this rate had declined to 11.2% *(3)*. Alongside the reduction in stunting, Brazil has also seen a decrease in the prevalence of underweight children, down from 5.6% in 1989 to 2.2% in 2006-07 *(2)*.

Some of this improvement has come from measures to reduce the direct causes of stunting. For instance, diarrhoea, a major direct cause of undernutrition, has declined significantly from being responsible for 17.3% of all registered infant deaths in 1985-1907 to 4.2% in 2003-2005 *(1)*. Exclusive breastfeeding in children younger than 4 months of age increased from 3·6% in 1986 to 48·1% by 2006-07 *(2)*. Among the many other contributing factors are Brazil's successful efforts in achieving the MDG-1 (eradicating extreme poverty and hunger) and in being on-track to achieve the MDG-7 water and sanitation targets by 2015.

Broad socioeconomic improvements have generally accompanied reductions in the prevalence of child stunting, which have occurred alongside significant reductions in neonatal, infant, and child mortality. Mechanisms to improve income distribution, such as the Bolsa Familia, a national cash-transfer programme in which 80% of the benefits go to the poorest 30% of the population, contribute to better diets for people most affected by undernutrition; severe food insecurity was reduced by 27% between 2004 and 2006-07 *(1)*. Neonatal mortality declined from 23.1 per 1000 live births to 13.6, infant mortality from 47.1 per 1000 live births to 20.0, and under-5 mortality from 53.7 per 1000 live births to 23.1 between 1990 and 2007 *(3)*. The reduction in disease incidence and severity that led to these mortality reductions is also likely to have contributed to the declines in incidence of stunting. The creation of a tax-funded national health service in 1988 and decentralisation of the healthcare system have improved access to health services, especially for poorer people *(3)*, and have contributed to these reductions in disease. Increased support for universal access to primary education and the improvement of education quality is also seen to correlate with improvements in child nutrition and lower neonatal, infant, and child mortality rates *(1)*. Overall, the Brazilian example provides "compelling evidence that proactive actions to reduce health disparities accompanied by socioeconomic progress can lead to major improvements in the health of children and mothers in a relatively short time period"*(3)*.

Sources

1. Monteiro CA, D'Aquino Benicio MH, Lisboa Conde W, et al. Narrowing socioeconomic inequality in child stunting: the Brazilian experience, 1974-2007. *Bulletin of the World Health Organization* 2012; 88: 305-11.
2. Victora CG, Aquino EML, do Carmo Leal M, et al. Maternal and child health in Brazil: progress and challenges. *Lancet* 2011; 377: 1863-76.
3. Barros FC, Matijasevich A, Harris Requejo J, et al. Recent trends in maternal, newborn, and child health in Brazil: progress toward Millennium Development Goals 4 and 5. *American Journal of Public Health* 2010; 10 (100): 1887-89.

of WHO. We believe that this goal, or one similar to it, should be an essential component of any country-based or global oversight mechanism for the Global Strategy. We will be reaching out to WHO to obtain the best available data to monitor progress on achieving progress on diminishing inequalities in women's and children's health.

68. ***Lack of attention to adolescent girls and gender discrimination.*** The relative global and national inattention to girls and adolescent women severely limits advances to women's and children's health. This neglect ranges from issues such as poverty among women to lack of educational opportunity, from sexual violence to poor living conditions. There is a large body of evidence

6. Mexico City: a legal abortion programme

In April, 2007, the Mexico City legislature passed a law permitting abortion-on-demand in the first 12 weeks of pregnancy. In response, the Ministry of Health (MOH) of Mexico City designated selected health facilities to provide abortion services either free of charge to Mexico City residents or on a sliding scale to non-residents according to their economic circumstances. According to MOH estimates, as of May, 2012, 78 544 legal first-trimester abortions had been performed, most of them free of charge (there are no figures from private providers). The rate of maternal mortality due to unsafe abortion in Mexico City declined from 9.9 per 100 000 live births before decriminalization in 2007 to only 3.8 in 2009 *(1-3)*.

Outside of Mexico City, abortion is only legal in limited circumstances such as rape (all 32 states), a threat to the woman's life (29 states), and congenital malformation (13 states). In response to the Mexico City legal reform, legislatures in 18 states passed amendments to their constitutions declaring "the sanctity of life from conception" and thereby further restricting access to legal abortion.

Illegal abortion services are widely available in Mexico, and for decades the government and health institutions have recognised them as a social and medical problem. A 2005 study estimated that complications from illegal abortions cost the Mexico City healthcare system US$ 1.6 million per year. Poor women and women from rural areas suffer disproportionately from the consequences of unsafe abortion. The increasing availability of medical, rather than surgical, abortion is likely to improve abortion outcomes outside of Mexico City *(4)*.

Women are generally very satisfied with the abortion services they receive in the Mexico City MOH facilities *(5)*. Pre- and post-procedure counselling, a non-judgmental attitude on the part of staff, and high-quality professional services contribute to patient satisfaction. Post-procedure uptake of modern methods of contraception is very high.

While abortion services remain severely restricted outside of Mexico City, the MOH facilities in Mexico City will be under pressure to serve women from other regions. But public opinion polls of attitudes towards abortion *(6,7)* and the interest of practitioners in increased training *(8)* are encouraging signs. The legalisation of abortion in Mexico City has the potential to be an effective model for the provision of reproductive health services in the rest of Mexico, and in other countries in Latin America and the Caribbean region.

Sources

1. Secretaría de Salud del Gobierno del Distrito Federal. Agenda estadística [Statistical agenda] 2008. SSDF Web site. http://www.salud.df.gob.mx/ssdf/media/Agenda2008/ Accessed March 26, 2012.
2. Secretaría de Salud del Gobierno del Distrito Federal. Agenda Estadística [Statistical agenda] 2009. SSDF Web site. http://www.salud.df.gob.mx/ssdf/media/Agenda_2009/index.html. Accessed March 26, 2012.
3. Secretaría de Salud del Gobierno del Distrito Federal. Agenda Estadística [Statistical agenda] 2010. SSDF Web site. http://www.salud.df.gob.mx/ssdf/info_salud/Pagina%20Web%20Agenda%20Estad%C3%ADstica%202010/inicio.html. Accessed March 26, 2012
4. Levin C, Grossman D, Berdichevsky K, et al. Exploring the costs and economic consequences of unsafe abortion in Mexico City before legalisation. *Reproductive Health Matters* 2009; 17(33): 120–32.
5. Diaz-Olavarrieta C, García GS, Arangure A, et al. Women's experiences of and perspectives on abortion at public facilities in Mexico City three years following decriminalization. *International Journal of Gynecology and Obstetrics* 2012. In press.
6. Valencia Rodríguez J, Wilson KS, Díaz Olavarrieta C, et al. Public opinion on abortion in eight Mexican states amid opposition to legalization. *Studies in Family Planning*, 2011; 42(3): 191–98.
7. Wilson KS, Garcia SG, Diaz Olavarrieta C, et al. Public opinion on abortion in Mexico City after the landmark reform. *Studies in Family Planning* 2011; 42(3): 175–82.
8. Dayananda I, Walker D, Atienzo E, Haider S. Abortion practice in Mexico: a survey of health care providers. *Contraception* 2012; 85: 304–10.

to show that reproductive health issues among girls and adolescent women are frequently marginalised. About 16 million adolescent girls between 15 and 19 give birth each year, 11% of total births worldwide, 95% of which occur in low and middle income countries. Several issues are important to consider—comprehensive sexuality education, access to family planning services (37), sexual coercion (38), sexual violence (39), the persistent prevalence of female genital cutting (40), lack of educational and employment prospects, lack of access to safe abortion, and lack of access to skilled care. In these countries, pregnancy and childbirth are the leading causes of death among adolescent girls aged 15 to 19 years. Key interventions can make a difference, yet are neglected: reducing marriage before the age of 18; creating understanding and support to reduce pregnancy before the age of 20; increasing the use of contraception; reducing coerced sex; reducing unsafe abortion; and increasing the use of skilled antenatal, childbirth, and postpartum care. One aspect is indeed the lack of provision of services. But another is the low uptake of available services—demand has to be created as well as supply (41). Some countries are making progress in addressing gender in health and related sectors (42). But the systematic lack of attention to the health of girls and adolescent women is a further important obstacle to raising attention about this complex, but urgent, set of issues (43).

69. *Pervasive neglect of safe abortion services.* One taboo that remains in international discussions about improving women's and children's health is that of unsafe abortion. This omission is deeply regrettable and reflects a fear among many health advocates, programme managers, and political leaders about addressing an issue that still divides opinion so passionately. Yet the evidence is overwhelming: *Every Woman, Every Child* will not be fully delivered unless the huge burden of unsafe abortion is confronted by public health strategies of harm reduction—namely, the provision of family planning and safe abortion services. The latest best estimates indicate that there were 43.8 million induced abortions worldwide in 2008 (27.3 million in Asia, 6.4 million in Africa, and 4.4 million in Latin America) (44). 49% of these abortions were unsafe and their complications add huge costs to the health system. Unsafe abortion continues to be a major contributor to maternal death—14% of maternal deaths can be attributed to unsafe abortion (45). Induced abortion is also closely linked to other dimensions of women's health, such as their risk of intimate partner violence (46). The policies that countries, including major donors, adopt towards abortion can have a profound—including profoundly negative—impact on women's health (47). Thankfully, despite considerably adverse political conditions, WHO has taken an important lead by providing technical and policy guidance to help countries deliver safer abortion practices (48). Indeed, if countries and partners are serious about delivering *Every Woman, Every Child*, they must embrace such evidence-informed policies to reduce the large and preventable toll of mortality and morbidity associated with unsafe abortion.

70. *Inattention to conflict-affected and displaced populations.* The iERG's remit extends to 75 priority countries where over 98% of maternal, newborn, and child deaths take place. However, we are also aware that the full realisation of the Global Strategy requires attention to populations that are not fully recognised within nation-states. Two particular groups concern us—internally displaced populations and women and children living under occupation. The UN Refugee Agency, UNHCR, identified 42.5 million people forcibly displaced worldwide by the end of 2011 (49). 49% of those displaced were women and girls, and 17 700 were unaccompanied children (a figure that was substantially higher than the 15 600 children identified in 2010). Displacement is expected to grow in coming years, partly because of population growth, and mostly in Africa and Asia. Conflict is a major cause of displacement. The nations where most of this displacement took place include priority countries for women's and children's health. Major source countries for refugees among the Global Strategy's priority nations are: Afghanistan (2.7 million), Iraq (1.4 million), Somalia (1.1 million), Sudan (0.5 million), and the DRC (0.5 million). Major refugee-hosting countries include: Pakistan (1.7 million), Kenya (0.6 million), Chad (0.4 million), China (0.3 million), and Ethiopia (0.3 million). However, as far as we can tell, there is no specific assessment of the predicament of women and children who are internally displaced, and so they are largely invisible in our accountability framework. When one considers that in 40 countries there are women and children who have been displaced for more than 5 years, the potential importance of this issue becomes clear. We need to build a mechanism to include displaced women and children into our accountability assessment, including those who do not fall within our 75 country remit (the exodus and displacement of families from Syria since March, 2011, is a particular ongoing concern). Internally displaced peoples are entitled to all the guarantees enshrined in international human rights and humanitarian law. Many of the health predicaments women and children face require health services, in addition to pregnancy and child care, focused on chronic disease management (50). We are also concerned about those women and children living under occupation, but who, again, are not part of our 75 priority countries. They experience special circumstances of dispossession and exclusion from health services (51). Finally, women and children are especially vulnerable in zones of conflict. Currently,

8 countries are experiencing conflicts in which over 1000 deaths per year are taking place—Afghanistan, Somalia, Pakistan, Mexico, Sudan, South Sudan, Iraq, and Syria. The health of women and children amid these conflagrations should be a higher priority concern for the global community.

71. ***Insufficient intersectoral collaboration.*** Progress on women's and children's health requires almost unprecedented levels of intersectoral collaboration. An example of the need for such collaboration is nutrition, where there must be cooperation between those responsible, at a minimum, for water and sanitation, agriculture, and transportation. In particular, civil registration and vital statistics require a multisectoral approach—these are not the sole responsibility of the health sector. Another example is reproductive health, where the education sector has an important part to play by making comprehensive education about sexual and reproductive health widely available. Central roles exist for the statistical and civil registration communities. Each of these communities often sees a different value in health information, placing a greater or lesser emphasis on security, human rights, identity, or epidemiology. All of these perspectives need to be accommodated and understood in devising a plan for strengthening the health information system. This process takes time and needs encouragement and support. Critical areas, such as water and sanitation (52,53), the urban environment (54), and the education and employment of girls (55) are decisive determinants of women's and children's health—determinants whose broad neglect by the health sector has slowed overall progress towards MDGs 4 and 5.

72. ***Weak information technology platforms.*** Countries may not have ways to record and report critically important data on women and children. Establishing these IT systems takes time, and may need national legislation. One of the major priorities for all 75 priority countries is the need to invest in routine health facility data systems to improve the availability and quality of data for annual monitoring and sub-national analyses. But, as yet, few countries have established nationwide systems for using ICT in their health information systems. Scaling up pilot projects to national levels requires long-term funding and infrastructure. Continuous advocacy is essential to maintain momentum around what can sometimes be a protracted and complex political process. We will be returning to ICT and eHealth in more detail in subsequent reports. We make a specific recommendation on ICT for accountability in Chapter 4.

73. ***Overburdened national oversight capacity.*** While it is important to strengthen oversight, this must be done in ways that do not duplicate well-established monitoring arrangements within countries. Indeed, these existing mechanisms need constant attention and support—funding of country surveys, database management and quality control, investment in people (the technical capacity of the country), and effective use of findings in policy and practice. The country accountability workshops led by WHO have revealed the need to strengthen substantially capacity to prepare analytical reports for review and their subsequent translation into policy. That said, there are clearly challenges to using annual health sector reviews as effective accountability mechanisms. Participation needs to go beyond the health sector, to include, for example, civil society (especially women's groups), communities, parliamentarians, and other government departments. There also needs to be a direct line between the national accountability forum and the Office of the Head of State and government. Too often, this does not happen.

74. ***Sustaining advocacy.*** Support for the continuum of care is vital for country and global progress. But the institutions and networks needed to protect and strengthen advocacy are often fragmented and fragile. Robust and cohesive RMNCH advocacy needs to be established through national and sub-national civil society coalitions. They will provide the crucial links, for example, between parliamentarians and the media. Civil society has a vital, sometimes neglected and certainly underexploited, part to play in advocacy. It is civil society that can act as an accountability mechanism itself, providing "citizen surveillance" of government policies. Their focus on grassroots accountability, especially in alliance with the media, is an essential element of advocacy. But the constraints on civil society also need to be recognised. One cannot assume that civil society has the resources of information and time to gather and interpret evidence about progress on women's and children's health. Non-state actors may justifiably be concerned about the consequences of criticising government policies. PMNCH reports that over three-quarters of commitments to the Global Strategy include advocacy—for accountability, political and policy support, human rights, financing, service delivery, and citizen participation. While we welcome these commitments, we are disappointed at the lack of detail available to us about what these commitments have achieved. Moreover, we are concerned by PMNCH's finding that restrictive funding environments, weak technical capacity, and adverse political contexts are threatening the sustainability of advocacy for women's and children's health in many settings. International funders have an obligation to support civil society organisations.

75. In the final section of our report, we turn to our proposals for a framework to encompass these challenges and accelerate progress to MDGs 4 and 5.

7. Nigeria: scaling up sexuality education nationwide

The development and implementation of sexuality education[1] programmes is challenging and complex, especially in countries with ethnic, religious, and social diversity, under-resourced school systems, and complicated, multi-party arrangements for social service delivery *(1)*. Despite the enormous sensitivities involved, Nigeria has moved steadily and systematically through the process from initial concept to nationwide scale-up, covering all 36 states. Evaluations are needed in all states to assess how successfully the programme has been implemented and the impact it has had. However, studies in the state of Lagos show signs of success.

The process began in 1995 with the convening of a national coalition of all concerned stakeholders. Guidelines were published in 1996, and in 1999 the National Council on Education took the decision to integrate sexuality education into school curricula. One year later the National Education Research Council and Action Health Incorporated (a leading youth NGO) developed National Comprehensive Sexuality Education Curricula. The curriculum was primarily intended to reduce levels of HIV infection, but with the secondary goals of increasing factual knowledge about sex, supporting rational decision-making, and limiting sexual behaviour with the potential for adverse consequences. It was agreed that sexuality education would be taught to public junior and secondary school students. Youth and reproductive health NGOs were tasked with providing in-service training of teachers and ongoing support to schools, and teacher training institutes were given the responsibility of orienting student-teachers to the new curriculum.

Responsibility for implementation was decentralised to state Ministries of Education, who were free to adapt the prescribed format within certain parameters to respond to social and cultural sensitivities. However, despite proactive, energetic, and ongoing consultations with a range of stakeholders (political leaders, religious leaders, school administrators, teachers' unions, parent-teacher associations, the media), there has been strong opposition to the programme from some quarters. For example, vocal objections from religious leaders and conservative politicians led to a name change in 2002 from "Sexuality Education" to "Family Life and HIV Education" (FLHE) *(1)*.

In 2008, following recognition that there was considerable variation between states and within schools in terms of methodology, content, and quality of FLHE teaching, the Ministry of Education issued National Implementation Guidelines. This guidance was combined with documented success stories from states that have demonstrated good practice *(2)*.

One impact study in the state of Lagos *(3)* found that students who had three full years of exposure to the curriculum had higher levels of knowledge about sexuality and reproductive issues, were more likely to endorse gender equity, and were more likely to say no to intercourse with someone they liked. Boys exposed to the curriculum were less likely to say they would pressure girls in to sex, more girls felt confident saying no to sexual activity, and fewer students of both sexes reported being sexually active.

Most interestingly, the implementation of the FLHE programme has been paralleled by a decline in HIV prevalence among young people in Nigeria. The use of modern contraception in Nigeria has also doubled since 1990 *(1)*. Because of the breadth of initiatives designed to bring about change in these areas, it is difficult to establish positive relationships between these statistics and the FLHE; nonetheless, the correlation is promising.

Sources

1. UNESCO. Levers of success. *Case studies of national sexuality education programmes.* Paris: UNESCO, 2011. http://unesdoc.unesco.org/images/0018/001884/188495e.pdf
2. Lagos State Ministry of Education and Action Health Incorporated. *Foundations for a Healthy Adulthood.* Lagos: Action Health Incorporated, 2010.
3. UNESCO and Radbout University Nijmegen Medical Center, *Cost and Cost-Effectiveness Analysis of School-Based Sexuality Education Programmes in Six Countries*. Section 4: "The Family Life and HIV Education Programme in Lagos State, Nigeria". Paris: UNESCO, 2011.

[1] UNESCO defines sexuality education as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, and non-judgemental information. Sexuality education provides opportunities to explore one's own values, and attitudes and to build decision-making, communication, and risk reduction skills about many aspects of sexuality. See UNESCO's International Technical Guidance on Sexuality Education (Vol. 1) unesdoc.unesco.org/images/0018/001832/183281e.pdf

4. RECOMMENDATIONS FOR STRENGTHENING ACCOUNTABILITY

76. The Commission on Information and Accountability asked the iERG to make recommendations to improve the effectiveness of the accountability framework developed by the Commission. We make 6 recommendations to do so.

77. Strengthen the global governance framework for women's and children's health. The launch of *Every Woman, Every Child* has accelerated political commitment to women's and children's health in an extraordinary way. Countries and partners have launched diverse initiatives to support the broad goals of the Strategy. Some examples from 2012 include the Child Survival Call to Action; the London Summit on Family Planning; and the Saving Mothers, Giving Life initiative. Each event brings valuable global attention to its specific focus of concern. Nevertheless, as mentioned earlier, we are conscious of concerns raised by some partners. First, the great strength of the MDGs is that they are goals agreed multilaterally by all UN member states. Their moral force is backed by political mandate. The subsequent success in mobilising countries and donors around these goals came, in large part, from the multilateral process that produced them. Sometimes, new initiatives have included policies or set targets outside of this democratic, participatory, and multilateral process. In addition, a decade of work has forged a strong consensus around the notion of the continuum of care—the idea that the health of women and children are indivisible. Vertical initiatives dedicated to one part of the continuum could jeopardise the idea that programmatic success in reaching MDGs 4 and 5 depends on implementing a comprehensive plan for reproductive, maternal, newborn, and child health. The iERG welcomes all efforts to strengthen the goals of *Every Woman, Every Child*. But these efforts may risk sending signals of confusion to countries. How is a country, for example, supposed to respond to the separate calls to action around commodities, child survival, and family planning? The risk of fragmentation, duplication, and inefficiency is real. To maximise the impact of these initiatives and to ensure coordination and coherence in their implementation, we believe that a more formal global governance (or guidance) framework for *Every Woman, Every Child* is needed. We are not advocating the creation of a new bureaucracy to administer the Global Strategy. We are conscious that issues of governance can provoke complex and ambitious proposals that may have little chance of full realisation (56,57). But we are proposing that an existing governance gap needs to be filled by a mechanism that is inclusive of partner countries, multilateral agencies, donors, non-governmental organisations, healthcare professionals, researchers, foundations, and the private sector. We advocate a renewed effort to promote effective interaction and cooperation between all partners dedicated to improving women's and children's health.

78. Devise a global investment framework for women's and children's health. The issue of global financing for women's and children's health has been controversial. Some observers have long advocated for a Global Fund for Maternal, Newborn, and Child Survival, akin to the Global Fund to Fight AIDS, TB, and Malaria (GFATM) (58). But there has been little appetite in the global community for creating another Global Fund, at least one similar in size and structure to the GFATM. At the same time, the case for better tracking of resources for RMNCH has been repeatedly made, especially on grounds of donor accountability (4). The need for stronger global accountability mechanisms for resource tracking was one of the main conclusions and recommendations of the Commission on Information and Accountability. It is even more relevant today as the growth of funding for development assistance for health is slowing (59). Other financing institutions have recognised their commitment to women's and children's health, albeit within their existing mandates. The GFATM, for example, has recommended that countries "strengthen the MNCH content of their Global Fund-supported investments". (Although the Fund has still been reluctant to include women's and children's health within its spending portfolio.) Meanwhile, new opportunities exist to support women and children through expanded investments. The UN Commission on Life-Saving Commodities for Women and Children has identified the impact and costs of 13 interventions for RMNCH. The Commission recommends that "By the end of 2013, at least one innovative financing mechanism is in place to rapidly increase access to the 13 commodities and foster innovations." Therefore, a key question is: how will the needs for priority countries be fully costed and met? PMNCH and others are investigating options for RMNCH financing and endorse the need for more targeted and easily accessible funding for women's and children's health. The likelihood is that an RMNCH financing facility or facilities will be created within existing organisations, such as the World Bank, in order to scale-up the delivery of high-impact RMNCH intervention packages. The gradual coordination of financing for RMNCH invites a further question: is there a global investment framework to guide a more targeted and strategic approach to supporting women's and children's health? The answer, so far, is no. The best we have is a very rough estimate of the funding gap for women's and children's health—US$ 88 billion (7). This was the position for HIV/ AIDS too, until UNAIDS, with partners, devised a fully costed investment framework to guide financing and to give some quantitative sense of what the returns on different levels of investment might be. As with AIDS, advocacy for resources for women's and

children's health has tended to be conducted through parallel initiatives and, within each initiative (eg, family planning, child survival), for particular commodities. The goal of the new strategic investment framework for AIDS was to support the better management of country and global AIDS responses (60). The framework set clear objectives, identified specific programme activities, noted critical enablers, and emphasised additional synergies with other development sectors. It calculated the resources needed to deliver this framework, together with the returns on that investment. The response to this investment framework has been broadly positive. Programme managers report that it simplifies and yet adds valuable structure to their work. Ministers of Health and donors have welcomed it too. The iERG believes there is scope for strengthened country and global accountability through the creation and implementation of a more strategic investment approach to women's and children's health. This investment approach must include and take account of national investments and allocations for women's and children's health. The AIDS investment framework provides strong support, and perhaps a good model, for doing so. We recommend that a global investment framework for women's and children's health be developed as a priority.

79. *Set clearer country-specific strategic priorities for implementing the Global Strategy and test innovative mechanisms for delivering those priorities.* The recent rapid accumulation of evidence around women's and children's health and essential interventions has helped to sharpen priorities for action in the 3 years remaining until the MDG target date of 2015. These priorities need to be more rapidly embraced and acted upon by all partners, with the appropriate governance and investment frameworks in place for their delivery.

- *Reproductive health:* The latest UN Millennium Development Goal Report (61) shows persistently high unmet needs for contraceptive use in low-income countries. The inclusion of universal access to reproductive health as an MDG target in 2008 was a belated recognition of the importance of sexual and reproductive health to the continuum of care. But its late arrival into the MDG framework has meant that considerable work has had to be done to establish reproductive health services and to integrate those services, where possible, into existing plans for maternal and child health. The burden of reproductive morbidity is still under-appreciated (62). To accelerate progress on reproductive health, the current focus on maternal health must be expanded to include access to contraceptive information and services, sexual health, and safe abortion. Reproductive health must be part of a country's health plan, and the financing of that plan must cover a minimum basic package of reproductive health services, including resources to strengthen the health system (in particular, health workers) (63). Efforts must also be made to ensure that services are youth friendly and integrated with comprehensive education about sexual and reproductive health.

- *Maternal health:* MDG-5 remains the MDG most off-track (61). Although maternal mortality has declined impressively during the past two decades, we can do better. A focus, again, on human resources is critical—skilled birth attendance, facility-based delivery, and emergency obstetric care being the most important gaps of all. Postpartum care has to focus not only on the newborn but also on the mother. Missed opportunities in postpartum care include the provision of reproductive health services such as family planning, cervical cancer screening, screening for HIV and sexually transmitted infections, and nutrition. Scaling up midwifery services and facility-based care will also have enormous benefits, not only for mothers, but for newborns too.

- *Stillbirths:* 2.6 million stillbirths occur each year, 98% of which take place in low and middle income countries, and over half of which take place in rural areas (64). Although rates of stillbirth are falling, they are falling more slowly than those for mothers and children. Most of the major causes of stillbirths are avoidable—complications of childbirth, maternal infections, maternal diseases (eg, hypertension), and maternal undernutrition. Provision of emergency obstetric care alone would have the biggest impact on reducing stillbirth rates.

- *Newborn health:* Over 3 million newborn children die each year, largely from preventable causes. Complications of preterm birth cause over 1 million of those deaths and these preterm births are increasing (65,66). Over the past decade, the rate of reduction of newborn mortality has increased but has not kept pace with reductions in maternal or under-5 mortality (67). Aid directed towards newborn deaths has been hard to track. What we do know is that aid targeted exclusively at newborns is extremely small (67). Rapid scale up of interventions in the preconception period, during pregnancy and birth, and for the premature baby after birth could quickly accelerate progress towards MDG-4.

- *Child health:* The latest cause of death analyses for under-5s again show the priorities that need to be addressed: pneumonia (1.1 million deaths), diarrhoea (0.8 million deaths), and malaria (0.6 million deaths) (12). UNICEF has embraced these new data to make a compelling case for more concerted action (68). An

integrated global action plan for scaling up diarrhoea and pneumonia interventions needs to be fast-tracked and implemented as a matter of urgency.

- *Adolescent health.* Adolescents are often neglected by health systems geared more towards adults and children. The reproductive and sexual health needs of adolescents are especially important because of their lifelong implications. Providers need training to respond in non-judgemental ways and create friendly environments where adolescents are neither stigmatised nor discriminated against. Proper attention to adolescents requires a multisectoral approach: schools need to provide sexuality education and school clinics can greatly enhance access to services. Young people should be engaged meaningfully into decision-making bodies responsible for the policies and programmes that affect them.

- *Innovative approaches to scaling up coverage.* Here, we point to five opportunities that deserve more serious scrutiny. First, *equity-focused policies* for child survival not only accelerate progress to MDG-4 but also do so in a cost-effective way (69). Second, *community mobilisation* is both a serious bottleneck if absent (70) and a powerful intervention if present (71,72) to reduce newborn mortality, yet community initiatives—eg, supporting women's groups—receive little or no serious donor support. Third, *integration of services.* One of the biggest opportunities for integration is linkage of programmes for women's and children's health with those for HIV/AIDS. The most obvious connection is through PMTCT services (73) and related HIV programmes (74). In important ways, the AIDS community created our modern concept of global health. The AIDS community could once again, in partnership with advocates for women's and children's health, redefine the direction of global health towards a more integrated future. But there are other connections too—through vaccination programmes (75) or schooling (76), for example. Fourth, the *media* are crucial, yet too often forgotten, partners in disseminating health messages to the public and in holding institutions accountable for improving the health of citizens. And finally, *poverty alleviation.* Measures, such as conditional cash transfers, must be increasingly focused on the health and nutrition issues of poor families.

80. *Accelerate the uptake and evaluation of eHealth and mHealth technologies.* ICT has transformed the world's ability to store and communicate information (77). Although barriers exist—not least, low participation, few trained staff, and limited opportunities for data sharing—the potential of digital technology to accelerate improvement in women's and children's health is great (78,79). The iERG sees particular opportunities in linking the Commission's recommendation 3 to recommendation 1—namely, the use of ICT to support the strengthening of country civil registration and vital statistics systems (80). There has been a steep increase in numbers of pilot projects of ICT in strengthening health and health information systems. But the strong message from these early and preliminary studies is that evaluations of their impact are often weak or non-existent, funding is fragile, and there is frequently inadequate support for the adoption and implementation of new technologies (81-83). We urge partners to assist countries with the development and implementation of national eHealth plans (aligned with country needs), to focus on sustainable long-term investment in eHealth, to encourage coordination between providers, and to support evaluation.

81. *Strengthen human rights tools and frameworks to achieve better health and accountability for women and children.* There is a view, expressed by the former High Commissioner for Human Rights, Mary Robinson, for example, that the rights of women are under direct attack from conservative forces and institutions seeking to roll-back the progress of recent decades (84). Yet human-rights based approaches to the health of adolescents, women, and children have a crucial part to play in the delivery of the Global Strategy, and especially in enhancing accountability (37). The Commission put human rights at the centre of its accountability framework, as do we. A human rights lens focuses attention on inequalities, discriminatory practices, and unjust power relations, all of which can adversely affect health. This rights-based approach sets the objective of attaining the highest level of health for adolescents, women, and children. For children, for example, this goal is enshrined in the UN Convention on the Rights of the Child. But a human-rights based approach provides not only a goal but also a process to progressively reach that goal. In 2011, the Committee on the Elimination of Discrimination against Women became the first UN human rights body to state that countries have an obligation to guarantee, and take responsibility for, women's timely and non-discriminatory access to maternal health services. This judgment has been described as a "landmark decision" with "global significance" for women's health (85). It shows how international remedies can be sought and won when national mechanisms fail. From the iERG's perspective, the decision marks an important turning point in strengthening accountability for women's health. In addition, human rights law has established (through General Comment 14) that the right to health means the availability, accessibility, acceptability, and quality of health care as well as tackling the underlying determinants of health. Adolescents, women, and children have a right to participate in decisions about their health, which means education, information

sharing, and freedom of association. They have a right to equality and non-discrimination. And they have a right to hold states accountable for the healthcare they provide. In 2012, UNHCHR issued technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality (86). This guidance will assist policymakers in strengthening women's health and reducing maternal mortality. Its robust implementation will be an important tool to reach MDG-5. We recommend that better ways be found to measure the performance of priority countries—ie, to strengthen their accountability—by the standards set out not only in this latest technical guidance but also in other human rights instruments that affect the health of women and children. Specifically, we recommend that the treaty bodies that interface with health—the Committee on Economic, Social, and Cultural Rights; the Committee on the Elimination of Discrimination Against Women; the Committee on the Elimination of Racial Discrimination; the Committee on the Rights of the Child; and the Committee on the Rights of Persons with Disabilities—routinely incorporate the health of women and children, where appropriate, into their work. The goal must surely be to transform the role of women in society, not only delivering health services that meet women's and children's expectations (87), but also strengthening the autonomy of women in society as an important aspect of their reproductive health (88).

82. ***Expand the commitment and capacity to evaluate initiatives for women's and children's health.***
Evaluation is a key component of accountability. The importance of evaluation in global health programmes has been strongly endorsed by WHO (89). In an era of multiple initiatives across different domains, there are huge challenges to the conventional means of conducting evaluations. Some critics argue that "traditional [evaluation] designs...are no longer relevant at a time when many programmes are being scaled up in virtually every district in the world" (90). In 2012, WHO led an initiative to establish a global research network to support the Global Strategy for Women's and Children's Health. The network is focused on securing adequate and equitable investments for research and research capacity building, generating a reliable evidence base to inform practice and policy, and ensuring that the outputs of research are leading to measurable improvements in health outcomes for women and children. It will engage in advocacy, technical support, and coordination. However, there are several obstacles to ensuring that evaluation lies at the heart of implementing the Global Strategy. First, a lack of human, technical, and financial capacity to conduct evaluations, especially for women and children in hard-to-reach areas. Second, a lack of capacity to prioritise evaluations in countries. Third, a lack of evidence about implementation itself. And fourth, a disconnect between policymakers and those conducting evaluations. We therefore welcome the collaboration between USAID and NIH to establish a new grant programme called Partnerships for Enhanced Engagement in Research (PEER). This initiative was launched after the June, 2012, Child Survival Call to Action and aims to provide funding to address research-to-practice barriers. (The International Initiative for Impact Evaluation [3ie] is another example of the commitment to learn from experience. Based in Cairo, 3ie's mission is to advance development effectiveness by supporting the generation and use of evidence from rigorous impact studies). The iERG recommends that partners accelerate their work to establish a global research network to support the Global Strategy. Without reliable evidence, openly and freely accessible, to inform what works for women and children (and what does not), results will fall short of expectations, and resources will be wasted. We also urge all research funders to consider investing more into women's and children's health. Research itself can be a powerful accountability tool, measuring progress and identifying weaknesses in global and country efforts to improve health (91). We see evaluation—the relentless pursuit of results—becoming one of the foundations of effective independent accountability.

8. Brazil, Peru: upholding a woman's human right to health

The Committee on the Elimination of Discrimination against Women has taken the lead among treaty bodies in considering cases of violations of women's human right to health. The Committee is charged with overseeing States parties' implementation of their obligations under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Adopted on 18 December, 1979, CEDAW is an international agreement that affirms the principles of fundamental human rights and equality for women around the world. It has been ratified by 187 countries.

The Committee reviews periodic reports from State parties and makes recommendations highlighting areas where more progress is needed. But there is an important additional mechanism that can be used by individuals and groups to hold countries to account for violations of rights protected under the Convention *(1)*. This complaints procedure is known as the Optional Protocol to CEDAW.

In August, 2011, the Committee became the first international human rights body to determine that governments have a duty to prevent avoidable maternal deaths. The historic ruling involved the case of Alyne da Silva Pimentel, a Brazilian woman of African descent who died in 2002 after a local health centre in Rio de Janeiro misdiagnosed her symptoms and delayed providing her with emergency obstetric care. The Committee found that the Brazilian government had violated the Convention and the 28-year-old woman's rights to life, health care, and legal redress. In addition to recommending that Brazil provide reparation, including monetary compensation, to Alyne's family, the Committee urged the government to ensure that all women in the country have access to affordable and adequate emergency obstetric care, as well as to judicial remedies. It also concluded that the government should better regulate private healthcare institutions to ensure they too comply with national and international standards in reproductive healthcare. Importantly, the decision makes it clear to all governments that they have a human rights obligation to ensure that all women—regardless of income or racial background—have access to timely, non-discriminatory, and appropriate reproductive and maternal health services *(2,3)*.

Another example of a landmark ruling came in November, 2011, in the case of L.C. v Peru. The Committee found that several articles of the Convention were violated when the welfare of the foetus was prioritised over the mother's *(4)*. L.C. attempted suicide after she became pregnant at age 13 as a result of sexual abuse, was refused surgery for her spinal injuries due to pregnancy resulting from the abuse, and was unable to obtain a therapeutic abortion. The Committee recommended the Peruvian government provide adequate compensation to L.C., who is paralyzed and needs constant care, and (i) review its laws with a view to establishing a mechanism for effective access to therapeutic abortion under conditions that protect women's physical and mental health; (ii) take measures to ensure that reproductive rights are known and observed in all healthcare facilities; (iii) review its legislation with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse; and (iv) review its restrictive interpretation of therapeutic abortion.

These two examples show that the Committee's recommendations extend far beyond reparation to individual women whose human rights have been breached; its more general recommendations are intended to improve women's access to essential health services and to strengthen national and international accountability *(3)*.

Sources

1. Cusack S. Mechanisms for Advancing Women's Human Rights: A Guide to Using the Optional Protocol to CEDAW and Other International Complaint Mechanisms. Australian Human Rights Commission, 2011.
2. Bueno de Mesquita J, Kismödi E. Maternal mortality and human rights: landmark decision by United Nations human rights body. *Bulletin of the World Health Organization* 2012;90:79-79A. doi: 10.2471/BLT.11.101410. Available from: www.who.int/bulletin/volumes/90/2/11-101410/en/index.html [accessed on 31 July 2012]
3. Views. Communication No. 17/2008. Committee on the Elimination of Discrimination against Women, forty-ninth session, 11 to 29 July 2011. New York: CEDAW; 2011. Available from: http://www2.ohchr.org/english/law/docs/CEDAW-C-49-D-17-2008.pdf [accessed on 31 July 2012]
4. Views. Communication No. 22/2009. Committee on the Elimination of Discrimination against Women, fiftieth session, 3 to 21 October 2011. New York: CEDAW; 2011. Available from: http://www2.ohchr.org/english/law/docs/CEDAW-C-50-D-22-2009_en.pdf [accessed on 31 July 2012]

CONCLUSION

83. This report is the first of four up to and including the MDG target date of 2015. Its origin lies in the UN Secretary-General's Global Strategy for Women's and Children's Health, *Every Woman, Every Child,* and the Commission on Information and Accountability for Women's and Children's Health. The Global Strategy has triggered unprecedented energy and activity around reproductive, maternal, newborn, and child health. 220 individual commitments have been made to the Global Strategy. Considerable new investment has been pledged. The fact that these milestones have been achieved in just two years is remarkable. But the test of the Global Strategy's impact lies not in promises, but in results. As yet, it is too early to say whether the Global Strategy has accelerated progress in improving women's and children's health in the 75 countries where most maternal and child deaths take place.

84. Part of the difficulty in assessing progress is agreeing criteria by which to judge country results. Different methods yield different mortality estimates, and different criteria for deciding whether a country is on track (or not) produce different judgements. These diverging assessments are confusing for national and global accountability. We urge all parties responsible for deriving estimates of, and drawing conclusions about, maternal, newborn, and child mortality to come together, with country experts, to agree on methodologies to assess which countries are (or are not) on track to meet the MDGs.

85. What an impartial review of existing commitments to the Global Strategy does show are considerable weaknesses in the enabling environment needed to turn promises into results. There are serious gaps in political leadership, financing flows, human resource capacities, coverage of key interventions, technical support from partners, intersectoral responses, and efforts to protect the most vulnerable groups of women, children, and youth, especially the girl child, in society. Unless these broader issues are addressed urgently, not only will the MDGs for women and children not be met, but also the gains that have been made will not be protected and secured for the future.

86. The Commission on Information and Accountability set four goals for 2012—on health indicators, country compacts, national oversight, and reporting aid. On health indicators, especially with respect to health outcomes in the bottom quintile of the income distribution, there is a lack of reliable evidence to be sure that countries are making progress. Worse, what evidence we do have suggests that whatever the overall coverage of interventions, there are deep inequities that affect many countries. On country compacts, fewer than half of 75 priority countries have a compact in place—that is, a written commitment between a government and its development partners, which sets out how they will work together to improve health outcomes. Even where compacts have been agreed, we have no reliable data to show how these compacts have led to strengthened actions for women and children. A similar situation exists for national oversight. For too many countries there is simply no information to show what national oversight mechanisms, when in place, are achieving. More positively, OECD-DAC has agreed a new global reporting mechanism for RMNCH financial flows, which will begin in 2014. While we would have wished for a more urgent response from OECD-DAC (beginning tracking aid for women and children in 2013), this result is an important step forward. That said, even the improved reporting system will remain highly subjective, as well as being unable to hold donors accountable for frequently stated objectives about targeting aid to the poor. The iERG recognises that better performance by donors on accountability for the level of their aid, together with the coverage of interventions and impacts on recipient countries, will require additional resources. Donors with a particular concern about accountability may wish to invest in a higher standard for themselves in the expectation that others will follow.

87. The remaining recommendations of the Commission have to be delivered in future years. But given the failure by many countries, both partner and donor, as well as national and international stakeholders, to meet 3 out of the first 5 recommendations on time, we have serious concerns about the likelihood of achieving the Commission's other recommendations on schedule. On vital events reporting, use of information and communication technology, resource tracking and review of health spending in countries, and transparency, there are indications that insufficient action is being taken.

88. To address these shortfalls, we make 6 recommendations that we believe would put countries committed to *Every Woman, Every Child* on track for success—a global governance and investment framework; clearer country-specific strategic priority setting for implementing the Global Strategy; acceleration of the uptake and evaluation of eHealth and mHealth technologies in the hands of adequately trained health workers; strengthened human rights tools to improve accountability for women's and children's health in countries; and an expansion of the commitment to independently evaluate programmes and initiatives in women's and children's health, including the extent to which donor commitments, financial and programmatic, have been met, and met on time.

89. The grounds for moving fast to implement our recommendations are strong. Evidence is gradually growing to show that investing in adolescent's,

women's, and children's health has important economic as well as health returns. Investment in health and welfare, for example, has the potential to increase female participation in the labour market, with resultant powerful effects on economic growth. Studies of countries that have enrolled more women into the workforce (eg, Norway) show a hitherto hidden economic dividend of women to the economy. Governments have a key role in stimulating high levels of female workforce participation. This emerging evidence should give confidence to Ministries of Finance to invest in adolescents, women, and children for long-term economic prosperity.

90. Our recommendations are not being made in a static political or scientific environment. The past 12 months have seen many new initiatives launched to accelerate progress towards improving women's and children's health—a Child Survival Call to Action, the London Summit on Family Planning, renewed emphasis on diarrhoea and pneumonia as preventable causes of child mortality, and the UN Commission on Life-Saving Commodities for Women and Children. While welcome, these flourishing projects need a means of coordination to avoid unnecessary duplication. We have been encouraged by the responses from two key initiatives launched in 2012. First, the Child Survival Call to Action, *A Promise Renewed,* is seeking collaboration with the iERG to track country mechanisms to accelerate the rate of reduction of child mortality. The lead partners of *A Promise Renewed,* UNICEF and USAID, have called on governments to make strategic shifts in their programming to reach those mothers and children who are most underserved with interventions that are known to work. To do so, UNICEF and USAID have asked countries to sharpen their plans and to track progress towards 5-year milestones (the first being the MDG target). Subsequently, new targets will be set by each country from 2020 to 2035. UNICEF, USAID, and WHO are providing the technical support to countries to help governments achieve these targets. The goal is that each country with high rates of child mortality must work to reach a target of 20 under-5 deaths per 1000 livebirths by 2035. Second, the London Summit on Family Planning's extensive plans for monitoring and accountability raised concerns about duplication and inefficiency. But the UK's Department for International Development and the Bill and Melinda Gates Foundation have contacted the iERG to identify how national and global reporting and accountability mechanisms can be linked.

91. More subtle, but still important, trends are also discernible. First, accountability is an increasingly important force in global health. G8 and G20 leaders have ever more strongly committed themselves to holding one another accountable for their promises. And countries are devising their own accountability scorecards to measure progress (eg, the Africa Child Survival Scorecard, launched by the Africa Public Health Information Service in 2012). Second, the continuum of care spanning reproductive to child health has expanded to include the health of adolescents. Adolescents are too often omitted from debates about MDGs 4 and 5, and mistakenly so. One in 8 births in low-income settings are in girls aged 15-19 years old (92). In sub-Saharan Africa, girls aged 15-19 years account for a quarter of unsafe abortions. Adolescents need to be brought into the mainstream of women's and children's health. Third, measures of health system performance are becoming more prominent in judging the progress of women's and children's health, reflecting an understanding that commodities alone cannot deliver results. Technologies only fulfil their potential if they are delivered within effective and efficient health systems, systems that are concerned about health financing, the quality of the information on which decisions are made, the availability and quality of health workers, and equity, among other dimensions of health system performance (93). Fourth, the role of civil society activism and community mobilisation is increasingly being recognised as an important determinant of progress towards MDGs 4 and 5 (94,95). Fifth, the greater engagement of health professionals in advocacy for adolescents, women, and children has the potential to add considerable political force to accelerate action. One such example is the Global Health Policy Summit, launched in 2012, which set out to create a global community of health reformers, including around maternal health (96). Sixth, the academic community has emerged as a powerful accountability mechanism in its own right, although the results of research need to be brought together through an agreed mechanism for those findings to be channeled and amplified to policymakers. One example is the measurement of trends in stunting and underweight, and progress towards MDG 1 (91). In 2011, 314 million children under 5 were stunted and 258 million were underweight. Based on trends between 1990 and 2011, the chances of the lowest-income countries achieving the MDG-1 target—halving the proportion of people who suffer from hunger, measured as the prevalence of underweight in children under 5—is low. And finally, the concentration of preventable maternal and child death in Africa has elicited stronger efforts by African leaders, their regional organisations, and the global community to draw further attention to Africa's urgent needs. In July, 2012, the African Union published a roadmap to chart a new course against AIDS, tuberculosis, and malaria, based on health governance, diversified financing, and access to medicines. Effective national accountability mechanisms were a core part of the African Union plan. These accountability mechanisms would be strengthened still further if more accurate sub-national

(district) data became the norm for judging progress, instead of often crude national estimates. The use of district data is a powerful means to reveal otherwise hidden disparities (97).

92. Beyond these broadly positive trends, together with the concerns we raised in Chapter 3, we do have reservations about the environment for women's and children's health in the future. Awareness of *Every Woman, Every Child* is strong among countries. But the recommendations of the Commission on Information and Accountability have received far less attention and seem to be much less well known. Yet the Commission's recommendations are crucial to accelerate progress towards meeting the objectives of the Global Strategy. All partners supporting *Every Woman, Every Child* need to do more to make policymakers, parliamentarians, and political leaders aware of the Commission's work. We are also conscious that, in the words of one witness with direct experience of working with countries on the Commission's findings, "The word accountability makes [countries] nervous and we will have to be very careful in the engagement around the accountability framework." Again, all partners to the Global Strategy need to do more to show that accountability is not a stick with which to beat countries (or anyone else). Accountability is a practical means to a larger end—the improvement in adolescent's, women's, and children's health.

93. We also note one additional concern that has been brought to our attention—namely, the responsiveness of multilateral agencies to the need for normative guidance to countries. One example we are aware of concerns WHO and UNICEF's guidance on monitoring and evaluating prevention of mother-to-child transmission of HIV. A preliminary version of this guidance was disseminated at the 2010 international AIDS conference, held in Vienna (98). The document was a product of a monitoring and evaluation working group of the inter-agency task team on the prevention of HIV infection among pregnant women, mothers, and their children. The early draft was printed specifically for the Vienna meeting and an updated version was promised for September, 2010. As of August, 2012, that guidance has still not been published. A new version of the guidance was, we understand, ready in January, 2012, and is soon to be cleared by the responsible agencies for release in September, 2012. It seems that no-one has been able to hold either WHO or UNICEF accountable to a deadline for publishing this critical guidance. This will mean it has taken over 2 years to go from a printed draft to a final published document. On the positive side, the draft document has been widely disseminated to, and used by, countries. In addition, with the launch of the "Global Plan for the Elimination of Paediatric HIV Infections and Keeping Mothers Alive", the inter-agency task team working group did publish guidance on monitoring and measuring the impact of PMTCT. Nevertheless, if countries are to accelerate their efforts to improve women's and children's health, the bureaucratic obstacles that prevent guidance to countries from being finalised, published, disseminated, and implemented as a matter of urgency have to be addressed more directly by the leadership of these agencies.

94. In addition to the importance of delivering normative guidance in a timely way, financial donors need to be clear about the extent to which stated financial commitments are being met. We have not found this core element of donor accountability to be consistently in place. We plan to return to this subject more fully in subsequent years. There are disturbing suggestions that at least some donors are falling behind in their financial commitments.

95. This is the first report of the iERG. Inevitably, it takes time for any new accountability mechanism to find its place with partners in the complex global architecture that governs women's and children's health today. We have been fortunate to have had the help of many groups in gathering evidence for our report, and we wish to record our thanks for their advice and assistance. These collaborations have revealed challenges too, which are material to any assessment of the Global Strategy. PMNCH has played an invaluable part in gathering critical data to inform judgments about progress towards MDGs 4 and 5. But PMNCH needs additional help to obtain a true understanding about how commitments are tied to specific actions and results. The H4+ has a vital role in implementing the Global Strategy. But we were struck by the weakness of its own assessment of progress and needs in implementing commitments to the Global Strategy. WHO is the lead agency implementing the Commission on Information and Accountability. The agency has led the rapid roll-out of regional workshops to catalyse action on both the Commission and Global Strategy. The result is that WHO is in a difficult position—it has an inherent competing interest—when making judgments about progress towards the goals of the Commission. While its interpretations are often optimistic, a harder look at the available evidence reveals more fragile reasons to be hopeful. When one puts these observations together, what seems clear is that countries should not expect the UN system, or its partner bodies, to deliver the Global Strategy without much greater and sustained investment to do so, including committed investment to ensure reliable, comprehensive, and independent measurement of progress.

96. The iERG has itself learned lessons about the way it conducts its work. In future, we will be more engaged with partners delivering the Global Strategy

to understand how implementation is being achieved in countries and how those achievements are being measured. We will work more closely with partners to devise an effective indicator framework for measuring progress on the Commission's recommendations. We are considering whether the iERG needs additional members to bring special expertise in specific areas, such as economics and human rights. We are considering the technical support the iERG might need to assist its work in the future. Finally, we will be working with parnters to ensure that the iERG is financially viable to 2015.

97. As we conclude our report, we are fully conscious that mechanisms are already underway to plan the post-MDG period. The Secretary-General's High-Level Panel of Eminent Persons on the Post-2015 Development Agenda was recently appointed. Co-chaired by President Susilo Yudhoyono (Indonesia), President Ellen Johnson Sirleaf (Liberia), and Prime Minister David Cameron (UK), the Panel will present its report in the second quarter of 2013. One feature of a likely future focus on sustainable development post-2015 will be a renewed attention to universal predicaments—climate change, energy, and population, among others. For women and children, our focus on 75 priority countries might therefore exist in tension with this global and universal vision. But the predicaments facing adolescents, women, and children are global problems requiring global solutions. We will only make lasting progress if we understand this truth: the interdependence of all human beings, one with another, the literal and correct meaning of *Every Woman, Every Child*.

REFERENCES

1. The Bellagio Study Group on Child Survival. Knowledge into action for Child Survival. *Lancet* 2003; 362: 323-27.
2. Rosenfield A, Maine D, Freedman L. Meeting MDG-5: an impossible dream? *Lancet* 2006; 368: 1133-34.
3. Countdown to 2015. Tracking Progress in Child Survival: the 2005 Report. UNICEF, 2005.
4. Greco G, Powell-Jackson T, Borghi J, Mills A. Countdown to 2015: assessment of donor assistance to maternal, newborn, and child health between 2003 and 2006. *Lancet* 2008; 371: 1268-75.
5. Byass P, Ghebreyesus TA. Making the world's children count. *Lancet* 2005; 365: 1114-16.
6. Stoltenberg J. Our children: the key to our common future. *Lancet* 2006; 368: 1042-44.
7. *Every Woman, Every Child*. Global Strategy for Women's and Children's Health. UN, 2010.
8. Commission on Information and Accountability for Women's and Children's Health. Keeping Promises, Measuring Results. WHO, 2011.
9. Lozano R, Wang H, Foreman KJ et al. Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. *Lancet* 2011; 378: 1139-65.
10. The Interagency Group for Child Mortality Estimation (IGME). Estimates of under-five mortality rates by country, the 2011 release. www.childmortality.org.
11. WHO. World Health Statistics 2012. WHO, 2012.
12. Liu L, Johnson HL, Cousens S et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. *Lancet* 2012; 379: 2151-61.
13. Countdown to 2015. Accountability for Maternal, Newborn, and Child Survival: an update on progress in priority countries. WHO, 2012.
14. Barros AJD, Ronsmans C, Axelson H, et al. Equity in maternal, newborn, and child health interventions in Countdown to 2015: a retrospective review of survey data from 54 countries. *Lancet* 2012; 379: 1225-33.
15. Countdown to 2015. Building a future for women and children. WHO, 2012.
16. PMNCH. Analysing Commitments to advance the Global Strategy for Women's and Children's Health: the PMNCH 2011 Report. PMNCH, 2011.
17. Forouzanfar MH, Foreman KJ, Delosantos AM et al. Breast and cervical cancer in 187 countries between 1980 and 2010: a systematic analysis. *Lancet* 2011; 378: 1461-84.
18. Oddo VM, Rah JH, Semba RD et al. Predictors of maternal and child double burden of malnutrition in rural Indonesia and Bangladesh. *Am J Clin Nutr* 2012; 95: 951-58.
19. Cortina MA, Sodha A, Fazel M, Ramchandani PG. Prevalence of child mental health problems in sub-Saharan Africa. *Arch Pediatr Adolesc Med* 2012; 166: 276-81.
20. Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases. September 19, 2011.
21. The World Health Report. Health systems financing: the path to universal coverage. WHO, 2010.
22. Hosseinpoor AR, Victora C, Bergen N, Barros AJD, Boerma T. Towards universal health coverage: the role of within-country wealth-related inequality in 28 countries in sub-Saharan Africa. *Bull WHO* 2011; 89: 881-90.
23. UN Commission on Life-Saving Commodities for Women and Children. UN, 2012.
24. Glass R, Guttmacher AE, Black RE. Ending preventable child death in a generation. *JAMA* 2012; 308: 141-42.
25. Carr B, Gates MF, Mitchell A, Shah R. Giving women the power to plan their families. *Lancet* 2012; July 10: 4-6.
26. Rio+20. United Nations Conference on Sustainable Development. The Future We Want. June 19, 2012.
27. Health Metrics Network. Monitoring maternal, newborn, and child health: understanding key progress indicators. WHO, 2011.
28. Crowe S, Utley M, Costello A, Pagel C. How many births in sub-Saharan Africa and South Asia will not be attended by a skilled birth attendant between 2011 and 2015? *BMC Pregnancy and Childbirth* 2012; 12: 4.
29. UNFPA. State of the World's Midwifery. UNFPA, 2011.
30. Abimbola S, Okoli U, Olubajo O, et al. The Midwives Service Scheme in Nigeria. *PLoS Medicine* 2012; 9: e1001211.
31. Srofenyoh E, Ivester T, Engmann C, et al. Advancing obstetric and neonatal care in a regional hospital in Ghana via continuous quality improvement. *Int J Gynecol Obstet* 2012; 116: 17-21.
32. World Development Report. Conflict, Security, and Development. World Bank, 2011.
33. Ahmed T, Mahfuz M, Ireen S, et al. Nutrition of children and women in Bangladesh: trends and directions for the future. *J Health Popul Nutr* 2012; 30: 1-11.
34. Save the Children. A Life Free From Hunger. Save the Children, 2012.
35. Save the Children. Nutrition in the First 1000 Days. Save the Children, 2012.
36. Commission on Social Determinants of Health. Closing the Gap in a Generation: Health equity through action on the social determinants of health. WHO, 2008.
37. Cottingham J, Germain A, Hunt P. Use of human rights to meet the unmet need for family planning. *Lancet* 2012; 380: 172-80.
38. Osorio A, Burgo CL, Carlos S, et al. First sexual intercourse and subsequent regret in three developing countries. *J Adolesc Health* 2012; 50: 271-78.

39. Kayibanda JF, Bitera R, Alary M. Violence toward women, men's sexual risk factors, and HIV infection among women: findings from a national household survey in Rwanda. *JAIDS* 2012; 59: 300-07.
40. Sipsma HL, Chen PG, Ofori-Atta A, et al. *Bull WHO* 2012; 90: 120-27.
41. Singh L, Rai RK, Singh PK. Assessing the utilisation of maternal and child health among married adolescent women: evidence from India. *J Biosoc* Sci 2011; 44: 1-26.
42. Gender in Nigeria Report, 2012.
43. Patton GC, Coffey C, Cappa, et al. Health of the world's adolescents: a synthesis of internationally comparable data. *Lancet* 2012; 379: 1665-75.
44. Sedgh G, Singh S, Shah IH, et al. Induced abortion: incidence and trends worldwide from 1995 to 2008. *Lancet* 2012; 379: 625-32.
45. Ahman E, Shah IH. New estimates and trends regarding unsafe abortion mortality. *Int J Gynecol Obstet* 2011; 115: 121-26.
46. Stockl H, Filippi V, Watts C, Mbwambo JKK. Induced abortion, pregnancy loss, and intimate partner violence in Tanzania: a population based study. *BMC Pregnancy and Childbirth* 2012; 12: 12.
47. Bendavid E, Avila P, Miller G. United States aid policy and induced abortion in sub-Saharan Africa. *Bull WHO* 2011; 89: 873-80.
48. WHO. Safe abortion: technical and policy guidance for health systems (second edition). WHO, 2012.
49. UNHCR. A Year of Crises: Global trends, 2011. UNHCR, 2012.
50. Mateen F, Carone M, Al-Saedy H, et al. Medical conditions among Iraqi refugees in Jordan: data from the UN Refugee Assistance Information System. *Bull WHO* 2012; 90: 444-51.
51. Rahim HFA, Wick L, Halileh S, et al. Maternal and child health in the occupied Palestinian territory. *Lancet* 2009; 373: 967-77.
52. UNICEF/WHO. Progress on Drinking Water and Sanitation: 2012 update. UNICEF/WHO, 2012.
53. Cheng JJ, Schuster-Wallace CJ, Watt S, Newbold BK, Mente A. An ecological quantification of the relationships between water, sanitation, and infant, child, and maternal mortality. *Environmental Health* 2012; 11: 4.
54. UNICEF. Children in an Urban World: the State of the World's Children 2012. UNICEF, 2012.
55. Gakidou E, Cowling K, Lozano R, Murray CJL. Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis. *Lancet* 2010; 376: 959-74.
56. Ruger JP. Global health governance as shared health governance. *J Epidemiol Community Health* 2012; 66: 653-61.
57. Gostin LO. A framework convention on global health. *JAMA* 2012; 307: 2087-92.
58. Costello A, Osrin D. The case for a new Global Fund for maternal, neonatal, and child survival. *Lancet* 2005; 366: 603-05.
59. Leach-Kemon K, Chou DP, Schneider MT, et al. The global financial crisis has led to a slowdown in growth of funding to improve health in many developing countries. *Health Affairs* 2012; 31: 1-8.
60. Schwartlander B, Stover J, Hallett T, et al. Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet* 2011; 377: 2031-41.
61. UN Millennium Development Goals Report 2012. UN, 2012.
62. Chico RM, Mayaud P, Ariti C, et al. Prevalence of malaria and sexually transmitted and reproductive tract infections in pregnancy in sub-Saharan Africa. *JAMA* 2012; 307: 2079-86.
63. WHO. Universal access to reproductive health. WHO, 2011.
64. Lawn JC, Blencowe H, Pattinson R, et al. Stillbirths: Where? When? Why? How to make the data count? *Lancet* 2011; 377: 1448-63.
65. Blencowe H, Cousens S, Oestergaard MZ, et al. National, regional, and worldwide estimates of preterm birth rates in the year 2010 with time trends since 1990 for selected countries: a systematic analysis and implications. *Lancet* 2012: 379: 2162-72.
66. Born Too Soon: the Global Action Report on Preterm Birth. WHO, 2012.
67. Lawn JE, Kinney MV, Black RE, et al. Newborn survival: a multi-country analysis of a decade of change. *Health Policy Planning* 2012; 27: iii6-iii28.
68. Pneumonia and Diarrhoea: Tackling the Deadliest Diseases for the World's Poorest Children. UNICEF, 2012.
69. Corden CC, Azrak A, Begkoyian G, et al. Modelling and equity-focused approach to child survival, health, and nutrition. *Lancet* 2012 (in press).
70. Agrawal PK, Agrawal S, Ahmed S, et al. Effect of knowledge of community health workers on essential newborn care: a study from rural India. *Health Policy Planning* 2012; 27: 115-26.
71. Wilford R, Golden K, Walker DG. Cost-effectiveness of community-based management of acute malnutrition in Malawi. *Health Policy Planning* 2012; 27: 127-37.
72. Nahar T, Azad K, Aumon BH, et al. Scaling up community mobilisation through women's groups for maternal and neonatal health: experiences from rural Bangladesh. *BMC Pregnancy and Childbirth* 2012; 12: 5.
73. Van den Akker T, Bemelmans M, Ford N, et al. HIV care need not hamper maternity care: a descriptive analysis of integration of services in rural Malawi. *BJOG* 2012; 119: 431-38.
74. Winestone LE, Bukusi EA, Cohen CR, et al. Acceptability and feasibility of integration of HIV care services into antenatal clinics in rural Kenya. *Global Public Health* 2012; 7: 149-63.
75. Ryman TK, Wallace A, Mihigo R, et al. Community

and health worker perceptions and preferences regarding integration of other health services with routine vaccinations. *JID* 2012; 205 (S1): 49-55.
76. Baird SJ, Garfein RS, McIntosh CT, Ozler B. Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial. *Lancet* 2012; 379: 1320-29.
77. Hilbert M, Lopez P. The world's technological capacity to store, communicate, and compute information. *Science* 2011; 332: 60-65.
78. Lang T. Advancing global health research through digital technology and sharing data. *Science* 2011; 331: 714-17.
79. Seidenberg P, Nicholson S, Schaefer M, et al. Early infant diagnosis of HIV infection in Zambia through mobile phone texting of blood test results. *Bull WHO* 2012; 90: 348-56.
80. Lewis T, Synowiec C, Lagomarsino G, Schweitzer J. E-health in low and middle income countries: findings from the Center for Health Market Innovations. *Bull WHO* 2012; 90: 332-40.
81. Worton R, Geissbuhler A, Jethwani K, et al. Long-running telemedicine networks delivering humanitarian services: experience, performance, and scientific output. *Bull WHO* 2012; 90: 341-47.
82. Mair FS, May C, O'Donnell, et al. Factors that promote or inhibit the implementation of e-health systems: an explanatory systematic review. *Bull WHO* 2012; 90: 357-64.
83. Piette JD, Lun KC, Moura LA, et al. Impacts of e-health on the outcomes of care in low and middle income countries: where do we go from here? *Bull WHO* 2012; 90: 365-72.
84. Martinson J. World leaders accused of rolling back women's rights. *The Guardian* July 6, 2012: 15.
85. Bueno de Mesquita J, Kismodi E. Maternal mortality and human rights: landmark decision by United Nations human rights body. *Bull WHO* 2012; 90: 79.
86. UN Human Rights Council. Technical guidance on the application of a human-rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality. UNGA, July 2, 2012.
87. Ith P, Dawson A, Homer CSE. Women's perspective of maternity care in Cambodia. *Women and Birth* 2012; doi 10.1016.
88. Haque SE, Rahman M, Mostofa G, Zahan S. Reproductive health care utilisation among young mothers in Bangladesh. *Women's Health Issues* 2012; 22: e171-180.
89. WHO. The WHO Strategy on Research for Health. WHO, 2012.
90. Victora CG, Black RE, Boerma JT, Bryce J. Measuring impact in the Millennium Development Goal era and beyond: a new approach to large-scale effectiveness evaluations. *Lancet* 2011; 377: 85-95.
91. Stevens GA, Finucane MM, Paciorek CJ, et al. Trends in mild, moderate, and severe stunting and underweight, and progress towards MDG1 in 141 developing countries: a systematic analysis of population representative data. *Lancet* 2012; July 5.
92. Sawyer SM, Afifi KA, Bearinger LH et al. Adolescence: a foundation for future health. *Lancet* 2012; 379: 1630-40.
93. Howitt P, Darzi A, Yang GZ et al. Technologies for global health. *Lancet* 2012; 380: 507-35.
94. Ray S, Madzimbamuto F, Fonn S. Activism: working to reduce maternal mortality through civil society and health professional alliances in sub-Saharan Africa. Reproductive Health Matters 2012; 20: 40-49.
95. Women's Lives, Women's Voices. Empowering women to ensure family planning coverage, quality, and equity. Care International, 2012.
96. Arulkumaran S for the Maternal Health Working Group. Saving Mothers' Lives: Transforming Strategy into Action. The Global Health Policy Summit, 2012.
97. Ezzati M, Friedman AB, Kulkarni SC, Murray CJL. The reversal of fortunes: trends in county mortality and cross-county mortality disparities in the United States. PLoS Medicine 2008; 5: e66.
98. WHO, UNICEF. Monitoring and evaluating the prevention of mother-to-child transmission of HIV: a guide for national programmes. Preliminary version for AIDS 2010. WHO, UNICEF, 2010.

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ANNEXES

Annex 1: Evidence submitted to the iERG

In alphabetical order

Bill & Melinda Gates Foundation
1. Report on the recommendations

Canadian Network for Maternal, Newborn and Child Health
2. Global Mapping Exercise of Canadian Maternal, Newborn and Child Health Initiatives

Center for Reproductive Rights
3. Good practices for ensuring accountability for women's reproductive health

Development Media International
4. Mass media: evidence base

Ghana Health Service
5. Addressing gaps in service delivery using burden of disease interventions in reducing maternal and under five mortality to achieve the millennium development goals.
6. Mobile Technology for Community health in Ghana
7. Improving access to quality maternal and child health service an initiative of the Ghana health service and the Grameen foundation

International Committee for Monitoring Assisted Reproductive Technologies
8. Assisted Reproductive Technology

IPAS
9. Report on successes in achieving UN Global Strategy for Women's and Children's Health – September 2012

Marie Stopes International
10. RAISE overview
11. Using mobile finance to reimburse sexual and reproductive health vouchers in Madagascar
12. Voucher factsheet
13. Reproductive health in emergencies
14. Using evidence-based marketing activities to increase demand for safe and legal abortion services in Mexico City

MOMS Appeal
15. Using ICT to involve and improve communication for small community based organisations in relation to women and children's health

Organisation Mondiale des Associations pour l'Education Prénatale
16. Présentation OMAEP
17. Présentation des activités
18. Natural Prenatal Education: Foundation for Human Rights

Pathfinder International
19. Building Public Capacity to Hold Private Providers Accountable - Pathfinder International's Experience Improving Quality of Abortion Care in Viet Nam

The Wellbeing Foundation
20. Presentation of the Personal Health Record (PHR)
21. Report on the use of IMNCH PHR

University of Aberdeen
22. Identifying practices and ideas to improve the implementation of maternal mortality reduction programmes: findings from five South Asian countries

University of Sheffield
23. Letter to the iERG: recognition and treatment of infertility

Women's Health and Rights Advocacy Partnership - South Asia
24. WHRAP-SA position on implementing a rights based continuum of quality care approach to sexual and reproductive health in South-Asia
25. Prevalence of uterine prolapse amongst gynecology OPD Patients in Tribhuvan University teaching hospital in Nepal and its socio-cultural determinants
26. Investigating barriers to achieving safe motherhood in Pakistan

White Ribbon Alliance
27. Respectful maternity care: the universal rights of childbearing women
28. National Accountability for delivery
29. Letter to Mrs. Joy Phumaphi and Dr. Richard Horton, Co-Chairs, Independent Expert Review Group

Submitted evidence is available at:
http://www.who.int/woman_child_accountability/ierg/reports/evidence_submissions/en/index.html

Annex 2: Evidence commissioned by the iERG

UNSG
A data driven review of progress in implementation of the UN Global Strategy

PMNCH
A review of stakeholder commitments to the UN Global Strategy and of the extent to which those commitments have been delivered
A review of good practices and obstacles to accountability for RMNCH

Countdown to 2015
A summary of findings on use and quality of the 11 core indicators under Recommendation 2

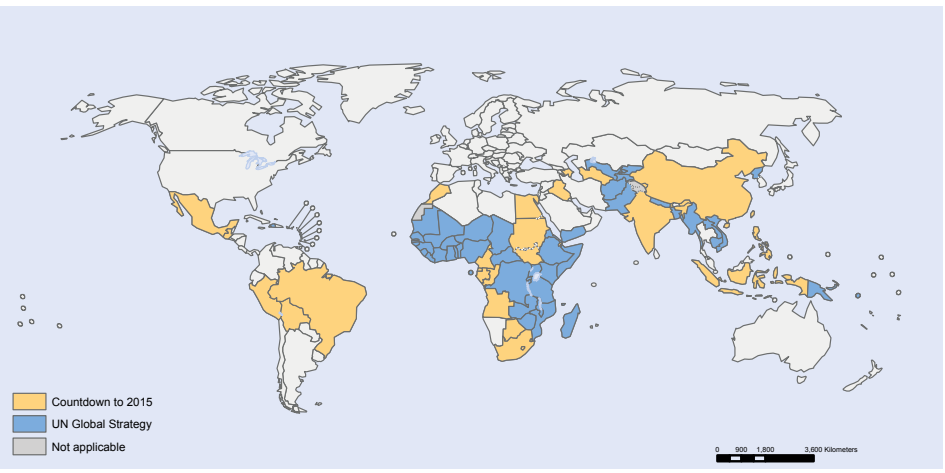
WHO
Translating Recommendations into Action: first progress report on implementation of recommendations November 2011 – June 2012

H4+
Mapping of Progress and Needs in Implementation of Country Commitments to UN Global Strategy to Improve Women's and Children's Health

Annex 3: The 75 countries with 98% of the world's maternal and child mortality

The global oversight covers 75 developing countries. As stated in the Strategic Workplan, these include 49 countries in the UN Global Strategy and 26 additional countries in the Countdown to 2015 (marked with *). The countries are grouped according to WHO regional classification[1].

The 75 countries with 98% of the world's maternal and child mortality



African Region (AFRO)

Angola*	Chad	Ethiopia	Lesotho*	Niger	South Africa*
Benin	Comoros	Gabon*	Liberia	Nigeria	Swaziland*
Botswana*	Congo*	The Gambia	Madagascar	Rwanda	Togo
Burkitna Faso	Côte d'Ivoire	Ghana	Malawi	Sao Tome and Principe	Uganda
Burundi	Democratic Republic of the Congo	Guinea	Mali	Senegal	United Republic of Tanzania
Cameroon*	Equatorial Guinea*	Guinea-Bissau	Mauritania	Sierra Leone	Zambia
Central African Republic	Eritrea	Kenya	Mozambique		Zimbabwe

Region of the Americas (AMRO)

Bolivia*	Brazil*	Guatemala*	Haiti	Mexico*	Peru*

Eastern Mediterranean Region (EMRO)

Afghanistan	Egypt*	Morocco*	Somalia	Sudan*	
Djibouti*	Iraq*	Pakistan	South Sudan*	Yemen	

European Region (EURO)

Azerbaijan*	Kyrgyzstan	Tajikistan	Turkmenistan*	Uzbekistan	

South-East Asia Region (SEARO)

Bangladesh	DPR Korea	India*	Indonesia*	Myanmar	Nepal

Western Pacific Region (WPRO)

Cambodia	Lao PDR	Philippines*	Viet Nam
China*	Papua New Guinea	Solomon Islands	

[1] The six regions into which WHO placed the countries of the world are based on geography, tempered or distempered by politics, and not on stages of development. Every region of the World Health Organization contains examples of countries at all degrees of development and no region is homogeneous in its races, religions, political or cultural organization, not in its resources, its industrial development, its trained manpower; not its diseases and health problems.

Annex 4: Core indicators for monitoring country progress in implementing the Commission's recommendations

Recommendation	Indicator name	Proposed indicator and target	Comments
1. Vital events and HIS	**Birth registration**	At least 75% of births registered	Actual birth registration coverage rate will be available for each country
	Death registration	At least 60% of deaths registered	Actual death registration coverage rate will be available for each country
	Maternal death reviews	At least 90% of maternal deaths notified and reviewed	Additional indicator could be % of countries in which maternal death is a notifiable event
	CRVS improvement	CRVS improvement plan approved by country government in place	This involves a systematic CRVS assessment and the development of a comprehensive multi-sectoral plan
2. Health indicators	**Coverage indicators**	Statistics for 8 coverage indicators are available for at least one of the two preceding years, disaggregated by equity stratifiers	The data may be derived from surveys or facility data, and are disaggregated by sex, wealth and district where possible; information will be gathered by indicator; reliability will be assessed; facility data will be available annual, survey data 2-3 times every 5 years
	Impact indicators	Data for the 3 impact indicators are available based on data collected in the preceding three years, disaggregated by equity stratifiers	The data may be based on surveys, census or registration systems, and are disaggregated by sex, wealth and district where possible; mortality data are usually collected in retrospective surveys
3. Innovation and eHealth	**eHealth strategy**	National eHealth strategy and plan is in place	These plans need to be comprehensive and cover all relevant health data sources
	Web based reporting	All districts are part of a national web based system to report health data and receive feedback	One country led system is operational, reporting facility and administrative data, forming the basis for good and rapid analysis and transparency
4. Resource tracking	**Total health Expenditure**	Total health expenditure per capita was tracked during the two preceding years, by financing source	To track data on both preceding years are required
	RMNCH expenditure	RMNCH expenditure per capita is tracked during the two preceding years, by financing source	To track data on both preceding years are required; the indicator refers to government and external sources
5. Country "compacts"	**Financial reporting system**	A country-led reporting system is in place for externally funded expenditure and predictable commitments	These include "Compacts", or similar mechanisms, which should be part of broader compacts between external partners and recipient countries on the health sector

Recommendation	Indicator name	Proposed indicator and target	Comments
6. Capacity to review health spending	**Reviews of health spending**	Annual reviews are conducted of health spending from all financial sources, including spending on RMNCH, as part of broader health sector reviews	This indicator focuses on the country capacity to conduct these analytical reviews
7. National oversight	**Reviews of performance**	The country has conducted a comprehensive review of health progress and performance in the last year	Involvement of civil society, parliamentarians, development partners, and other sectors; a report of the review is public; review includes review of resources /expenditures and results
8. Transparency	**Performance report public**	A health sector performance report for the preceding year is available in the public domain	Meets quality standards: data quality assessment, access to underlying data, equity, includes MNCH resources and results
	Global partners transparency	% of global partners that are publicly sharing information on commitments, resources provided, and results achieved	This indicator is based on a web-based review of main international agencies, bilateral donors, partnerships, foundations, etc.
9. Reporting Aid for MNCH	**OECD CRS**	External partners report annually to OECD-DAC their commitments and disbursements on health, with the components on RMNCH clearly identified	
10. Global oversight	**iERG - global strategy**	iERG has reported to the UNSG on results and resources related to the Global Strategy	Requires review of country and partner commitments to the Global Strategy
	iERG - accountability	iERG has reported to the UNSG on progress in implementing the Commission's recommendations	

Annex 5: Country progress towards Millennium Development Goals 4 and 5

Countries and territories	Under-five mortality rate					Maternal mortality ratio, modelled				
	Deaths per 1 000 live births			Average annual rate of reduction (%)	Assessment of progress[a]	Deaths per 100 000 live births			Average annual rate of reduction (%)	Assessment of progress[b]
	1990	2000	2010	1990–2010		1990	2000	2010	1990–2010	
Afghanistan	209	151	149	1.7	Insufficient progress	1 300	1 000	460	5.1	Making progress
Angola	243	200	161	2.1	Insufficient progress	1 200	890	450	4.7	Making progress
Azerbaijan	93	67	46	3.5	Insufficient progress	56	65	43	1.3	Insufficient progress
Bangladesh	143	86	48	5.5	On track	800	400	240	5.9	On track
Benin	178	143	115	2.2	Insufficient progress	770	530	350	3.9	Making progress
Bolivia (Plurinational State of)	121	82	54	4.0	On track	450	280	190	4.1	Making progress
Botswana	59	96	48	1.0	Insufficient progress	140	350	160	–0.7	No progress
Brazil	59	36	19	5.7	On track	120	81	56	3.5	Making progress
Burkina Faso	205	191	176	0.8	No progress	700	450	300	4.1	Making progress
Burundi	183	164	142	1.3	Insufficient progress	1 100	1 000	800	1.5	Insufficient progress
Cambodia	121	103	51	4.3	On track	830	510	250	5.8	On track
Cameroon	137	148	136	0.0	No progress	670	730	690	–0.2	No progress
Central African Republic	165	176	159	0.2	No progress	930	1 000	890	0.2	Insufficient progress
Chad	207	190	173	0.9	No progress	920	1 100	1 100	–0.7	No progress
China	48	33	18	4.9	On track	120	61	37	5.9	On track
Comoros	125	104	86	1.9	Insufficient progress	440	340	280	2.2	Making progress
Congo	116	104	93	1.1	Insufficient progress	420	540	560	–1.5	No progress
Congo. Democratic Republic	181	181	170	0.3	No progress	930	770	540	2.7	Making progress
Côte d'Ivoire	151	148	123	1.0	Insufficient progress	710	590	400	2.8	Making progress
Djibouti	123	106	91	1.5	Insufficient progress	290	290	200	1.9	Insufficient progress
Egypt	94	47	22	7.3	On track	230	100	66	6.0	On track
Equatorial Guinea	190	152	121	2.3	Insufficient progress	1 200	450	240	7.9	On track
Eritrea	141	93	61	4.2	On track	880	390	240	6.3	On track
Ethiopia	184	141	106	2.8	Insufficient progress	950	700	350	4.9	Making progress
Gabon	93	88	74	1.1	Insufficient progress	270	270	230	0.8	Insufficient progress
Gambia	165	128	98	2.6	Insufficient progress	700	520	360	3.4	Making progress
Ghana	122	99	74	2.5	Insufficient progress	580	550	350	2.6	Making progress
Guatemala	78	49	32	4.5	On track	160	130	120	1.5	Insufficient progress
Guinea	229	175	130	2.8	Insufficient progress	1 200	970	610	3.4	Making progress
Guinea-Bissau	210	177	150	1.7	Insufficient progress	1 100	970	790	1.7	Insufficient progress
Haiti	151	109	165	–0.4	No progress	620	460	350	2.7	Making progress
India	115	86	63	3.0	Insufficient progress	600	390	200	5.2	Making progress
Indonesia	85	54	35	4.4	On track	600	340	220	4.9	Making progress
Iraq	46	43	39	0.8	On track	89	78	63	1.7	Insufficient progress
Kenya	99	111	85	0.8	No progress	400	490	360	0.5	Insufficient progress
Korea. Democratic People's Republic	45	58	33	1.6	On track	97	120	81	0.9	Insufficient progress
Kyrgyzstan	72	52	38	3.2	On track	73	82	71	0.2	Insufficient progress
Lao People's Democratic Republic	145	88	54	4.9	On track	1 600	870	470	5.9	On track
Lesotho	89	127	85	0.2	No progress	520	690	620	–0.9	No progress
Liberia	227	169	103	4.0	On track	1 200	1 300	770	2.4	Making progress
Madagascar	159	102	62	4.7	On track	640	400	240	4.7	Making progress
Malawi	222	167	92	4.4	On track	1 100	840	460	4.4	Making progress
Mali	255	213	178	1.8	Insufficient progress	1 100	740	540	3.5	Making progress
Mauritania	124	116	111	0.6	No progress	760	630	510	2.0	Making progress
Mexico	49	29	17	5.3	On track	92	82	50	3.0	Making progress
Morocco	86	55	36	4.4	On track	300	170	100	5.1	Making progress
Mozambique	219	177	135	2.4	Insufficient progress	910	710	490	3.1	Making progress
Myanmar	112	87	66	2.6	Insufficient progress	520	300	200	4.8	Making progress

Countries and territories	Under-five mortality rate					Maternal mortality ratio, modelled				
	Deaths per 1 000 live births			Average annual rate of reduction (%)	Assessment of progress[a]	Deaths per 100 000 live births			Average annual rate of reduction (%)	Assessment of progress[b]
	1990	2000	2010	1990–2010		1990	2000	2010	1990–2010	
Nepal	141	84	50	5.2	On track	770	360	170	7.3	On track
Niger	311	218	143	3.9	Insufficient progress	1 200	870	590	3.6	Making progress
Nigeria	213	186	143	2.0	Insufficient progress	1 100	970	630	2.6	Making progress
Pakistan	124	101	87	1.8	Insufficient progress	490	380	260	3.0	Making progress
Papua New Guinea	90	74	61	1.9	Insufficient progress	390	310	230	2.6	Making progress
Peru	78	41	19	7.1	On track	200	120	67	5.2	Making progress
Philippines	59	40	29	3.6	On track	170	120	99	2.8	Making progress
Rwanda	163	177	91	2.9	Insufficient progress	910	840	340	4.9	Making progress
São Tomé and Príncipe	94	87	80	0.8	No progress	150	110	70	3.8	Making progress
Senegal	139	119	75	3.1	Insufficient progress	670	500	370	3.0	Making progress
Sierra Leone	276	233	174	2.3	Insufficient progress	1 300	1 300	890	1.8	Insufficient progress
Solomon Islands	45	35	27	2.6	On track	150	120	93	2.2	Making progress
Somalia	180	180	180	0.0	No progress	890	1 000	1 000	–0.7	No progress
South Africa	60	78	57	0.3	No progress	250	330	300	–0.9	No progress
Sudan[c]	125	114	103	1.0	Insufficient progress	1 000	870	730	1.6	Insufficient progress
Swaziland	96	114	78	1.0	Insufficient progress	300	360	320	–0.3	No progress
Tajikistan	116	93	63	3.1	Insufficient progress	94	120	65	1.8	Insufficient progress
Tanzania. United Republic of	155	130	76	3.6	Insufficient progress	870	730	460	3.2	Making progress
Togo	147	124	103	1.8	Insufficient progress	620	440	300	3.5	Making progress
Turkmenistan	98	74	56	2.8	Insufficient progress	82	91	67	1.0	Insufficient progress
Uganda	175	144	99	2.8	Insufficient progress	600	530	310	3.2	Making progress
Uzbekistan	77	63	52	2.0	Insufficient progress	59	33	28	3.7	Making progress
Viet Nam	51	35	23	4.0	On track	240	100	59	6.9	On track
Yemen	128	100	77	2.5	Insufficient progress	610	380	200	5.3	Making progress
Zambia	183	157	111	2.5	Insufficient progress	470	540	440	0.4	Insufficient progress
Zimbabwe	78	115	80	–0.1	No progress	450	640	570	–1.2	No progress

a. "On track" indicates that the under-five mortality rate for 2010 is less than 40 deaths per 1 000 live births or that it is 40 or more with an average annual rate of reduction of 4% or higher for 1990–2010; "insufficient progress" indicates that the under-five mortality rate for 2010 is 40 deaths per 1 000 live births or more with an average annual rate of reduction of 1%–3.9% for 1990–2010; "no progress" indicates that the under-five mortality rate for 2010 is 40 deaths per 1 000 live births or more with an average annual rate of reduction of less than 1% for 1990–2010.

b. "On track" indicates that the average annual rate of reduction of the maternal mortality ratio for 1990–2010 is 5.5% or more; "making progress" indicates that the average annual rate of reduction of the maternal mortality ratio for 1990–2010 is between 2% and 5.5%; "insufficient progress" indicates that the average annual rate of reduction of the maternal mortality ratio for 1990–2010 is less than 2%; "no progress" indicates that the average annual rate of reduction of the maternal mortality ratio for 1990–2010 is negative—that is, that the maternal mortality ratio has increased. Countries with a maternal mortality ratio below 100 deaths per 100 000 live births in 1990 are not categorized by the Maternal Mortality Estimation Inter-agency Group. *Countdown to 2015* calculated the assessment of progress for *Countdown* countries that fall into this group.

c. Data refer to Sudan as it was constituted in 2010, before South Sudan seceded. Data for South Sudan and Sudan as separate states are not available.

Annex 6: Country data by 2012 priority recommendation (next page)

Data availability for Recommendations 2, 5 and 7 of the Commission on Information and Accountability for Women's and Children's Health (see page 24, paragraph 38)

Country	Recommendation 2						
	Impact Indicators (Year of most recent data available)			Coverage Indicators (Year of most recent data available)			
	Maternal mortality ratio (MMR) [a]	Under-five child mortality [a]	Children under five who are stunted [b]	Met need for contraception [c]	Antenatal care (four or more visits) [d]	Antiretroviral for HIV-positive pregnant women to reduce MTCT [e]	Skilled attendant at birth [d]
Afghanistan	2010	2010	2004	-	2010	2010	2010
Angola	-	2009	2007	-	2008-2009	2010	2008-2009
Azerbaijan	2008	2006	2006	2006	2006	2010	2006
Bangladesh	2010	2009	2007	2007	2010	2010	2012
Benin	2006	2006	2006	2006	2006	2010	2006
Bolivia (Plurinational State of)	2008	2008	2008	2008	2008	2010	2008
Botswana	2011	2007	2008	-	2007	2010	2007
Brazil	2006	2009	2007	2006	2009	2010	2009
Burkina Faso	2010	2006	2010	2003	2003	2010	2010
Burundi	2010	2010	2010	2002	-	2010	2010
Cambodia	2010	2010	2011	2010	2010	2010	2010
Cameroon	2004	2004	2011	2006	2004	2010	2011
Central African Republic	2006	2006	2006	2006	-	2010	2009
Chad	2004	2010	2010	2004	2010	2010	2010
China	2009	2009	2010	2006	-	2010	2009
Comoros	2000	2000	2000	2000	-	2010	2010
Congo	2005	2005	2005	2005	2005	2010	2005
Côte d'Ivoire	2005	2005	2007	2006	2005	2010	2006
Democratic People's Republic of Korea	2008	-	2009	-	2009	-	2009
Democratic Republic of the Congo	-	2010	2010	2007	2010	2010	2010
Djibouti	-	2006	2010	-	2002	2010	2006
Egypt	2010	2008	2008	2008	2008	2010	2008
Equatorial Guinea	-	-	2004	-	-	2010	2000
Eritrea	-	2002	2002	2002	2002	2010	2002
Ethiopia	2011	2005	2011	2005	2011	2010	2011
Gabon	2000	2001	2001	2000	2000	2010	2000
The Gambia	-	2006	2006	-	-	2010	2006
Ghana	2007	2008	2008	2008	2008	2010	2008
Guatemala	2008	2008	2009	2002	-	2010	2009
Guinea	2005	2003	2008	2005	2007	2010	2007
Guinea-Bissau	-	2010	2010	-	2010	2010	2010
Haiti	2006	2005	2006	2006	2006	2010	2006
India	2009	2009	2006	2006	2008	2010	2009
Indonesia	2007	2007	2007	2007	2007	2010	2009
Iraq	2007	2006	2006	-	-	2010	2007
Kenya	2009	2008	2009	2009	2009	2010	2009
Kyrgyzstan	2006	2006	2006	2006	-	2010	2008
Lao People's Democratic Republic	2005	2005	2006	2005	-	2010	2010
Lesotho	2009	2009	2010	2010	2009	2010	2009

Most recent survey/data are from the preceding three years (2011, 2010 or 2009)
Most recent survey/data are from preceding four to five years (2008 or 2007)
Most recent survey/data date from six to 12 years (2000-2006)
\- No recent data later than 2000 or information available at the time of the review

Country	Recommendation 2 Coverage Indicators (Year of most recent data available)				Recommendation 5	Recommendation 7
	Postnatal care for mothers [d h]	Exclusive breastfeeding for first six months [d]	DTP-3 immunization among 1-year olds [f]	Antibiotic treatment for child pneumonia [d g]	A country-led reporting system is in place for externally funded expenditure and predictable commitments [i]	The country has conducted an annual health sector review in the last year [j]
Afghanistan	2010	-	2011	-	No	Yes
Angola	-	2001	2011	-	Yes	Yes
Azerbaijan	2006	2006	2011	-	No	No
Bangladesh	2010	2007	2011	2006	Yes	-
Benin	2006	2006	2011	-	Yes	Yes
Bolivia (Plurinational State of)	2008	2008	2011	2008	No	-
Botswana	-	-	2011	-	No	-
Brazil	-	2007	2011	-	No	-
Burkina Faso	2003	2009	2011	2006	Yes	Yes
Burundi	-	2010	2011	2005	Yes	Yes
Cambodia	2010	2010	2011	2010	No	Yes
Cameroon	2004	2011	2011	2006	No	Yes
Central African Republic	-	2006	2011	2006	No	No
Chad	2004	2010	2011	2010	Yes	No
China	-	2008	2011	-	Yes	Yes
Comoros	-	2000	2011	-	Yes	Yes
Congo	2005	2005	2011	-	No	No
Côte d'Ivoire	-	2006	2011	2006	No	No
Democratic People's Republic of Korea	-	2009	2011	2009	No	-
Democratic Republic of the Congo	2007	2010	2011	2010	Yes	Yes
Djibouti	2002	2006	2011	2006	No	No
Egypt	2008	2008	2011	2008	No	-
Equatorial Guinea	-	2000	2011	-	No	-
Eritrea	2002	2002	2011	-	No	-
Ethiopia	2005	2005	2011	2011	Yes	Yes
Gabon	2000	2001	2011	-	No	No
The Gambia	-	2010	2011	2006	No	-
Ghana	2008	2008	2011	2008	Yes	Yes
Guatemala	2009	2009	2011	-	No	-
Guinea	2007	2008	2011	-	No	No
Guinea-Bissau	-	2010	2011	2010	Yes	No
Haiti	2006	2006	2011	2006	No	-
India	2008	2006	2011	2006	No	-
Indonesia	2007	2008	2011	-	No	-
Iraq	-	2006	2011	2006	No	No
Kenya	2009	2009	2011	2009	Yes	Yes
Kyrgyzstan	-	2006	2011	2006	Yes	Yes
Lao People's Democratic Republic	-	2006	2011	2006	Yes	Yes
Lesotho	2009	2009	2011	-	Yes	-

Most recent survey/data are from the preceding three years (2011, 2010 or 2009)
Most recent survey/data are from preceding four to five years (2008 or 2007)
Most recent survey/data date from six to 12 years (2000-2006)
- No recent data later than 2000 or information available at the time of the review

Country	Recommendation 2						
	Impact Indicators (Year of most recent data available)			Coverage Indicators (Year of most recent data available)			
	Maternal mortality ratio (MMR) [a]	Under-five child mortality [a]	Children under five who are stunted [b]	Met need for contraception [c]	Antenatal care (four or more visits) [d]	Antiretroviral for HIV-positive pregnant women to reduce MTCT [e]	Skilled attendant at birth [d]
Liberia	2007	2009	2010	2007	2007	2010	2007
Madagascar	2009	2008	2009	2009	2009	2010	2009
Malawi	2010	2010	2010	2004	2010	2010	2010
Mali	2006	2006	2006	2006	2006	2010	2006
Mauritania	2007	2007	2010	2001	2001	2010	2007
Mexico	2009	2007	2006	2006	2009	2009	2009
Morocco	2010	2010	2011	2004	2004	2010	2010
Mozambique	2003	2008	2008	2004	2003	2010	2008
Myanmar	2005	2007	2010	2001	2007	2010	2010
Nepal	2009	2011	2011	2006	2011	2010	2011
Niger	2006	2010	2010	2006	2006	2010	2006
Nigeria	2008	2008	2008	2008	2008	2010	2008
Pakistan	2007	2006	2011	2007	2007	2010	2011
Papua New Guinea	2006	2006	2005	-	2008	2010	2008
Peru	2010	2010	2010	2009	2010	2010	2010
Philippines	2006	2008	2008	2008	2008	2010	2008
Rwanda	2010	2008	2011	2005	2010	2010	2010
Sao Tome and Principe	2009	2008	2009	2009	2009	2010	2009
Senegal	2011	2011	2011	2005	2011	2009	2011
Sierra Leone	2008	2008	2008	2008	2008	2010	2008
Solomon Islands	-	2007	2007	2007	2007	2010	2007
Somalia	2006	2006	2006	-	2006	2010	2006
South Africa	2007	2007	2008	2004	2008	2010	2003
South Sudan	2006	2010	2010	-	2010	-	2010
Sudan	2006	2010	2010	-	-	2010	2010
Swaziland	2007	2010	2010	2007	2010	2010	2010
Tajikistan	2005	2010	2007	-	2007	2010	2007
Togo	-	2010	2010	2010	2010	2010	2010
Turkmenistan	-	2006	2006	2000	2000	2010	2006
Uganda	2006	2009	2006	2006	2006	2010	2006
United Republic of Tanzania	2010	2010	2010	2010	2010	2010	2010
Uzbekistan	2006	2006	2006	2006	-	2009	2006
Viet Nam	2006	2008	2008	2002	2002	2010	2006
Yemen	2003	2006	2003	-	2003	2010	2006
Zambia	2007	2007	2007	2007	2007	2010	2007
Zimbabwe	2011	2009	2011	2006	2009	2010	2011
Disaggregation for equity (data can be disaggregated by wealth, gender, age, residence and geographical location)	Not available	Wealth, Gender, Age, Residence, Geographical location available	Wealth, Gender, Age, Residence, Geographical location available	Wealth, Age, Residence, Geographical location available	Not available as defined	Geographical location available	Wealth, Age, Residence, Geographical location available

Most recent survey/data are from the preceding three years (2011, 2010 or 2009)
Most recent survey/data are from preceding four to five years (2008 or 2007)
Most recent survey/data date from six to 12 years (2000-2006)
- No recent data later than 2000 or information available at the time of the review

Country	Recommendation 2 Coverage Indicators (Year of most recent data available)				Recommendation 5	Recommendation 7
	Postnatal care for mothers [d h]	Exclusive breastfeeding for first six months [d]	DTP-3 immunization among 1-year olds [f]	Antibiotic treatment for child pneumonia [d g]	A country-led reporting system is in place for externally funded expenditure and predictable commitments [i]	The country has conducted an annual health sector review in the last year [j]
Liberia	2007	2010	2011	2007	No	-
Madagascar	2009	2009	2011	-	Yes	Yes
Malawi	2010	2010	2011	-	Yes	Yes
Mali	2006	2007	2011	-	Yes	Yes
Mauritania	-	2010	2011	2007	Yes	Yes
Mexico	2009	-	2011	-	No	-
Morocco	2004	2007	2011	-	No	-
Mozambique	2003	2008	2011	-	Yes	Yes
Myanmar	-	2010	2011	2010	No	-
Nepal	2006	2006	2011	2011	Yes	Yes
Niger	2006	2010	2011	-	Yes	Yes
Nigeria	2008	2008	2011	2008	No	-
Pakistan	2007	2007	2011	2007	No	No
Papua New Guinea	-	2006	2011	-	Yes	Yes
Peru	2010	2010	2011	2010	No	-
Philippines	2008	2008	2011	2008	No	Yes
Rwanda	2005	2010	2011	2010	Yes	Yes
Sao Tome and Principe	2009	2009	2011	2009	No	No
Senegal	2005	2006	2011	-	Yes	Yes
Sierra Leone	2008	2008	2011	2008	Yes	Yes
Solomon Islands	2007	2007	2011	-	No	Yes
Somalia	-	2009	2011	2006	No	-
South Africa	-	2004	2011	-	No	-
South Sudan	-	2010	2011	2010	-	Yes
Sudan	-	2010	2011	2010	Yes	Yes
Swaziland	2007	2010	2011	2010	No	-
Tajikistan	-	2005	2011	2005	Yes	Yes
Togo	-	2010	2011	2010	Yes	Yes
Turkmenistan	2000	2006	2011	2006	No	-
Uganda	2006	2006	2011	2006	Yes	Yes
United Republic of Tanzania	2010	2010	2011	-	Yes	Yes
Uzbekistan	-	2006	2011	2006	Yes	-
Viet Nam	-	2006	2011	2006	Yes	Yes
Yemen	2003	2003	2011	2006	No	No
Zambia	2007	2007	2011	2007	Yes	Yes
Zimbabwe	2006	2011	2011	2009	No	Yes
Disaggregation for equity (data can be disaggregated by wealth, gender, age, residence and geographical location)	Not available as defined	Not available	Geographical location available	Not available	Not Applicable	Not Applicable

Most recent survey/data are from the preceding three years (2011, 2010 or 2009)
Most recent survey/data are from preceding four to five years (2008 or 2007)
Most recent survey/data date from six to 12 years (2000-2006)
- No recent data later than 2000 or information available at the time of the review

General note:
The table shows the status of data availability relating to the recommendations of the Commission on Information and Accountability for Women's and Children's Health, based on a desk review by WHO of publicly accessible databases, publications and country reports.

a. MMR and under-five mortality can be calculated from data collected through several methods including household surveys, disease surveillance systems, vital registration systems, verbal autopsies, censuses, or special studies. For the majority of middle and low- income countries, the main source of data indicated are based on household surveys including DHS, MICS and national surveys. For some countries, censuses or sample registration systems have been used as the latest reference year. Source: World Health Organization, United Nations Children's Fund, United Nations Population Fund and World Bank, Measure DHS, Countdown 2012 Report.
b. Data available from the Global Health Observatory, Global database on child growth and malnutrition (http://www.who.int/nutgrowthdb/database/en, August 2012) and Countdown to 2015: Building a Future for Women and Children, The 2012 Report.
c. Contraception refers to the usage of any method of contraception. Information on CPR and unmet need for family planning is collected through household surveys such as DHS, MICS, RHS, and national surveys based on similar methodologies. The surveys available from the 2011 Update for the MDG Database: Unmet Need for Family Planning (POP/DB/CP/B/MDG2011).
d. DHS, MICS and other national surveys from the World Health Statistics 2012 and Countdown to 2015: Building a Future for Women and Children, The 2012 Report.
e. PMTCT is calculated from national programme records aggregated from facility registers. Source: GLOBAL HIV/AIDS RESPONSE: Epidemic update and health sector progress towards Universal Access Progress report 2011. WHO/UNAIDS.
f. DTP3 estimates are derived from reports from health facilities of the numbers of children immunized on a monthly basis and WHO and UNICEF estimates of national routine immunization coverage. Source: WHO/UNICEF Joint Reporting Form and WHO Regional offices reports, July 2012 update.
g. Most recent survey year.
h. Includes postnatal care for babies.
i. Source: The WHO Country Planning database that is hosted by the IHP+ (http://www.nationalplanningcycles.org/) is the main source of data for this indicator along with the CAF tool (http://www.who.int/healthinfo/country_monitoring_evaluation/accountability/en/index.html).
j. Source: The WHO Country Planning database that is hosted by the IHP+ (http://www.nationalplanningcycles.org/) is the main source of data for this indicator along with the CAF tool (http://www.who.int/healthinfo/country_monitoring_evaluation/accountability/en/index.html).

Notes

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