2014

Every Woman, Every Child: A Post-2015 Vision

The Third Report of the independent Expert Review Group on Information and Accountability for Women's and Children's Health

iERG

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PREFACE

This year's report from the independent Expert Review Group on Information and Accountability comes at a vital moment in the history of global efforts to advance women's and children's health. So much progress has been made in reducing preventable mortality among women and children during the era of the Millennium Development Goals. These successes should be applauded. But how do we protect these gains and learn from the past to do even better in the future, a future that will be shaped by the broader idea of sustainable development? Providing an answer to this question lies at the centre of our 2014 report, *Every Woman, Every Child: A Post-2015 Vision*.

Our conclusion is that we must continue to make extraordinary commitments to accelerate achievements for women, newborns, children under-five, and adolescents. What kind of commitments do we propose? The remit of the iERG is accountability. We are a product of the 2011 Commission on Information and Accountability, led by the Governments of Tanzania and Canada. Therefore our recommendations are rooted in the belief that accountability—monitoring and reviewing the promises and commitments made by all partners, and ensuring that any shortfalls in meeting those promises and commitments are quickly remedied—is a crucial force for political and programmatic change.

Our recommendations for the post-2015 period are designed to create a robust strategic and financial platform to strengthen women's and children's health. We want to see concerted international action to scale up political and human rights commitments to women's and children's health. We want to see the voice of civil society enhanced in these deliberations. And finally, we want to ensure that independent accountability is an idea not only preserved but developed still further after the iERG ends its term of office in 2015. The UN Secretary-General's signature initiative, *Every Woman, Every Child*, has been a remarkably successful catalyst for promoting one of the most neglected domains in global health. We hope that our 2014 report can contribute to sustaining this success.

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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
AMHiN	Accountability for RMNCH in Nigeria
ANCs	Antenatal corticosteroids
CAF	Country Accountability Framework
CHAI	The Clinton Health Access Initiative
CIDA	The Canadian International Development Agency
CoIA	Commission on Information and Accountability for Women's and Children's Health
CRVS	Civil registration and vital statistics
CSO	Civil society organisations
DFID	The Department for International Development
DTP3	diphtheria-tetanus-pertussis
E4A	Evidence for Action
ERP	Expert Review Panel
EWEC	Every Woman, Every Child
FCI	Family Care International
FGM	Female genital mutilation/cutting
FP2020	Family Planning 2020
GAVI	The Global Alliance for Vaccines and Immunisation
GFATM	The Global Fund to Fight AIDS, TB, and Malaria
GIZ	German Society for International Cooperation
HEP	Health Extension Programme
HEWs	Health Extension Workers
HMIS	Health Management Information System
HNP	World Bank resources for health, nutrition, and population
HRH	Human resources for health
HRITF	The Health Results Innovations Trust Fund
IBRD	The International Bank for Reconstruction and Development
iCCM	Integrated community case management
ICPD	International Conference on Population and Development
ICT	Information and communication technology
IDA	The International Development Association
iERG	independent Expert Review Group
IGME	The Inter-agency Group for Child Mortality Estimation
IHME	Institute for Health Metrics and Evaluation
IHP+	International Health Partnership
JANS	Joint Assessment of National Strategies and Plans
LMIS	Logistics Management and Information System
LSC	Life-Saving Commodities
MCH	Maternal and child health
MDGs	Millennium Development Goals
MDSR	Maternal death surveillance and response
MgSO4	Magnesium sulfate
MMEIG	The Maternal Mortality Estimation Inter-Agency Group
MMR	Maternal mortality ratio
MoH	Ministry of Health
MTCT	Mother-to-child transmission
NCD	Non-communicable diseases
NiAM	The Nigerian Independent Accountability Mechanism
NORAD	The Norwegian Agency for Development Cooperation
NTDs	Neglected Tropical Diseases
OECD-DAC	Organisation for Economic Co-operation and Development – Development Assistance Committee
OHCHR	Office of the High Commissioner for Human Rights
ORS	Oral rehydration salts
PMNCH	Partnership for Maternal, Newborn, and Child Health
PPH	Post-partum haemorrhage
PQM	Programme to Qualify Maternity Services
RBF	Results-based financing
RMNCAH	Reproductive, maternal, newborn, child, and adolescent health
RMNCH	Reproductive, maternal, newborn, and child health
SDGs	Sustainable Development Goals
SHA	System of Health Accounts
TB	Tuberculosis
TRTs	Technical reference teams
UHC	Universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCoLSC	The UN Commission on Life-Saving Commodities for Women and Children
UNFPA	United Nations Population Fund
UNHCR	The UN High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNSD	UN Statistics Department
USAID	United States Agency for International Development
WHO	World Health Organization
WHO-EML	WHO essential medicines lists
WRAN	The White Ribbon Alliance Nigeria

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EXECUTIVE SUMMARY

The iERG's 2014 Recommendations: a Post-2015 Vision

1. Develop, secure wide political support for, and begin to implement a global plan during 2014-15 to end all preventable reproductive, maternal, newborn, child, and adolescent mortality for the 2016-2030 period—a new, broader, and more inclusive Global Strategy for Women's and Children's Health.

2. In 2015, create a results-based financing facility to support and sustain this new Global Strategy.

3. Between now and 2016, convene a Special Session of the UN General Assembly, led by the Secretary-General, to accelerate international collective action for women's and children's health—to align and harmonize the actions of partners, to promote leadership and stewardship, to ensure provision of global public goods, to manage externalities, and to provide direct country assistance.

4. In 2015, establish a Global Commission on the Health and Human Rights of Women and Children to propose ways to protect, augment, and sustain their health and wellbeing.

5. From 2015 onwards, hold a civil-society-led World Health Forum adjacent to the World Health Assembly to strengthen political accountability for women's and children's health.

6. In 2015, establish and fully resource a new Independent Expert Review Group to monitor, review, and propose actions to accelerate global and country progress towards improved women's and children's health during the period of the Sustainable Development Goals.

"Health should be at the centre of sustainable development", proclaimed Ban Ki-moon in May, 2014. He continued: "Accountability will be an important part of the new development agenda." The UN Secretary-General was speaking during the Government of Canada's Saving Every Woman, Every Child Summit, held in Toronto shortly after the World Health Assembly.

The Toronto meeting was an important milestone during a year of accelerated commitments to the future of women and children. This future is expressed most strongly in the Millennium Development Goals (MDGs), notably MDG-1c (on nutrition), MDG-4 (on child survival), and MDG-5 (on maternal, sexual, and reproductive health). But with the era of the MDGs rapidly drawing to a close, and with negotiations over the precise nature of the Sustainable Development Goals (SDGs) reaching their political climax, the opportunities for women and children (and the dangers too) between 2015 and 2030 are increasingly being debated. Those debates have been fuelled this past year by an unprecedented array of initiatives and promises.

The CoIA, chaired by Prime Minister Harper of Canada and Tanzania's President Jakaya Kikwete, was one of the most important follow-up initiatives after the launch of the UN Secretary-General's Global Strategy for Women's and Children's Health. The Commission was set up to "determine the most effective international institutional arrangements for global reporting, oversight, and accountability on women's and children's health". Its recommendations are shown in Appendix 1. The final CoIA recommendation was to create a time-limited independent Expert Review Group (iERG) to review progress on both the Global Strategy

and implementation of the CoIA recommendations. The 12 recommendations we made in our first two reports to strengthen progress towards both the Global Strategy and the goals of CoIA are shown in Appendix 2. These recommendations are designed to support the goals of *Every Woman, Every Child* and CoIA. In January, 2013, WHO's Executive Board requested the Director-General to provide support to the iERG so that it could also assess progress in the implementation of the recommendations of the UN Commission on Life-Saving Commodities for Women and Children.

Our 2014 report takes a broad scope in its review of progress towards the objectives of *Every Woman, Every Child* and fulfilment of the recommendations from CoIA. But our overriding goal this year is to present our own post-2015 vision—for the future of women's and children's health and for the future accountability arrangements needed to ensure that commitments to that vision are met. The process we have adopted for this year's iERG report is similar to that adopted for previous reports—invitations to key agencies and constituencies to submit evidence, stakeholder meetings and consultations, commissioning of country case studies, and an extensive review of all available published evidence. We introduced one innovation into this year's report—we completed two country visits (to Malawi and Peru) to focus on national oversight mechanisms as part of a robust accountability process for women and children. The purpose of each country visit was to assess the completeness, use, efficiency, and effectiveness of the national oversight mechanism. We see this type of country visit as a logical extension of the iERG's work on accountability—perhaps an example of the kind of strengthened accountability that might be adopted post-2015.

EVERY WOMAN, EVERY CHILD: THE FINAL APPROACH TO 2015

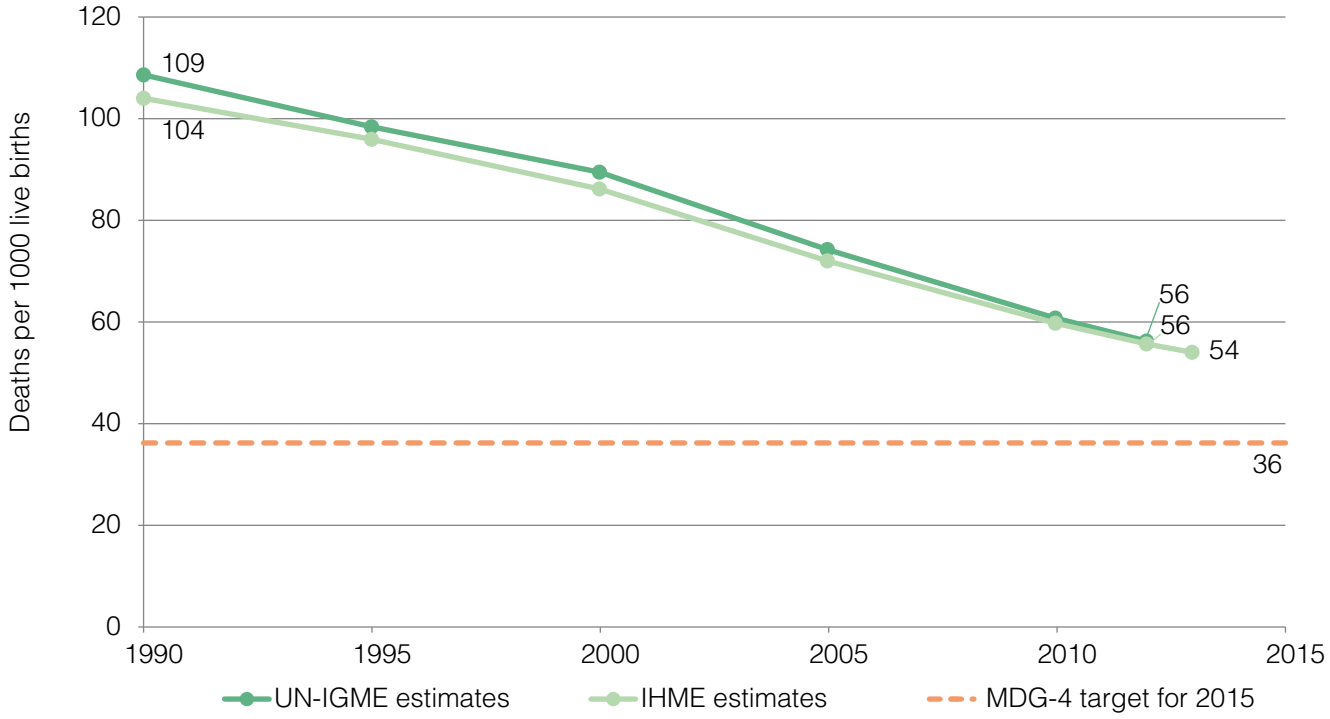
Seven countries of the iERG's 75 priority nations show concordance between the two major MDG estimation methods for reaching the MDG-4 target of reducing, by two-thirds, under-5 mortality between 1990 and 2015—Bangladesh, Brazil, China, Egypt, Liberia, Nepal, and Peru. A further 16 countries are identified by one or other method (from the UN or the Institute for Health Metrics and Evaluation) as being on target for MDG-4. For the African Region: Benin, Eritrea, Ethiopia, Madagascar, Malawi, Niger, Rwanda, Tanzania. For the South East Asian Region: Indonesia, Myanmar, Nepal. For the Americas: Bolivia, Mexico. For Europe: Azerbaijan, Kyrgyzstan. For the Western Pacific Region: Cambodia. An important driver of success has been improvements in maternal education. But, as Jennifer Bryce and colleagues noted in 2013, the key to further reductions in child mortality is "ruthless… prioritisation of quality delivery at scale for a small number of interventions that address the major causes of child deaths in their specific context." Overall progress towards MDG-4 for the iERG's 75 countries of concern is shown in the figure below.

MDG-5A is the reduction, by three-quarters, of the maternal mortality ratio by 2015. No countries are concordant on reaching this target, according to UN or IHME methods. The countries identified by one or other method include: Cambodia, China, Eritrea, Lao PDR, Morocco, and Rwanda.

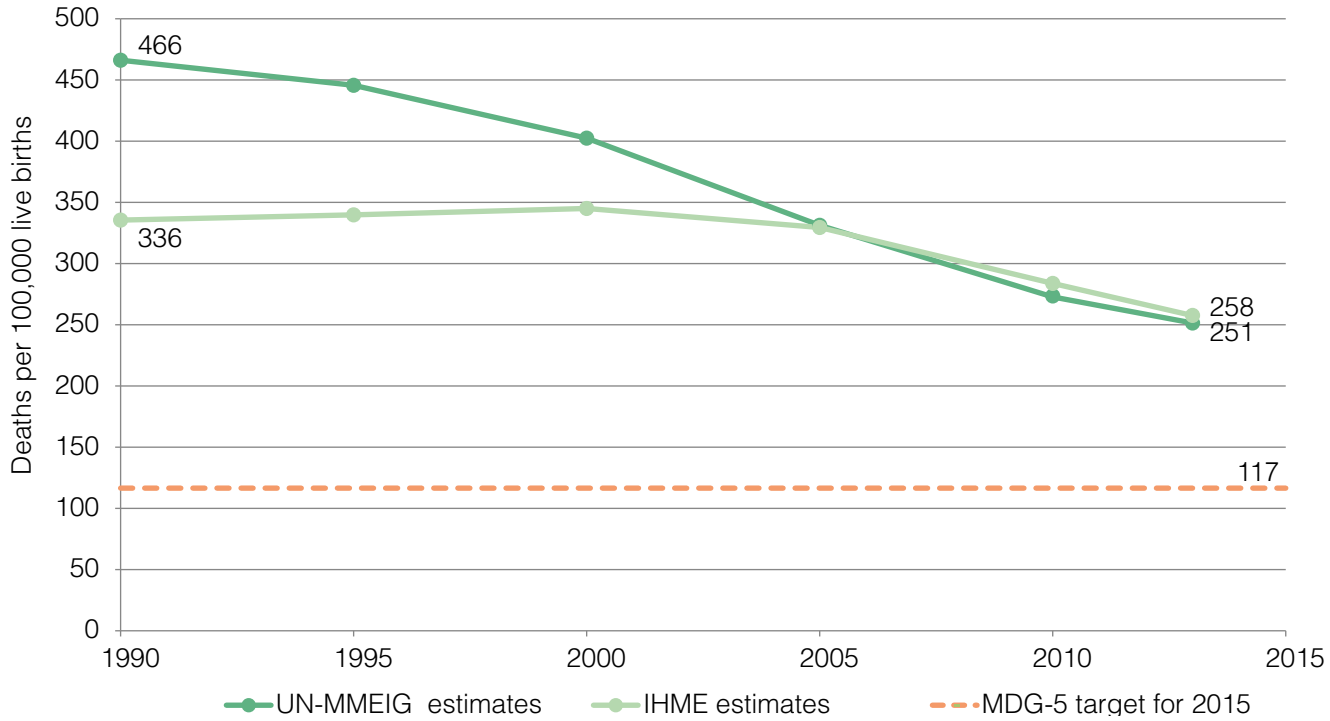
MDG-5B is universal access to reproductive health, measured by a range of indicators, such as contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and unmet need for family planning. There are substantial gaps across most iERG countries between their current status on these measures and the results target set for 2015 (see figure below).

Major and too often neglected priorities globally and in countries include: newborn mortality and stillbirths, sexual and reproductive health and rights, family planning, nutrition, the health workforce (especially midwives), women and children in zones of conflict, sexual violence, unsafe abortion, child marriage, and female genital mutilation.

Trends in under-5 mortality rate, 1990-2013 & MDG-4 target for the iERG's 75 countries of concern



Trends in maternal mortality ratio, 1990-2013 & MDG-5 target for the iERG's 75 countries of concern



THE COMMISSION ON INFORMATION AND ACCOUNTABILITY FOR WOMEN'S AND CHILDREN'S HEALTH: LEARNING FROM COUNTRIES

Summary of global progress on implementation of the recommendations from CoIA

Recommendation	Target year	2013	2014
Vital events	2015		
Health indicators	2012		
Innovation	2015		
Resource tracking	2015		
Country compacts	2012		
Reaching women and children	2015		
National oversight	2012		
Transparency	2013		
Reporting aid	2012		
Global oversight	2012		

The target will be difficult or impossible to achieve
Progress is being made, but continued and concerted effort is needed to achieve the target
The target is on track or has already been achieved

The key areas for recommendations from CoIA are shown in the figure above and Appendix 1. Since our 2013 report, we have seen substantial advances in meeting the goals and targets set by the Commission. 6 of the 9 goals have been upgraded in their progress. Our full report reviews progress in all of these domains, as well as the responses to the iERG's twelve recommendations from our earlier 2012 and 2013 reports.

2014 is the first year the iERG visited countries with the objective of understanding more about their progress towards meeting the recommendations of CoIA. iERG teams visited Peru and Malawi, and the complete reports of these visits are published in the iERG's 2014 report. There are several aspects of these reports that reveal common challenges. First, there was often a general lack of awareness of the Global Strategy for Women's and Children's health and CoIA. Second, national accountability mechanisms frequently suffered weaknesses that challenged the country's efforts to use accountability as a mechanism to advance women's and children's health. Third, transparency of data was a commonly discovered problem. And finally, health systems were often under great pressure—undergoing reform, but with limited management and health worker capacity to deliver on ambitious political goals.

These visits showed why no single blueprint for success can simply be projected on (or parachuted into) a country. The differing political, economic, social, and environmental predicaments between countries all shape their health challenges and responses in unique ways. The iERG plans further visits to countries in our final year of operation.

THE UN COMMISSION ON LIFE-SAVING COMMODITIES FOR WOMEN AND CHILDREN: AN INTERIM REVIEW

Interventions matter. As the table overleaf shows, the UN Commission on Life-Saving Commodities takes an optimistic view of its progress to date (the table shows self-reported results from the Commission's implementers). However, we raise signals of concern about financing (the lack of a well-resourced, results-based financing facility for women's and children's health), product innovation (difficulties securing commitments for research and development), implementation plans (weak demand-generation and communication programmes), and accountability (lack of progress of key milestones). The Strategy

and Coordination Team responsible for ensuring the Commission's recommendations are delivered has identified its own challenges: translating global learning into country responses; misalignment in countries between WHO recommendations, essential medicines lists, treatment guidelines, and approved life-saving commodities; providers not being required to administer commodities where they could have the greatest impact; supply chain bottlenecks; and health workers not yet fully prepared for the latest treatment protocols. The Commission's goals are supposed to be delivered by the end of 2015. The time window for success is extremely narrow.

Progress against UNCoLSC milestones per recommendation

Recommendation	Year of completion	Specified milestone	Completed	Partial	Not commenced
1 Shaping Global Markets	2014	Sign volume guarantee with at least one manufacturer of contraceptive implants, if appropriate pricing and volume terms can be agreed upon	x		
	2013	Aligning the market data collection efforts being undertaken by various groups (including CHAI, USAID, WHO, and the commodity TRTs) and consolidating this data in a web-based portal	x		
	2014	Evaluate the increase in availability and affordability of contraceptive implants	x		
	2013	Working with the commodity TRTs and other groups engaged in generating demand forecasts to consolidate this information at the global-level		x	
2 Shaping Local Delivery Markets	2014	Develop toolkits for a portfolio of interventions to engage private sector suppliers (manufacturers and distributors) to produce, distribute, and promote appropriate products	x		
	2013	Identify appropriate supply interventions and begin implementing select supply side interventions for relevant life-saving commodities in targeted countries	x		
	2014	Expand implementation of supply interventions and supply side communication to regional initiatives (such as pooled procurement and local manufacturer engagement)	x		
3 Innovative Financing	2012	Agree on the host of a results-based funding mechanism for life-saving commodities	x		
	2013	At least 10 EWEC countries enter into an agreement with the funding mechanism to increase access to life-saving commodities		x	
	2014	Guidance developed for countries to implement in-country RBF-approaches to strengthen access to life-saving commodities at all levels		x	
4 Quality Strengthening	2012	Expert Review Panel for dispersible amoxicillin	x		
	2012	Development of optimal quality assurance for zinc (e.g., market surveillance approach Expert Review Panel)	x		
	2013	Expert Review Panel for chlorhexidine	x		

Recommendation	Year of completion	Specified milestone	Completed	Partial	Not commenced
5 Regulatory Efficiency	2013	WHO-EML includes all 13 life-saving commodities	x		
	2013	Joint inspections or dossier reviews are implemented for at least 3 life-saving commodities	x		
	2013	Regulators in pathfinder countries agree on a common pathway for at least 5 life-saving commodities	x		
6 Supply and Awareness	2013	Briefs/guidance and/or reference documents published on a range of supply chain topics		x	
	2013	Quantification and forecasting guidance for all life-saving commodities available to countries (including harmonized definitions of forecasting and quantification and forecasting algorithms)	x		
	2013	Toolkit for private sector engagement in supply chain functions available	x		
	2014	Commodity-related functionality for an open source Logistics Management Information System (LMIS 1.0) developed, and pilot integration with HMIS in at least one country	x		
7 Demand and Utilization	2013	Global demand generation implementation kit developed with adaptable communication strategies for at least 9 priority commodities	x		
	2014	Country-specific communication strategies developed in at least two pathfinder countries that incorporate life-saving commodities from at least one health area (e.g. family planning)		x	
	2014	Demand generation programs implemented in at least 4 pathfinder countries that incorporate life-saving commodities from at least one health area (e.g. family planning)		x	
8 Reaching Women and Children	2013	Eight EWEC countries have financial protection programmes with a commodity focus			x
	2014	Evaluate the increase in use of (a sub-set of) life-saving commodities in concerned countries			x
9 Performance and Accountability	2014	The status of national availability and use of the 13 commodities and available guidelines (including m-applications) in 8 pathfinder countries for their use have been analyzed	x		
	2013	Development of generic checklists for implants and safe birth, including use of MgSO4, has begun		x	
	2014	Training and scalable strategies for checklist use including e- and m-learning have been developed and deployed		x	
	2014	Feasibility assessments on the use of social audits to improve accountability have been carried out in 10 countries			x
10 New Product Innovation	2014	Form a coordinating group to lead reviews, prioritization and monitoring of product improvements/innovations	x		
	2014	Prioritize four product improvement/ innovation areas		x	
	2014	Secure commitments including donor and private industry earmarks for innovation and research and development		x	

A SUSTAINABLE POST-2015 VISION FOR WOMEN AND CHILDREN

This year's iERG report is published at a crucial moment in planning for the post-MDG era. We wish to make two specific contributions—first, on the health of women and children; and second, on accountability.

First, we lay a foundation based on a comprehensive framework of human rights instruments and commitments. This framework now exists—technical guidance on the application of a human-rights-based approach to reduce maternal morbidity and mortality, similar technical guidance on a human-rights-based approach to reduce and eliminate preventable child mortality and morbidity, and General Comment 15 (the right of the child to the enjoyment of the highest attainable standard of health). These three documents make up an intergovernmental platform for accelerated action on women's and children's health. They underline the fact that we see health for women and children as a right and not a privilege. We believe that these human rights instruments, together with the mechanisms of universal periodic review and the human rights treaty bodies, provide a powerful force to reveal breaches of the universally agreed commitments to improve women's and children's health.

We propose to expand the well-established idea of a continuum of care to a cycle of wellbeing, embedding women's and children's health in a fuller life-course perspective (see figure). This life-course approach takes account of the multisectoral nature of advances in women's and children's health. We also believe that universal health coverage has special importance. That means ensuring women and children have access to care, that services are designed with women and children in mind, and that women and children are assured of financial risk protection.

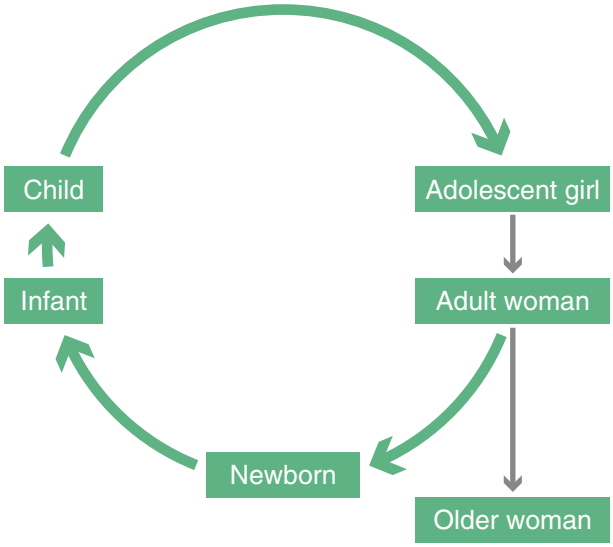
Our second area of concern is accountability. Although accountability is gaining strength as a powerful means to accelerate political action, there is very little reliable evidence to guide us as to the appropriate mechanism of accountability to adopt. There are many models of accountability to draw on. There is no single perfect accountability mechanism that one can choose. The truth is that a pluralistic array of overlapping accountability processes, especially involving civil society, may be the only practical way forward. We have one caveat to our endorsements of pluralism. We believe that an officially legitimised (via the UN) independent accountability mechanism reporting directly to the UN Secretary-General is an essential component of global accountability. This globally configured entity gives accountability a powerful platform and convening point for advocacy and influence. Multiple actors alone—all engaging in mutual accountability—risk creating an unruly cacophony of voices with diminished impact.

What does it mean to talk about sustainable development for women and children? The traditional model of sustainability is tripartite—social, economic, and environmental. But this definition does not take us to the core of the meaning of sustainability. Sustainability is about all people, not just some people. It is about paying as much attention to the future as we do to the present. It means going beyond the control and eradication of disease to assert the importance of a healthy life and wellbeing. Sustainability is about the value we put on our lives and on the lives of our children. It is about the freedom to flourish, the opportunity to choose our futures without harming others, and to live in a state of dignity. If these qualities can be the measures against which the health and wellbeing of women and children are measured, we are confident and optimistic that the post-2015 era will present the greatest possibilities women and children have ever enjoyed.

A proposed new framework for women's and children's health in an era of sustainable development (from the continuum of care to a cycle of wellbeing)

Health Sector

- Health systems (UHC)
- Sexual and reproductive health and rights
- Adolescent health
- Pre-pregnancy care
- Maternal health
- Newborn health
- Child health
- Nutrition
- Early child development
- Risk behaviours / environment
- AIDS, TB, malaria
- NCDs
- Mental health
- Aging



Non-Health Sector

- Information (CRVS)
- Education
- Women's political and socio-economic participation
- Good governance
- Economic development
- Infrastructure and urbanization
- Food security
- Environment (including water and sanitation)
- Realizing human rights
- Science and technology

Universal framework for human rights

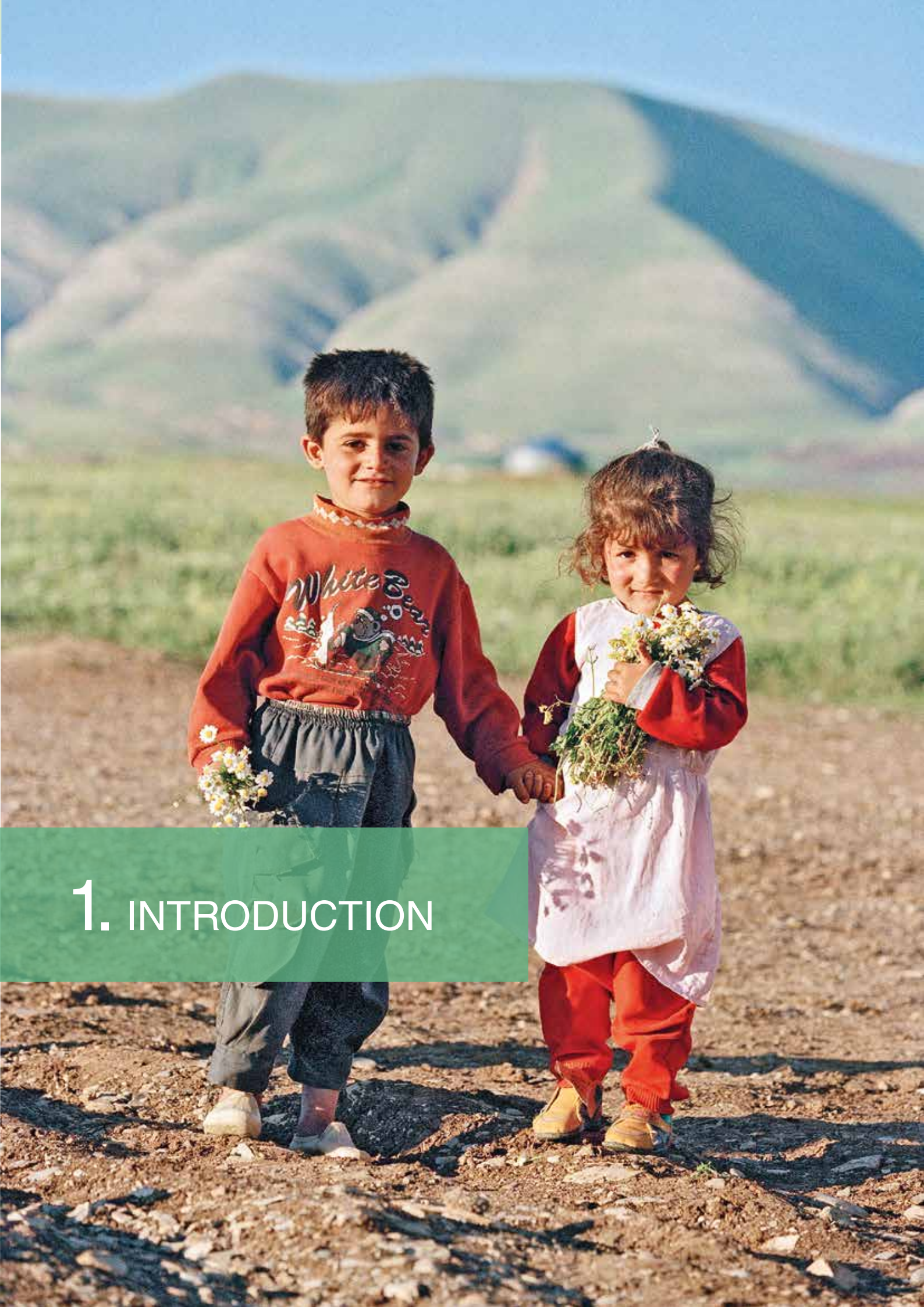
Independent accountability mechanism

CONCLUSIONS AND RECOMMENDATIONS

The iERG makes 6 new recommendations to strengthen accountability and progress towards better women's and children's health. These recommendations are shown in the box at the beginning of this Executive Summary. The full explanations behind these recommendations are given in our complete 2014 report.

At an Accountability Stakeholders Meeting, held in Geneva in January, 2014, Dr Margaret Chan, Director-General of WHO, noted that accountability had become "the norm in any global health discourse, debate, or discussion." But she also pointed out that women's and children's health was the "hardest test case" for accountability. "Why is every initiative," she asked, "having a separate accountability mechanism? Countries ask why. Don't have parallel systems. They undermine already limited capacity. I don't mind telling you how unhappy many countries are." Her challenge is important because she also argued that a "vigorous and independent mechanism for accountability" was essential for the post-2015 era.

This 2014 report from the iERG, in addition to describing progress on *Every Woman, Every Child*, the CoIA recommendations, and the Commodities Commission, has tried to set out its vision for women and children, and for accountability to those women and children, in an era of sustainable development. In our final report next year, we will seek to sum up the impact of this work and the lessons we should take with us into a very different political era.



1. INTRODUCTION

1. "Health should be at the centre of sustainable development", proclaimed Ban Ki-moon in May, 2014. He continued: "Accountability will be an important part of the new development agenda." The UN Secretary-General was speaking during the Government of Canada's *Saving Every Woman, Every* Child Summit, held in Toronto shortly after the World Health Assembly. Prime Minister Stephen Harper, the co-Chair of the Commission on Information and Accountability for Women's and Children's Health (CoIA), had just announced his Government's extraordinary commitment of $3.5 billion to improve the health of mothers and children for the period 2015-20. Prime Minister Harper said, "Canada believes that eliminating the preventable deaths of women and children in developing countries is within the reach of the international community… we must ensure that the global spending [on women and children] is targeted, effective, and accountable. Our commitment will not waver."

2. The Toronto meeting was an important milestone during a year of accelerated commitments to the future of women and children. This future is expressed most strongly in the Millennium Development Goals (MDGs), notably MDG-1c (on nutrition), MDG-4 (on child survival), and MDG-5 (on maternal, sexual, and reproductive health). But with the era of the MDGs rapidly drawing to a close, and with negotiations over the precise nature of the Sustainable Development Goals (SDGs) reaching their political climax, the opportunities for women and children (and the dangers too) between 2015 and 2030 are increasingly being debated. Those debates have been fuelled this past year by an unprecedented array of initiatives and promises.

3. The year began at the 2013 UN General Assembly meeting in New York, with a high-level review of progress towards reaching the MDGs. The review was entitled "MDG Success", leaving little room for disagreement or doubt as to the message the UN wished to convey to its audience. There were certainly reasons to be optimistic. The UK Government had just pledged US$1.6 billion to the Global Fund to Fight AIDS, TB, and Malaria between 2014 and 2016, in addition to US$4.5 billion from the US and US$1.5 billion from France. The World Bank Group projected $700 million in new financing to the end of 2015 in support of women's and children's health. And the Government of Norway contributed $75 million over 3 years to a new "Reproductive, Newborn, and Maternal Health Trust Fund." In total, US$1.15 billion was committed over 3 years to help save the lives of children and women.

4. But in May, 2014, new figures for maternal and child mortality were published, showing not only success but also the extent of the remaining challenge. This challenge cannot easily be airbrushed aside in the general and understandable desire to showcase only victory. The Institute for Health Metrics and Evaluation (IHME), for example, reported that 6.3 million under-5 children died in 2013, down from 17.6 million in 1970 (a remarkable 64% reduction) (1). But now neonatal deaths accounted for 42% of these deaths (compared with 37% in 1990). For maternal mortality, IHME's estimates were even more sobering. In 2013, IHME estimated that there were 292 982 maternal deaths, compared with 376 034 in 1990 (a 22% fall) (2). Although these declines in maternal mortality are, indeed, signs of success, they mean that at best 6 iERG countries will achieve their MDG-5 target by 2015.

5. These challenges were reinforced in the latest Countdown to 2015 report, published during the Partnership for Maternal, Newborn, and Child Health (PMNCH) Partners' Forum, held in Johannesburg in June-July, 2014 (the meeting was co-sponsored by PMNCH, the iERG, Countdown to 2015, and A Promise Renewed) (3,4). Countdown identified three major gaps in current strategies to reduce maternal and child mortality—access to contraceptives, newborn care, and case management of childhood diseases. They also emphasised the importance of investing in good data, encouraging partners to support country capacity to collect and use high-quality information to enhance national decision-making. Countdown drew further attention to the critical part played by cross-cutting sectors, such as nutrition and education.

6. Despite these challenges, there have been major new initiatives launched this past year to address some of these increasingly visible shortcomings. The *Every Newborn Action Plan* is one such example (5). Another is *The State of the World's Midwifery 2014* (6). Another is the *Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development (ICPD) Beyond 2014* (otherwise known as Cairo plus 20) (7). These initiatives illustrate the continued political and technical commitment to advancing women's and children's health.

7. The CoIA, chaired by Prime Minister Harper of Canada and Tanzania's President Jakaya Kikwete, was one of the most important follow-up initiatives after the launch of the UN Secretary-General's Global Strategy for Women's and Children's Health (8,9). The Commission was set up to "determine the most effective international institutional arrangements for global reporting, oversight, and accountability on

women's and children's health." Its recommendations are shown in Panel 1. The final CoIA recommendation was to create a time-limited independent Expert Review Group (iERG) to review progress on both the Global Strategy and implementation of the CoIA recommendations (the Terms of Reference of the iERG and the countries within our mandate are shown in Annex 1). The 12 recommendations we made in our first two reports to strengthen progress towards both the Global Strategy and the goals of CoIA are shown in Panel 2. These recommendations are designed to support the goals of *Every Woman, Every Child* and CoIA. In January, 2013, WHO's Executive Board requested the Director-General to provide support to the iERG so that it could also assess progress in the implementation of the recommendations of the UN Commission on Life-Saving Commodities for Women and Children (10).

8. In 2014, work towards defining the post-2015 framework accelerated substantially. The 2016-30 period presents a once-in-generation opportunity to end preventable mortality for women and children (11). That aspiration, together with realising the notion of sustainable development, was given to an Open Working Group on Sustainable Development Goals, chaired by the Governments of Hungary and Kenya. The Open Working Group has 30 seats, occupied by five groupings—Africa, Asia-Pacific, Latin America and Caribbean, Western Europe, and Eastern Europe. Although WHO is not a formal member of the Open Working Group, those positions being occupied by UN member states only, the agency has made its own position clear with respect to the post-2015 era. Women's and children's health is a prominent part of that vision.

9. As Ban Ki-moon indicated, accountability will be a central idea post-2015. But the nature of that accountability mechanism remains uncertain. The UN Secretary-General's Office has instigated an external review of the accountability work for women's and children's health. The objectives of that review are to evaluate the effectiveness of the various elements of the *Every Woman, Every Child* accountability process—for example, CoIA, the iERG, and Countdown to 2015. The goal is to make recommendations about how accountability can be assured for women's and children's health within the post-2015 development agenda. These recommendations are likely to include proposals on governance arrangements, data needs, financing, and the roles of key constituencies.

10. Our 2014 report takes a broad scope in its review of progress towards the objectives of *Every Woman, Every Child* and fulfilment of the recommendations from CoIA. But our overriding goal this year is to present our own post-2015 vision—for the future of women's and children's health and for the future accountability arrangements needed to ensure that commitments to that vision are met. The process we have adopted for this year's iERG report is similar to that adopted for previous reports—invitations to key agencies and constituencies to submit evidence, stakeholder meetings and consultations, commissioning of country case studies, and an extensive review of all available published evidence. We introduced one innovation into this year's report—we completed two country visits (to Malawi and Peru) to focus on national oversight mechanisms as part of a robust accountability process for women and children. The purpose of each country visit was to assess the completeness, use, efficiency, and effectiveness of the national oversight mechanism. We see this type of country visit as a logical extension of the iERG's work on accountability—perhaps an example of the kind of strengthened accountability that might be adopted post-2015.

Panel 1. CoIA recommendations

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 expenditures.

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.

Resuscitaire in delivery room

Panel 2. Recommendations from the iERG 2012-13

iERG 2012 recommendations

1. **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.

2. **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.

3. **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).

4. **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 nonexistent. 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.

5. **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.

6. **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.

iERG 2013 recommendations

1. **Strengthen country accountability:** Ministers of Health, together with partners, must demonstrably prioritise and evaluate country-led, inclusive, transparent, and participatory national oversight mechanisms to advance women's and children's health.

2. **Demand global accountability for women and children:** Advocate for and win an independent accountability mechanism to monitor, review, and continuously improve actions to deliver the post-2015 sustainable development agenda.

3. **Take adolescents seriously:** Include an adolescent indicator in all monitoring mechanisms for women's and children's health, and meaningfully involve young people on all policymaking bodies affecting women and children.

4. **Prioritise quality to reinforce the value of a human-rights-based approach to women's and children's health:** Make the quality of care the route to equity and dignity for women and children.

5. **Make health professionals count:** Deliver an expanded and skilled health workforce, especially in sub-Saharan Africa, which serves women and children with measurable impact.

6. **Launch a new movement for better data:** Make universal and effective Civil Registration and Vital Statistics systems a post-2015 development target.

Entry to Maternity ward

2. *EVERY WOMAN, EVERY CHILD:* THE FINAL APPROACH TO 2015

11. The goal of the UN Secretary-General's Global Strategy is to save 16 million lives by 2015 in the 49 lowest-income countries of the world. At the Toronto Summit held in May, 2014, Ban Ki-moon set out his personal views about what it would take to achieve the objective of *Every Woman, Every Child.* First, strong leadership at the highest political level. Second, commitment by a multistakeholder partnership. Third, predictable financing. Fourth, accountability for results and resources. And finally, innovation. The deadlines to meet global goals for child and maternal mortality reduction are only a year away. What is the current state of progress? The best evidence available to us comes from estimates provided by groups of independent researchers and their UN colleagues. In 2014, several new sets of estimates were published to inform discussions about progress towards MDGs 4 and 5. First, we focus on MDG-4—to reduce, by two-thirds, between 1990 and 2015, the under-5 mortality rate. Haidong Wang and colleagues, from IHME, reported that in 2013 an estimated 6.3 million children under-5 died (1). This 64% reduction in child mortality compared with 1970 is an immense achievement by countries working together with the international community. Under-5 mortality rates fell from 143 per 1000 livebirths in 1970, to 85 per 1000 in 1990, to 44 per 1000 in 2013. Wang et al are surely right to claim that this success is "among the more important achievements for humanity in the past 60 years." Indeed, 90% of countries (43 of 48) in sub-Saharan Africa had a faster rate of decline between 2000-13 than between 1990-2000. The progress in some countries has been little short of spectacular. 9 countries—India, China, Ethiopia, Bangladesh, Indonesia, Pakistan, Brazil, Afghanistan, and Nigeria—account for two-thirds of the reduction in child deaths between 2000 and 2013. But Wang et al also concluded that, despite this progress, only 27 low and middle income countries would reach their MDG-4 target. The 9 countries that lie within the mandate of the iERG are shown starred in Panel 3. These countries—Bangladesh, Benin, Brazil, Myanmar, China, Egypt, Liberia, Nepal, and Peru—are all likely to reach MDG-4. The UN uses different methods to calculate reductions in under-5 mortality. The result is a slightly different set of countries that are judged to be succeeding (these UN success countries are labelled +). 7 countries show concordance between the two estimation methods for reaching MDG-4: Bangladesh, Brazil, China, Egypt, Liberia, Nepal, and Peru. But, taken overall, under-5 mortality rates have fallen by 48% since 1990, a considerable way short of the two-thirds target. Figures 1 and 2 show these trends, for both the Wang et al and UN estimates (12), together with the MDG-target for our 75 countries of concern. Despite progress, one child under 5 still dies every 5 seconds. The vast majority of these deaths are preventable.

Panel 3. Countries expected to reach MDG-4

Azerbaijan +
Bangladesh *+
Benin *
Bolivia +
Brazil *+
Burma (Myanmar) *
Cambodia +
China *+
Egypt *+
Eritrea +
Ethiopia +
Indonesia +
Kyrgyzstan +
Liberia *+
Madagascar +
Malawi +
Mexico +
Nepal *+
Niger +
Peru *+
Rwanda +
Tanzania +

It should be noted that using UN estimates of under-5 mortality, and the decline in these rates over time, 20 rather than 9 iERG countries are on track to achieve MDG-4. This stark difference – 9 vs 20 – points both to inherent uncertainty in numbers from many countries and, perhaps more importantly, to the need to ensure capacity in the UN system to coordinate and communicate effectively. It is also worth noting that in the period 2000-2012—ie, the period after the MDGs were promulgated – 32 out of 75 iERG countries had rates of improvement in under-5 mortality consistent with the 4.3% per year rate implied by MDG-4.

Figure 1. Trends in under-5 mortality rate, 1990-2013 & MDG-4 target for the iERG's 75 countries of concern

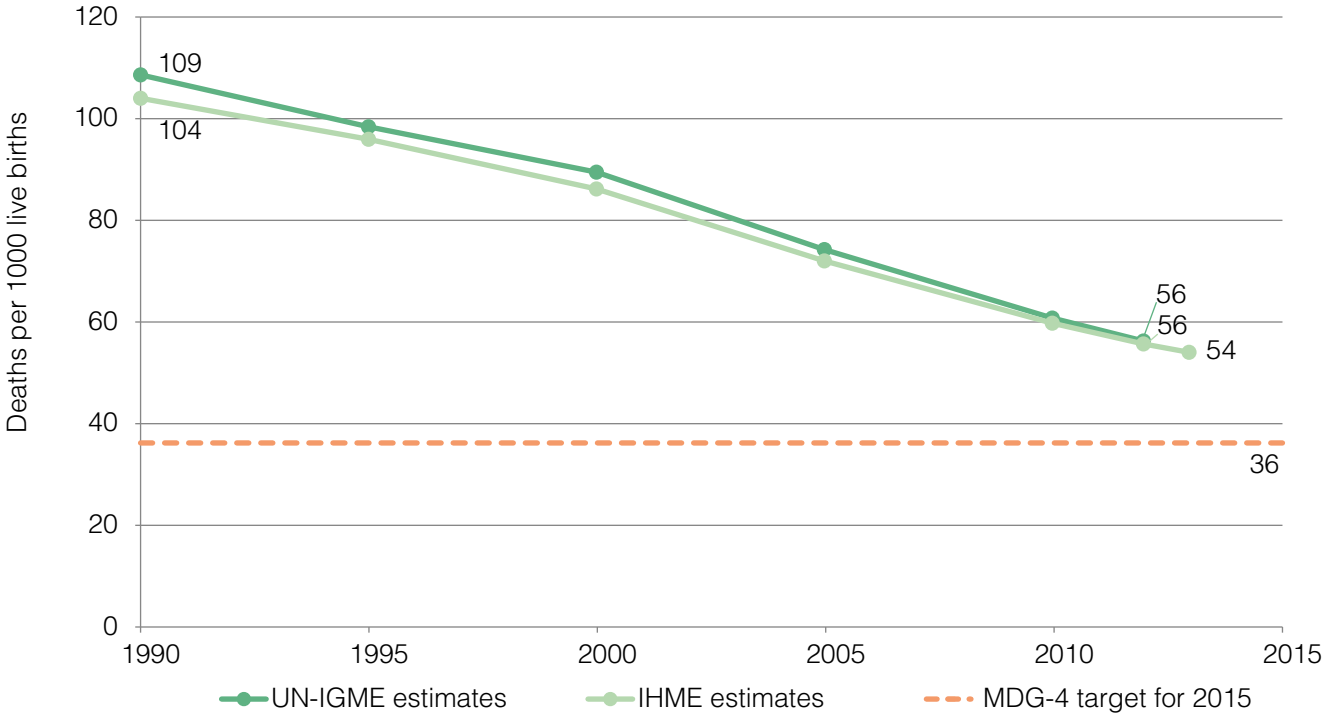
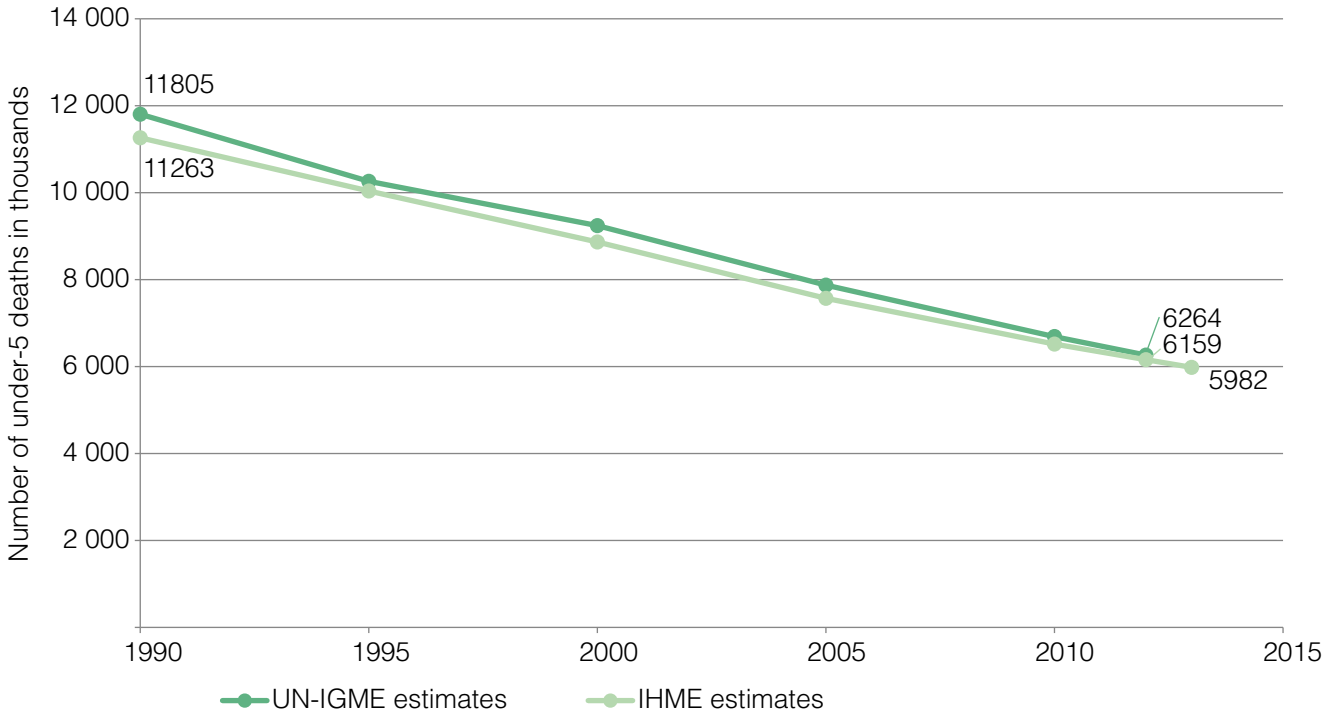


Figure 2. Trends in number of under-5 deaths for the iERG's 75 countries of concern, 1990-2013



12. What is the explanation for improvements that have taken place since 1990 (and, by extension, what might be the reasons for non-improvement in many countries)? Maternal education seems to be one key and underappreciated factor. Wang et al showed that for every additional year of maternal education, there was a corresponding decrease in under-5 mortality rate of 8.5%. As these authors put it: "improved levels of maternal education in low-income and middle-income countries have a far greater effect on reduction of child mortality than do any other intervention." In absolute terms, 2.2 million fewer under-5 deaths each year are estimated to have taken place between 1990 and 2013 thanks to improved maternal education. In accelerating progress to 2015 and beyond, and in a new (conceptually very different) era of sustainable development, maternal education and literacy need to be much more serious issues for the global health community to champion than has hitherto been the case—and variations in education and literacy need to be more consistently reflected and incorporated in the way care is delivered. To be fair, education has long been recognized as an important contributor to women's and children's health. The 1993 World Development Report, *Investing in Health*, singled out education as a key factor shaping health outcomes. These old and newer lessons need greater attention by the policy community.

13. It is also important, as Jennifer Bryce, Cesar Victora, and Robert Black wrote in 2013, to "be ruthless in prioritisation of quality delivery at scale for a small number of interventions that address the major causes of child deaths in their specific context" (13). But often these interventions need strong health systems and appropriately educated health workers to ensure that coverage is effective. Such systems are rarely in place. To add to these difficulties, the lack of adequate health information systems in countries means that monitoring coverage to ensure equity is often impossible. The comforting slogans used by the global community—"no one left behind" and "reaching the unreached"—are technically correct. But presently there is almost no reliable way to ensure that these slogans are turned into reality.

14. The MDG-5 goal is in two parts: first, to reduce by three-quarters the maternal mortality ratio (MMR) (target 5A, with two indicators: MMR and the proportion of births attended by skilled health personnel); and second, to achieve universal access to reproductive health (target 5B). In relation to 5A, two sets of data have recently been released. Nicholas Kassebaum and his colleagues from an international collaboration led by IHME reported that the global MMR fell from 283.2 deaths per 100 000 livebirths in 1990 to 209.1 deaths per 100 000 livebirths in 2013, a 26% decline, again considerably short of the 2015 goal (2). The overall number of maternal deaths fell by 22% during the same period, from 376 034 to 292 982. New UN data this year reached a similar 2013 estimate—289 000 maternal deaths (14). But the UN figure for 1990 is substantially higher than that from IHME—523 000 maternal deaths versus 376 034—rendering their reduction of 45% more than double that calculated by IHME (see Figures 3 and 4 for a comparison between IHME and UN numbers for the 75 countries within the iERG mandate). The rate of change in MMR between 2003-13 was higher than during an earlier period (1990-2003). But this progress concealed high variability between countries. In South Asia, for example, the total number of maternal deaths *fell* from 174 416 in 1990 to 107 827 in 2013 (this region includes Afghanistan, Bangladesh, Bhutan, India, Nepal, and Pakistan). In South-East Asia, the number of maternal deaths *fell* from 35 339 in 1990 to 18 028 in 2013 (this region includes Indonesia, Myanmar, and the Philippines). However, in Central sub-Saharan Africa, maternal deaths *increased* between 1990 and 2013 from 12 178 to 15 355 (this region includes the Democratic Republic of Congo, DRC). In Eastern sub-Saharan Africa, maternal deaths *increased* from 45 250 in 1990 to 52 269 in 2013 (this region includes Ethiopia). In Southern sub-Saharan Africa, maternal deaths *increased* from 2455 to 4898 between 1990 and 2013 (this region includes South Africa). And in Western sub-Saharan Africa, total maternal deaths *increased* from 44 133 to 70 858 between 1990 and 2013 (this region includes Nigeria). It is important to note that for the Eastern and Southern regions of sub-Saharan Africa, the 2013 estimates represent a decline on 2003 numbers, indicating that the tide has turned in favour of mortality reduction. The same is not the case for the Central and Western regions of sub-Saharan Africa, where the number of maternal deaths is still rising, albeit at slower rates. According to IHME, only 2 iERG countries—China and Morocco—will reach their MDG-5A target (Panel 4; IHME success countries are starred; those countries judged to be on track by UN estimates are shown with a +).

Panel 4. Countries expected to reach MDG-5

Cambodia +
China *
Eritrea +
Lao PDR +
Morocco *
Rwanda +

As with under-5 mortality, the UN estimates that far more countries have high rates of decline in maternal mortality than does the IHME. Indeed, in 63 out of 75 iERG countries the UN estimates more rapid progress, and often by quantitatively significant margins.

Figure 3. Trends in maternal mortality ratio, 1990-2013 & MDG-5 target for the iERG's 75 countries of concern

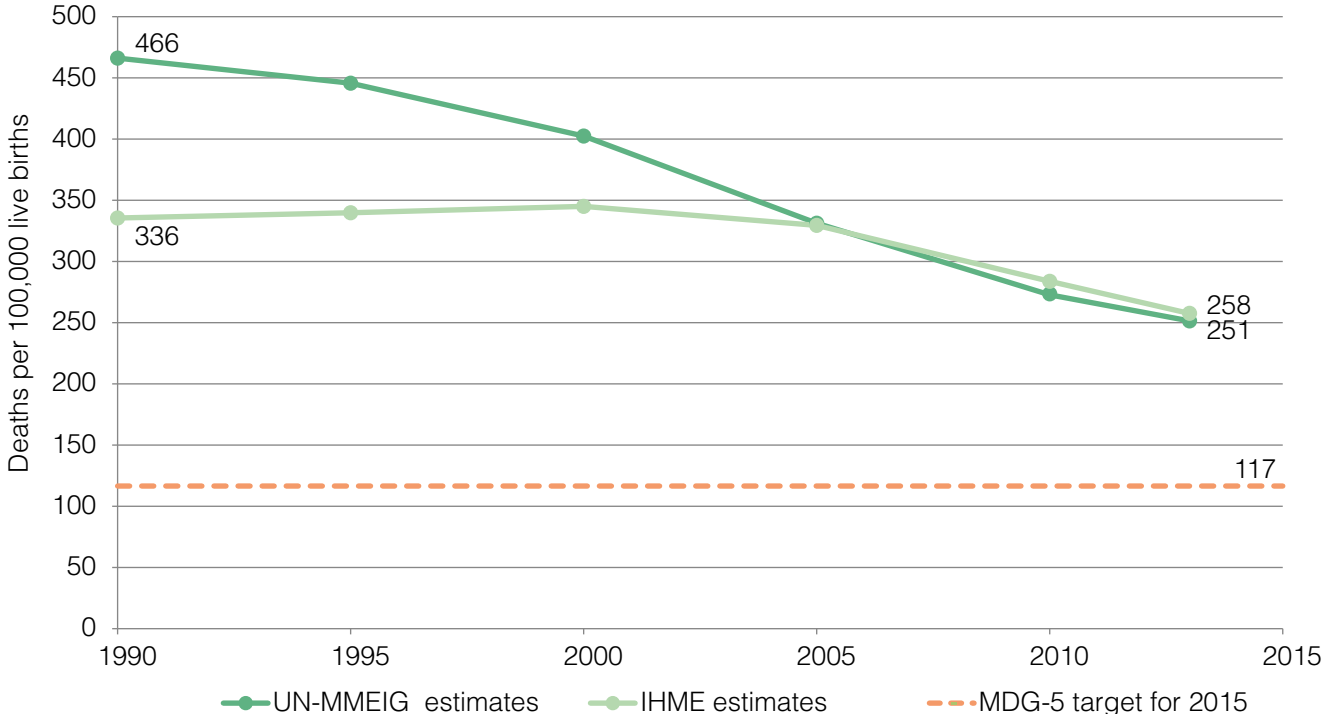
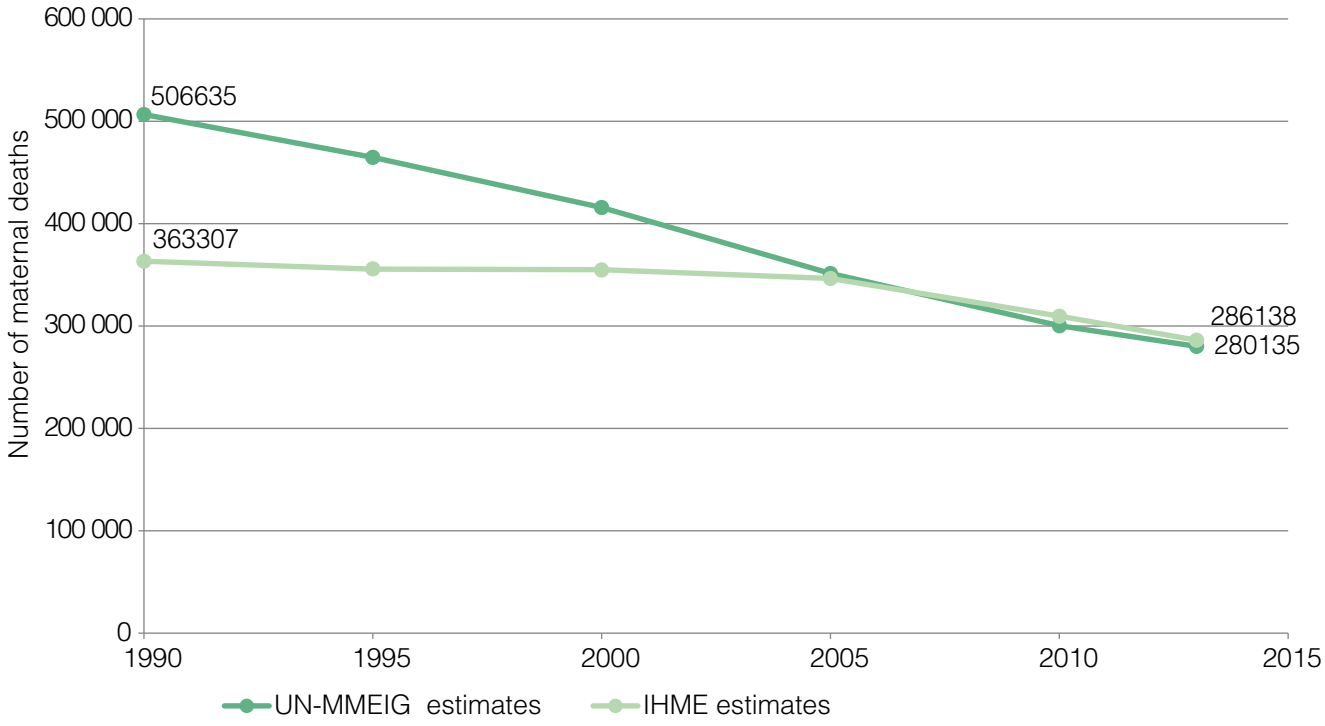


Figure 4. Trends in number of maternal deaths in the iERG's 75 countries of concern, 1990 -2013



15. According to IHME, 5 countries with the highest numbers of maternal deaths accounted for over half the total (Table 1). The comparable estimates from the UN are shown in the same table. What is immediately apparent is the wide differences at country level between the two sets of estimates. This finding is disturbing. Indeed, in discussions with countries and regional representatives at the 2014 World Health Assembly, the large differences between IHME and UN estimates, despite overlap in uncertainty intervals, caused confusion and concern for decision-makers. Table 2 shows differences between UN and IHME estimates for the 75 countries within the iERG's mandate broken out by WHO region. Again, the differences are, in some cases, substantial. In our first report, we concluded that, "These differences are confusing for those judging the progress and effectiveness of national programmes… 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." It is clear however that major differences remain in country estimates (although there is substantial convergence in global totals). In light of this, we urge two steps to improve generation and utilization of key health indicators that are standardized for cross-country and intertemporal comparability. First, recognize the mandate of UN agencies to generate, disseminate, and be held accountable for the quality of critical data. This implies adequate funding which is not now the case for under-5 and maternal mortality series. (That the UN agencies have this clear accountability in no way devalues the importance of independent, critical groups undertaking their own analyses, which can be an important impetus for quality improvement.) Second, insist that the UN system and other analytic groups make their underlying data as well as their results easily available for independent scientific corroboration. Journal editors and research funding agencies have particular responsibilities in this regard.

Table 1. Countries accounting for over half of maternal deaths in 2013

	IHME (2)	UN (14)
India	71 792	50 000
Nigeria	36 698	40 000
Pakistan	17 876	7 900
Ethiopia	15 234	13 000
DRC	10 125	21 000
Total	151 725	131 900
Global total	**292 982**	**289 000**
%	**52%**	**46%**

Note: The UN estimates that two countries have maternal death numbers equal to or higher than Pakistan—Indonesia (8800) and Tanzania (7900)

Table 2. Regional differences between IHME and UN estimates for the iERG's 75 countries of concern

	IHME (2)	UN (14)	IHME difference
AFRO	141 252	169 976	- 28 724
SEARO	94 275	67 310	+ **26 965**
EMRO	36 289	25 205	+ **11 084**
WPRO	8 689	11 143	- 2 454
PAHO	5 210	5 940	- 730
EURO	420	561	- 141

16. MDG-5B is concerned with achieving universal access to reproductive health. The indicators recommended for monitoring progress include: contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and unmet need for family planning. Figure 5 shows the estimates and projections of unmet need for contraception (15). As can be seen, the unmet need is projected to rise well beyond 2015. The "assumption" in the figure is that ongoing efforts to increase access to modern contraceptive methods will be successful. We will discuss access to family planning later in this chapter. Data on adolescent fertility rate are provided by WHO in their World Health Statistics report. These data, together with data for other MDG-5 indicators, for the iERG's 75 countries of concern are shown in Table 3. The variation between countries is perhaps the most striking finding. The proportion of births attended by skilled health personnel ranges, for example, from 9% (Somalia) to 100% (eg, Azerbaijan, Turkmenistan, Uzbekistan). 27 countries have antenatal care coverage (at least 4 visits) below 50%, whereas some countries report coverage rates above 80% (eg, Ghana, Brazil, Peru, Indonesia). And for adolescents, even in regions where progress in access to contraceptives might have been quite fast, young women still face huge obstacles that numbers sometimes do not fully capture.

Delivery room

Figure 5. Estimates and projections of unmet need for modern contraceptive methods (1990-2020) and potential effect of London Summit on Family Planning objective of 120 million new modern method users in the world's 69 poorest countries (≤US$2500 gross national income per head in 2010)

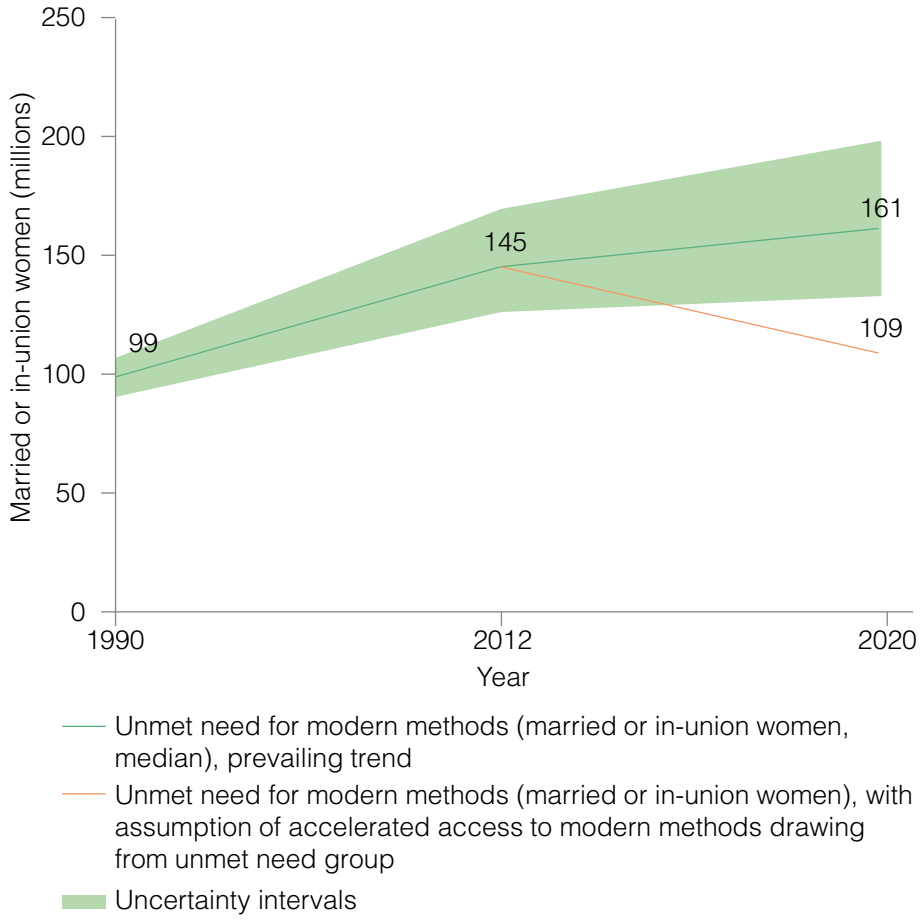


Table 3. MDG 5a & 5b data (6 indicators)

iERG 75 countries	5.2	5.3	5.4	5.5		5.6
	Births attended by skilled health personnel (%)	Contraceptive prevalence (%)	Adolescent fertility rate (per 1000 girls aged 15–19 years)	Antenatal care coverage (%): At least 1 visit	Antenatal care coverage (%): At least 4 visits	Unmet need for family planning (%)
AFRO						
Angola	49	18	70	68	47	-
Benin	84	13	29	86	61	27
Botswana	99	53	85	94	73	-
Burkina Faso	67	16	29	95	34	25
Burundi	60	22	87	99	33	32
Cameroon	64	23	71	85	62	24
Central African Republic	40	19	57	55	38	-
Chad	17	5	35	43	23	28
Comoros	82	-	76	92	-	-
Congo	90	45	-	90	79	-
Côte d'Ivoire	57	18	57	89	44	-
Democratic Republic of the Congo	80	18	61	89	44	24
Equatorial Guinea	68	-	94	91	67	-
Eritrea	-	-	69	-	-	-
Ethiopia	10	29	39	34	19	26
Gabon	89	31	89	95	78	-
Gambia	57	13	51	86	72	22
Ghana	67	24	71	96	87	36
Guinea	45	6	25	85	50	-
Guinea-Bissau	43	14	55	93	68	6
Kenya	44	46	72	92	47	26
Lesotho	62	47	76	92	70	23
Liberia	61	11	43	96	66	36
Madagascar	44	40	64	86	49	19
Malawi	71	46	61	95	46	26
Mali	58	8	33	74	35	28
Mauritania	57	9	59	72	-	-
Mozambique	19	12	51	60	51	-
Niger	29	14	-	83	15	16
Nigeria	38	14	51	61	57	19
Rwanda	69	52	66	98	35	21
Sao Tome and Principe	81	38	70	98	72	38
Senegal	51	13	50	95	50	30
Sierra Leone	61	11	43	91	75	27
South Africa	-	-	93	-	-	-
Swaziland	82	65	88	97	77	13
Togo	44	15	60	51	55	37
United Republic of Tanzania	49	34	68	88	43	25
Uganda	58	30	73	95	48	34
Zambia	47	41	61	94	60	27
Zimbabwe	66	59	84	90	65	15

iERG 75 countries	5.2	5.3	5.4	5.5		5.6
	Births attended by skilled health personnel (%)	Contraceptive prevalence (%)	Adolescent fertility rate (per 1000 girls aged 15–19 years)	Antenatal care coverage (%): At least 1 visit	Antenatal care coverage (%): At least 4 visits	Unmet need for family planning (%)
PAHO						
Bolivia (Plurinational State of)	71	61	91	86	72	20
Brazil	99	80	90	97	89	6
Guatemala	51	-	76	93	-	-
Haiti	37	35	49	90	67	37
Mexico	95	71	94	96	-	12
Peru	87	69	90	96	94	6
EMRO						
Afghanistan	36	22	-	46	15	-
Djibouti	78	18	-	81	-	-
Egypt	79	60	74	74	66	12
Iraq	91	53	78	78	50	8
Morocco	74	67	67	77	55	12
Pakistan	52	27	55	73	28	25
Somalia	9	15	-	22	6	-
Sudan	20	9	-	69	47	29
South Sudan	17	4	-	40	17	-
Yemen	34	28	65	65	29	-
EURO						
Azerbaijan	100	51	100	77	45	15
Kyrgyzstan	99	48	99	97	-	-
Tajikistan	87	28	100	79	53	-
Turkmenistan	100	-	100	99	-	-
Uzbekistan	100	65	99	99	-	-
SEARO						
Bangladesh	31	61	58	50	26	14
Democratic People's Republic of Korea	100	-	100	100	94	-
India	67	55	63	75	50	21
Indonesia	83	62	93	96	88	11
Myanmar	71	46	93	83	43	-
Nepal	36	50	57	58	50	28
WPRO						
Cambodia	71	51	74	89	59	17
China	96	85	95	94	-	-
Lao People's Democratic Republic	40	-	-	53	37	-
Papua New Guinea	43	32	62	65	29	27
Philippines	72	49	95	95	78	22
Solomon Islands	70	35	-	74	65	11
Viet Nam	92	78	93	94	60	4

Source: World Health Statistics 2013. Latest available since 2006.

Ethiopia: Prioritizing community capacity strengthening to achieve and sustain MDGs 4 and 5

Since the 1990s, the Ethiopian government has prioritised access to primary health care for the rural population. In 2004, Ethiopia launched the Health Extension Programme (HEP) (1) that became a flagship of the Health Sector Development Plan and the institutional framework to achieving the health-related MDGs. This innovative programme underpins community participation and universal access to essential promotive, preventive, and selected high-impact curative services focused on achieving MDGs 4 and 5. Health Extension Workers (HEWs), the lead players in the HEP strategy, bridge the gap between the community and health facilities. Since the launch of the HEP, Ethiopia's health workforce has doubled due to the deployment of more than 34 000 HEWs (2).

HEWs are primarily young, local women with high school education recruited by *Kebele* and *Woreda* councils and given one year's pre-service training (3). (*Kebeles* are the lowest community administrative units; *Woredas* are the next higher level.) The HEW training covers 16 health programme packages in four categories: (i) family health services, (ii) disease prevention and control, (iii) hygiene and environmental health, and (iv) health education and communication (4).

HEWs, salaried by the government, are assigned to health posts built by the *Kebeles*. Two HEWs serve approximately 5000 people (5). 75% of HEWs' time is spent on household visits and educating and organising communities for the HEP. The HEP is linked with the national health services system through supportive supervision and referral services (6). Unique in the HEP is its promotion of "model households". These are empowered households that uninterruptedly practise the HEP packages, including appropriate use of latrines, hand washing, cleanliness of kitchen utensils, use of safe water, immunization, and other critical services for young children, including immediate treatment for malaria and other childhood illnesses (7). In 2010/11, the Ethiopian government initiated another community capacity development strategy, the Health Development Army (5), whereby model households are mobilised, trained, and formally organised into one-to-five networks, one lead household organising a network of five households to work closely with HEWs and ensure the sustainability of the HEP.

The HEP is having an impact on reproductive, maternal, and child health outcomes in Ethiopia (8,9). For example:

- Ethiopia may have already achieved MDG 4.
- Primary health-care coverage increased from 76.9% in 2005 to 90% in 2010.
- Contraceptive use rate increased from 10.9% in 2005 to 50% in 2010.
- Antenatal visits increased from 67.7% in 2008 to 71.4% in 2010. Substantial improvements in tetanus toxoid vaccination coverage, iron-folic acid supplementation, and HIV testing of pregnant women were also observed.
- Fewer than 10% of deliveries were assisted by health professionals as compared with fewer than 5% in 2005.
- 92% of households now live within 5 kilometres of a health facility (8).

Substantial investment in strengthening first-level referral facilities for obstetric emergency management, together with increased health awareness and utilisation of MCH services, are imperative to achieve MDG 5 in Ethiopia as well as to sustain all the gains so far achieved.

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17. Evidence submitted to the iERG from the Partnership for Maternal, Newborn, and Child Health (PMNCH) indicates major successes and continuing problems in mobilising and adequately financing programmes to end preventable child and maternal mortality. PMNCH draws 10 conclusions from its findings, which this year are focused exclusively on financial commitments to the Global Strategy (we have added one more).

- The Global Strategy has mobilised unprecedented high-level political support for women's and children's health. The total number of commitments made now totals 401 from 300 stakeholders (see Annex 2)
- As of May, 2014, the value of financial commitments to the Global Strategy was US$41.1-45.1 billion (once double counting had been eliminated)
- Just under half of this figure—US$18.2-22.3 billion is confirmed new and additional funding
- Disbursements by commitment makers against committed funding seem to be on track (US$27.2 billion of non-double-counted funds since September, 2010)
- The Global Strategy has had a positive impact on RMNCH donor financing
- RMNCH donor disbursements continue to be targeted at countries with high numbers of maternal and child deaths
- Donor disbursements for family planning in iERG countries grew by 47%—from US$382 million in 2010 to US$561 million in 2012
- Although donor funding for maternal and newborn health increased by a fifth in iERG countries compared with 2010, this additional money is insufficient to close the US$7.9 billion per year funding gap estimated by the Global Strategy
- RMNCH spending from the governments of the 49 Global Strategy countries increased by 15% from 2010 to US$2.7 billion in 2012
- For the entire period of the Global Strategy, PMNCH estimates that a total of US$18.7 billion in additional disbursements will be available to RMNCH in the Global Strategy's 49 focus countries
- During the PMNCH Partners' Forum, held in Johannesburg in June, 2014, 40 new commitments from governments, multilaterals, foundations, civil society, health professionals, academia, and the business sector were pledged to the *Every Newborn Action Plan*

18. The largest single financial contribution to the Global Strategy came in May, 2014, from the Government of Canada—$3.5 billion to improve the health of mothers and children for the period 2015-20. At this Toronto *Saving Every Woman, Every Child* Summit, Prime Minister Stephen Harper emphasised Canada's priorities in making this new investment—newborn survival, immunisation, and better data through civil registration and vital statistics systems. Harper said that, "Canada will continue to be an international leader in pressing for real results on maternal, newborn, and child health. We galvanised international attention at the Muskoka Summit in 2010, have spearheaded global efforts on how to move forward at the Toronto Summit, and have led by example in our efforts to save the lives of some of the most vulnerable women and children on the planet." Ban Ki-moon, the UN's Secretary-General, commented, "I call on other leaders of the world to follow Canada's example." But despite the warm praise for Canada, there was serious concern that Prime Minister Harper's interpretation of maternal, newborn, and child health ignored the critical importance of sexual and reproductive health services.

19. The importance of sexual and reproductive health and rights to the overall health of women and children—as well as to broader Sustainable Development Goals—cannot be overstated. And yet

there remains anxiety that, despite strong advocacy and the marshalling of considerable evidence (7), reproductive health issues are not only still de-emphasised in discussions about accelerating progress towards the MDGs, but are also in jeopardy for the post-2015 period. The prevailing "avoidance behaviour" about the importance of sexual and reproductive health and rights needs to be forcefully challenged. For example, high numbers of births worldwide contributed to 1.42 million more child deaths in 2013 compared with 1990 (1). The PMNCH report to the iERG emphasises this point still further. They conclude, "While there is a lot of global attention on the need to support family planning, and there has been an increase in funding for family planning, more political leadership at country level is needed to create demand for family planning…High-level political commitment is needed to address, social, cultural, and behavioural factors that inhibit women, girls, and couples from accessing family planning services."

20. In July, 2012, at the London Summit on Family Planning, unprecedented political commitments were made to expand access to voluntary family planning for an additional 120 million women and girls by 2020. Commitments totalling US$2.6 billion were made by 150 developing countries, donors, foundations, UN agencies, the World Bank, civil society organisations, and the private sector. FP2020's first progress report was published in November, 2013. While it is too early to make confident statements about "bending the curve" of unmet need for modern contraceptives downwards, FP2020 has certainly triggered much important new energy and activity around a previously flagging issue. Costed country plans to scale up access to family planning services have been made for around a quarter of FP2020 commitment-making countries. 29 countries have increased their budgets for family planning. And improvements in delivery systems for contraceptives have been reported. In a detailed and comprehensive submission to the iERG, FP2020 sets out how it has used its first full year to set up the infrastructure to monitor reliably the impact of family planning programmes in its 69 priority countries. FP2020 is led by a Reference Group, run on a daily basis by a Task Team, and is hosted by the UN Foundation. The operational structure is complex—4 working groups provide technical guidance on country engagement, rights and empowerment, market dynamics, and performance monitoring and accountability. Core indicators to monitor progress have been selected. In sum, the enormity of the demand for modern contraceptive use must not be minimised. The best available data tell us that, in 2012, 222 million women had an unmet need for contraception—53 million women in Africa, 83 million women in South Asia, and 14 million women in Western Asia (16). Meeting the needs of these women will be the measure by which FP2020 is judged.

21. A further area where commitments made at a global summit are now being translated into country action is nutrition. In June, 2013, the UK Government hosted the Nutrition 4 Growth Summit in London. The commitments made at this Summit were substantial—to ensure, by 2020, that 500 million pregnant women and children under 2 are reached with effective nutrition interventions; to prevent 20 million children under-5 from being stunted; and to save 1.7 million lives by reducing stunting, increasing breast feeding, and by treating severe acute malnutrition. New financing was pledged in London: US$4.15 billion. The Nutrition 4 Growth Summit is not the only initiative to tackle global undernutrition. There have been additional efforts by the World Health Assembly, Scaling up Nutrition Movement, European Union, UN Secretary General (his Zero Hunger Challenge), the L'Aquila Food Security Initiative, the New Alliance for Food Security and Nutrition, and the Food Assistance Convention, among others. This proliferation of efforts raises questions about accountability. But what is clear is that stunting, wasting, low birth weight, anaemia, and now overweight are some of the most stubborn obstacles to further progress on women's and children's health. Around 3 million under-5 deaths annually can be attributed to undernutrition (17). And as the 2014 Countdown to 2015 Report makes clear, stunting is highly concentrated among the poor. Among Countdown countries, stunting prevalence is some 2.5 times higher among the poorest wealth quintile than among the richest. In 2014, an important effort to track progress will be launched—the Global Nutrition Report, led by its own Independent Expert Group chaired by Lawrence Haddad and Srinath Reddy. Again, it is too early to be sure that the political commitments made in 2013 are delivering success for those women and children most at risk. There are concerns, for example, that organisational divisions between nutrition initiatives are being reflected in countries (13). But what we can say is that the instruments and infrastructure is being put in place to accelerate progress towards addressing this most pervasive predicament.

22. 2014 has seen its own signature initiatives too. The launch of the *Every Newborn Action Plan* is the best opportunity in a decade to place newborns high on the current and post-2015 political agenda (18-22). Newborns have been persistently excluded from the global movement to scale-up action for women's and children's health. And yet the figures are striking—2.9 million newborn deaths annually and 2.6 million stillbirths. That is 15 000 babies dying each day, or 10 babies a minute. The key messages of a

second *Lancet* series on newborn health, launched at the World Health Assembly in May, 2014, together with the Every Newborn Action Plan, are six-fold.

- First, although newborn health is talked about, not enough is being done to deliver on our promises. Investments are too small. Implementation is too weak. And stillbirths are simply ignored
- Second, leadership for newborns must be strengthened—globally, regionally, and in countries. We need to communicate more effectively that we have interventions that work. We need to integrate action on newborns with action on maternal health. And partners must improve their coordination technically, programmatically, and politically. We also need to persuade countries to increase their domestic investments in newborn health
- Third, look at the prize: by 2025, based on what we know now, the deaths of 1.9 million newborns and 160 000 mothers can be averted. 820 000 stillbirths can be prevented. That is 3 million lives saved, at low cost
- Fourth, the priorities must now be to strengthen services and facilities for women and newborns; recruit, educate, and train a skilled workforce; and ensure leadership and investment to support this plan. 40% of stillbirths and newborn deaths occur at the time of labour and the day of birth—1 million babies die on the day they are born. The birth day is the most dangerous day of all for mothers and their newborns
- Fifth, civil registration and vital statistics systems must be created to end the scandal of invisibility for half of all newborn deaths. 1 in 3 newborns does not receive a birth certificate before their first birthday.
- And finally, we must deliver a newborn and stillbirth sustainable development goal.

The opportunity for a remarkable new coalition beckons. Can we convert the multisectoral commitments to newborn health (23) into an FP2020 and Nutrition 4 Growth like major global initiative?

23. It is a universal truth, as the Global Health Workforce Alliance argued in 2013, that there is "No Health Without a Workforce" (24). One group of health professionals that could have a decisive impact on the health of women and children, but whom have so far been a neglected group in efforts to deliver *Every Woman, Every Child*, is the midwife. *The State of the World's Midwifery 2014* makes uncomfortable reading (6). 73 out of 75 Countdown countries, where 92% of global maternal and newborn deaths and stillbirths take place, are home to only 42% of the world's medical, midwifery, and nursing personnel. Only 4 of these countries have a midwifery workforce that is able to provide universal access to reproductive, maternal, and newborn health services. Although many countries are attempting to scale up their investments in midwifery services, few data are available in countries to guide appropriate decision-making. The report goes on to detail country-specific data on workforce availability, midwifery education and regulation, professional associations, and the projected workforce to 2030, together with several "what if…" scenarios—for example, what if the number of pregnancies was reduced by 20% by 2030?; what if the number of midwives, nurses, and physicians doubled by 2020? Also in 2014, a series of papers presented a framework to help countries scale up their midwifery workforce. If the evidence presented in this series was implemented, over 80% of maternal and newborn deaths, including stillbirths, could be averted (25-28).

24. One challenge is that midwifery is widely misunderstood. A common view is that midwifery is about childbirth. It is, but it is also much more than that. Midwifery is "skilled, knowledgable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum, and the early weeks of life." Midwifery includes, for example, family planning and the provision of sexual and reproductive health services. Midwifery services are a core part of universal health coverage. But midwifery is not only about interventions. It is also about the needs of the woman and her newborn infant. The values of midwifery are therefore important—respect, communication, community knowledge and understanding, and care tailored to a woman's circumstances and needs. The philosophy of midwifery is important too: to optimise the normal biological, psychological, social, and cultural processes of childbirth, reducing the use of interventions to a minimum. As with new awareness around newborn health, the attention being given this year to midwifery services is an opportunity to mobilise political action and partner investment. But again, we must ask: will this opportunity be seized?

25. In previous reports, we have identified issues of central concern to any global assessment of women's and children's health. We wish to draw attention to 5 areas that we believe not only remain important but also have still failed to trigger sufficient international concern—women and children in conflict settings, violence against women and children, unsafe abortion, child marriage, and female genital mutilation.

26. Women and children in zones of conflict. The UN High Commissioner for Refugees (UNHCR) reported in 2014 that 51.2 million people were forcibly displaced by the end of 2013, 6 million more than the 45.2 million reported in 2012. This figure makes 2013 a milestone: the first time since World War II that the number of those forcibly displaced exceeded 50 million people.

Obsolete and used equipment filling up corridors

The ongoing conflict in Syria was the major driver for this huge increase—2.5 million refugees and 6.5 million internally displaced people in 2013. But new displacements in the Central African Republic and South Sudan also made important contributions to this human misery. In 2013, a total of 10.7 million individuals were newly displaced. Children under 18 years made up half of the refugee population, the highest number for a decade. 25 300 asylum applications were made by unaccompanied or separated children in 77 countries—again, the highest number recorded by UNHCR since they began collecting such data in 2006. Countries such as Iraq, Afghanistan, and Somalia do have national acceleration plans for maternal and child health. But the ongoing violent conflict presents near intractable challenges to governments seeking to deliver human security for women and children. For women seeking access to antenatal, delivery, and postnatal care, the obstacles are often impossible to overcome. Routine services, including emergency obstetric care, are no longer available in many areas. Skilled birth attendants are absent. Transportation to facilities that are functioning is hindered. As UNHCR's António Guterres noted, "We are seeing here the immense costs of not ending wars, of failing to resolve or prevent conflict. Peace today is dangerously in deficit. Humanitarians can help as a palliative, but political solutions are vitally needed. Without this, the alarming levels of conflict and the mass suffering that is reflected in these figures will continue."

27. The situation for children in Syria is especially disturbing. It is a crisis that has received far too little political or media attention. The reality or threat of continuous violence has completely disrupted health services. Health facilities are no longer able to provide even basic care. Mortality and morbidity have risen. The risks of infectious disease outbreaks have increased. Safe water is in short supply (half of water supply systems are out of operation across the country). And vulnerability to mental health disorders has deepened. Four specific areas of health crisis deserve special attention. First, trauma. At least 1.2 million Syrian have fled the conflict. 4.3 million children need urgent humanitarian assistance. WHO Syria estimates that over 200 000 children have been affected by trauma or burns. Second, vaccination. Vaccination coverage in Syria has fallen sharply—from over 90% before the conflict to 52% by March, 2014. The risk of a resurgence in vaccine-preventable disease is real and has already started—eg, for measles. Interruptions to vaccine

distribution, cold chains, and mobile vaccination units have all had an adverse effect. Polio was detected in Syria in October, 2013—36 cases have so far been reported. Monthly vaccination campaigns have begun, but insecurity has blocked access to some regions, especially rural areas, villages, and refugee camps. National and sub-national vaccination campaigns are planned for the second half of 2014. Third, nutrition. The nutritional status of children has declined since the start of the Syrian conflict. Breastfeeding already suffered low coverage before hostilities broke out; but since violence overran Syria, breastfeeding rates have fallen still further. Instances of moderate and severe acute malnutrition are common. In April, 2014, WHO supported the creation of a network of therapeutic feeding centres, which, the agency reported to the iERG, has saved the lives of over 45 children under-5 who were suffering complicated severe acute malnutrition. And finally, non-communicable diseases. Services for cancer, renal failure, heart disease, and diabetes, among many other conditions, have been severely disrupted across the country.

28. In June, 2014, the UK Government hosted a Global Summit to End Sexual Violence in Conflict. The goal was to create "irreversible momentum against sexual violence", to "shatter the culture of impunity for sexual violence in conflict", to encourage countries to pass and enforce laws against sexual violence, to support survivors, and to change attitudes—"to debunk the myth that rape in war is somehow inevitable or a lesser crime." The outcomes of this meeting build on the UK's 2013 Declaration of Commitment to End Sexual Violence in Conflict. Sexual violence in conflict is of particular interest to the iERG because it raises important issues of accountability in the context of severe damage to women's and children's health—injury, HIV infection and other sexually transmitted infections, unwanted pregnancies, mental health sequelae, and social exclusion. The message of the conference, the largest gathering ever brought together on the subject, was that the international community must do more to hold perpetrators accountable for acts of sexual violence (29, 30). Governments cannot use the lack of reliable data as an excuse to put off action. So what action will now be taken? The Summit made promises in four areas—improving accountability, providing greater support to survivors of sexual violence (including children), ensuring gender-based violence responses are routinely included in peace and security efforts, and increasing international strategic cooperation.

29. Unsafe abortion remains a serious threat to women's health. According to the most recent and reliable data (2008), one in 5 pregnancies ends in abortion. The estimate for 2008 was that 49% of 43.8 million abortions were unsafe (21.5 million abortions), compared with 44% of 45.6 million abortions in 1995 (20.1 million abortions). The decline in abortion rates since 1995 stabilised after 2003-08. WHO is currently working on new estimates, which are expected at the end of 2014 or early 2015. New data from the Institute for Health Metrics and Evaluation published this year estimated that in 2013 there were 43 684 abortions that could be attributed as the cause of death among pregnant women (2). That figure translates into 15% of maternal deaths being attributable to abortion and its related complications. (It is worth noting that a different analysis by WHO put the proportion of maternal deaths caused by abortion at 8% [31].) In the meantime, WHO published a *Clinical Practice Handbook for Safe Abortion* in 2014. Disappointingly, many commitment-makers to *Every Woman, Every Child* consider safe abortion too "divisive"—the word used by Prime Minister Harper at his Toronto Summit—an issue to address directly or publicly. When one looks at the numbers of women who suffer unsafe abortion, and who die as a consequence, this preference to call unsafe abortion "divisive" seems little short of disgraceful. Those who claim they see equal value in all lives seem happy to exclude women who desperately need access to safe abortion services. In other settings, that contradiction might be called hypocrisy.

30. Child marriage abuses the health, wellbeing, and dignity of girls, and it is a widespread problem. 34% of girls (excluding China) are married by the age of 18 years. 11% of girls marry before the age of 15 years. Global rates of child marriage have hardly changed for a decade. Nine out of 10 countries with the highest rates of child marriage are in sub-Saharan Africa. Of 16 million adolescent girls who give birth each year, about 90% are already married. Pregnancy-related complications are the leading cause of mortality in these girls. Stillbirths and newborn deaths are 50% higher in mothers younger than 20 years. So what is being done about this devastating problem for young women? The Inter-Parliamentary Union has raised the issue of child marriage among its members. And Save the Children has submitted evidence to the Human Rights Council about child marriage. Save's approach is to treat child marriage as a human rights violation—"one of the most pressing development concerns in the world today." They recommend that national laws should conform with international treaties on child marriage, that awareness raising must continue, that girls must be protected from harassment in public spaces, that child protection mechanisms should be strengthened, that birth and marriage registration is a powerful way to defeat child marriage, and that one of the most protective actions would be to invest

in girls' education. But the question remains: where will the political leadership come from to tackle the issue of child marriage? The research community has an important part to play in maintaining high-level political focus on child marriage. Key questions remain unanswered. What are, and how do we respond to, the health and social needs of child brides? Can specific educational interventions prevent child marriage? How can laws against child marriage be applied more effectively? What factors help or hinder intergenerational change? Knowledge could be a powerful catalyst for social change.

31. Female genital mutilation (FGM) affects over 125 million girls and women concentrated in 29 countries in Africa and the Middle-East. It is a procedure performed in girls mostly between infancy and the age of 15 years. FGM, which involves the partial or total removal of external genitalia, is a violation of the human rights of girls and women. It delivers no health benefits. Indeed, the negative health sequelae are considerable—infection, difficulty urinating, cysts, infertility, complications during childbirth, and increased risks to the newborn. In 2012, the UN General Assembly adopted a resolution on the elimination of FGM. But, although the prevalence of FGM has declined, at least 30 million girls are still at risk of the procedure, some even being sent from homes in high-income countries to be mutilated (this practice is known as "vacation cutting"). Perhaps worse still, there is now a trend towards FGM being conducted by healthcare providers (in over 18% of cases). It is welcome that 24 countries in regions where FGM takes place have made the practice a criminal offence. But that law is insufficiently applied in practice. Despite there being an International Day of Zero Tolerance for FGM (held annually on February 6), too little advocacy and action characterise efforts to address FGM. Genital cutting is an extreme form of discrimination against women and girls. Resolutions passed by the UN General and World Health Assemblies are important. But they are not enough.

Sweden's development cooperation policy: prioritising RMNCH

Swedish development policies, including the new aid policy framework, clearly state that maternal health is not only a health issue, but also a serious human rights issue (1).

Sweden has a long history of supporting sexual and reproductive health and rights (SRHR), and has also played an important role globally, raising these issues at UN conferences (2). The topics raised are considered to be important for combating maternal mortality, including sensitive and controversial topics such as safe abortion, contraceptives, and sex education.

In 2012, the Swedish government decided to further strengthen its comprehensive efforts and funding to improve maternal and child health, in part to support the United Nations Secretary General's Global Strategy for Women's and Children's Health (3). Sweden accounts for about 2% of the world's total health assistance, which in 2012, for example, contributed to 1.9 million children receiving full vaccination, 130 000 women giving birth in health-care institutions, and 229 000 obtaining access to contraceptives (4).

One of Sweden's special initiatives for improving global maternal health has been strengthening the role of midwives in maternal health care (5). Sweden, which has one of the world's lowest maternal mortality rates (6), has developed a strong midwifery profession and has long advocated for midwives as the most important human resource for reducing maternal mortality (7). Being the biggest donor to UNFPA (8), Sweden has also supported the *Investing in Midwives and others with Midwifery Skills* programme, a UNFPA-International Confederation of Midwives (ICM) Joint Initiative launched in 2006. Since then, several countries have signed up as donors and this is becoming the world's leading international midwifery programme (9).

One positive highlight resulting from this initiative is in Bangladesh, where Swedish midwives have worked for many years (employed by UNFPA), contributing to an increase in both the quality of midwifery education and the quantity of midwives trained. In addition to the 350 midwifery graduates, 138 midwifery teachers were trained under the programme between 2010 and 2012 (10).

More than half of Sweden's health assistance goes to health-care services, mainly as multilateral funding through the GAVI Alliance, The Global Fund to Fight Aids, Tuberculosis & Malaria, and UNICEF, which in 2010 helped to save the

lives of 120 000 children through the distribution of mosquito nets against malaria, immunization of children, and the fight against TB and HIV/AIDS (11).

When it comes to health assistance through bilateral programmes (representing around 40% of Sweden's total support for health) (12) results are more difficult to quantify. Nevertheless, an internal evaluation of results achieved in four bilateral partner countries concluded that there have been positive health developments in three countries (Bangladesh, Uganda, and Zambia) during the ten years from 2001 to 2010. Sweden contributed to these long-term health gains, which in turn contributed to poverty reduction in these countries.

In Bangladesh (13) Sweden has been cooperating in the provision of health services since the early 1980s. The country is on track to achieve the health-related MDGs: in 2010, the MMR was 194 per 100 000 births, compared with 322 in 2001. This decline in maternal mortality is due mainly to the improved service delivered through the Health Nutrition and Population Sector Programme (HNPSP) and to improved female literacy and economic empowerment. Sweden has funded 2% of the HNPSP, thus contributing to 28 million women obtaining access to contraceptives and 58 000 more women obtaining access to early abortions in 2011, among other results (14). Sweden has also financed the Swedish Association of Midwives' training in Bangladesh.

Another initiative supported by Sweden is the H4+, a UN partnership between UNFPA, UNICEF, WHO, UNAIDS, UN Women, and the World Bank, targeting countries with the highest maternal and child mortality rates. Sweden is contributing US$350 million (2013-2015) to fund innovative efforts in national RMNCH health plans in six high-burden countries in Africa (Cameroon, Ethiopia, Guinea-Bissau, Ivory Coast, Liberia, and Zimbabwe). Part of the funding is being used to improve coordination between the partners.

Efforts to achieve MDGs 4 and 5 will continue after 2015. One recent decision was to extend Swedish support for the UNFPA Maternal Health Thematic Fund, amounting to US$ 55 million for 2014 to 2017. This should contribute to reducing MMR in 40 countries, primarily in sub-Saharan Africa.

Being a major donor to RMNCH (15) Sweden has contributed to the very positive developments in RMNCH over the years. There is now a consensus on what actually needs to be done, which has not always been the case; and the issue of maternal survival is now high on the international political agenda.

But there are also many challenges, particularly the fragmentation of aid which is divided between various donors and channels, making it less effective. Also there are still no well functioning global mechanisms to support countries' own establishment of health systems, and Sweden identifies the need to make greater demands for organisations to collaborate fully at the country level.

The Global Fund's role in coordinating major resources from various countries to achieve MDG 6 is highlighted as a positive example of successful coordination and alignment with national systems.

Another challenge from Sweden's point of view is that many countries still see the SRHR agenda as controversial, with high levels of resistance to abortion. Unsafe abortion is the reason behind 8-15% of all maternal deaths. The lack of funding for maternal and child health is another big problem that will remain after 2015, and the reproductive health agenda, with its controversial issues, makes it more difficult to mobilise resources.

As a major donor to maternal and child health, Sweden has developed a wide network of contacts with both recipient countries and global players, and has seen excellent results from this cooperation. However, Sweden sees the potential to become even better at creating effective contacts at the local level and then utilising those contacts globally in bilateral cooperation.

After 2015, Sweden will continue to prioritise SRHR. If the post-2015 agenda is to move away from the health-related MDGs 4, 5, and 6, in favour of a single broader health goal of ensuring children's and women's health, that could make it easier to collaborate and coordinate health efforts. Nevertheless, some people in Sida and the Ministry of Foreign Affairs consider that a broader agenda risks being perceived as less tangible, which might make it less clear which actions are needed to achieve the goals.

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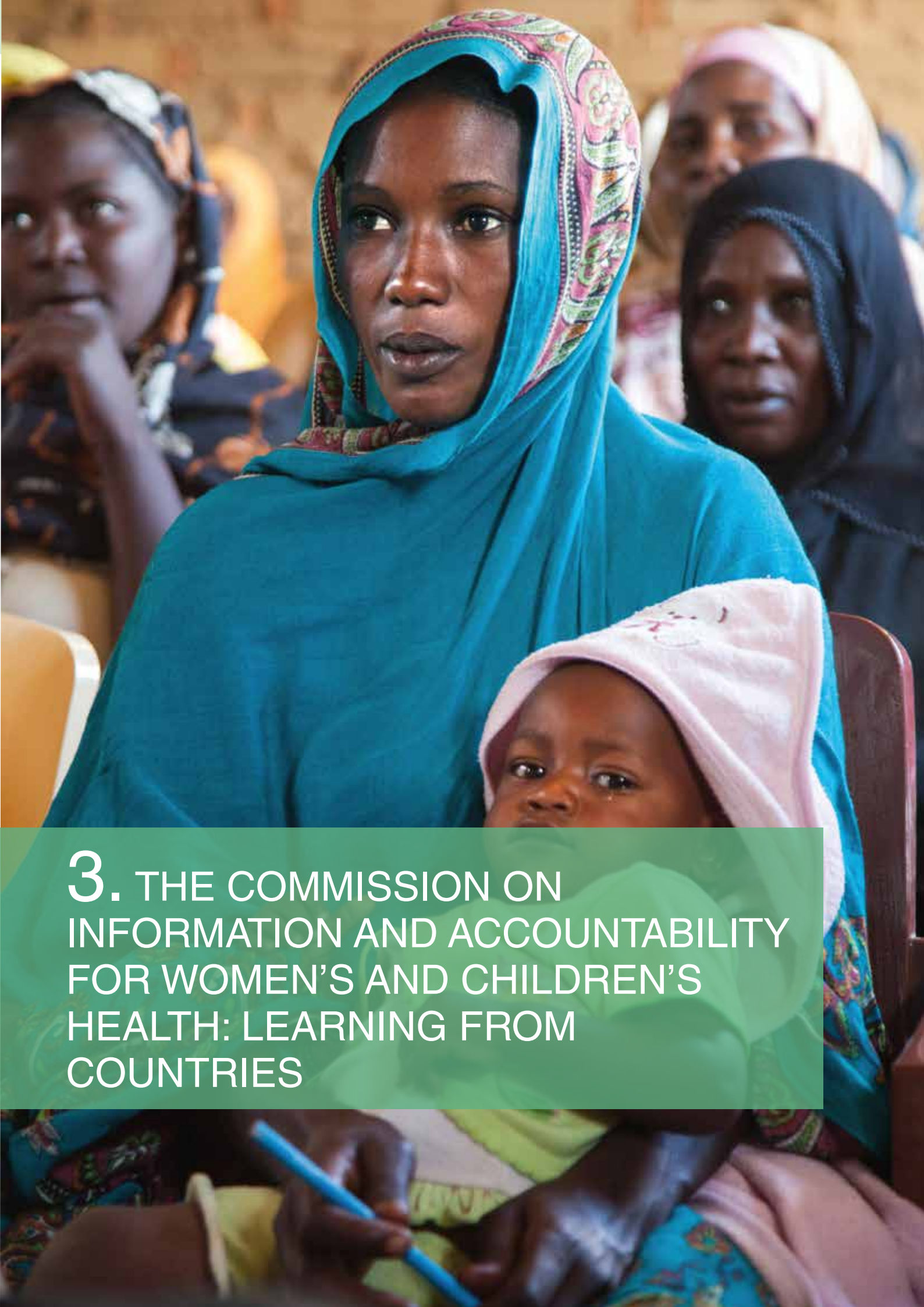

3. THE COMMISSION ON INFORMATION AND ACCOUNTABILITY FOR WOMEN'S AND CHILDREN'S HEALTH: LEARNING FROM COUNTRIES

32. The recommendations of CoIA are shown in Panel 1. As can be seen, each recommendation is tied to a year for its completion. Six of the 10 recommendations were to be delivered by the end of 2013. The final 4 recommendations do not have to be delivered fully until the final year of the Commission's timetable. In our 2013 report we summarised global progress on these recommendations. Based on the evidence we have received, we now update our judgements, which can be seen in Figure 6. In sum, we have seen substantial advances since last year in meeting the goals and targets set by CoIA. 6 of 9 goals have been upgraded in their progress.

Figure 6. Summary of global progress on implementation of the recommendations from CoIA

Recommendation	Target year	2013	2014
Vital events	2015		
Health indicators	2012		
Innovation	2015		
Resource tracking	2015		
Country compacts	2012		
Reaching women and children	2015		
National oversight	2012		
Transparency	2013		
Reporting aid	2012		
Global oversight	2012		

The target will be difficult or impossible to achieve
Progress is being made, but continued and concerted effort is needed to achieve the target
The target is on track or has already been achieved

Financial support from donors for implementing CoIA recommendations is shown in Table 4. Table 5 shows the distribution of funds to CoIA workstreams to May, 2014.

Table 4. Financial support from donors for implementing CoIA recommendations, US$

Donors	Phase I - Funding received				Totals
	2011	2012	2013	2014	
CIDA	150 045	19 672 117			**19 822 162**
DFID		796 133	1 561 232	2 388 420	**4 745 785**
NORAD	155 039	11 927 656	2 395 522		**14 478 217**
NORAD/iERG			300 000		**300 000**
GIZ			884 297		**884 297**
Totals:	**305 084**	**32 395 906**	**5 141 051**	**2 388 420**	**40 230 461**
Running Totals	**305 084**	**32 700 990**	**37 842 041**	**40 230 461**	

Table 5. Financial distribution by work streams from inception to 31 May 2014, US$

Recommendations and work streams	Distribution				Total
	Countries	HQ/RO	Partners	Global Oversight / Project Management	31 May 2014
Development of CAF, including self-assessment	780 000	0	0	0	780 000
Vital Events and Health Information Systems					
CRVS	2 711 000	0	0	0	2 711 000
MDSR and Quality of Care	3 691 000	1 429 921	251 725	0	5 372 646
Health Indicators and Information Systems					
Monitoring of results (Health Information Systems and data quality) and indicators	3 555 000	1 993 894	150 000	0	5 698 894
Innovation and eHealth					
eHealth and Innovation	965 000	583 434	441 063	0	1 989 497
Resource Tracking					
Resource tracking	2 114 000	1 114 000	199 615	0	3 427 615
Compacts and health reviews					
Compacts and health reviews	948 000	838 007	638 900	0	2 424 907
National Oversight and transparency					
Advocacy, outreach, and transparency	1 366 000	0	733 716	0	2 099 716
Country Countdowns (dissemination, interpretation, use)	0	85 000	483 716	0	568 716
Human rights	0	100 000	0	0	100 000
Adolescent health	0	100 000	0	0	100 000
Global Oversight / Project management					
Independent Expert Review Group / Project management and secondments	0	0	0	7 981 666	7 981 666
Programme support costs					4 628 283
Undistributed amount *					2 347 521
Grand Total	**16 130 000**	**6 244 256**	**2 898 735**	**7 981 666**	**40 230 461**

* Funds undistributed to countries pending the approval of their Country Accountability Frameworks and in addition to the US$16 130 000 already allocated

33. *Vital events.* Progress on civil registration and vital statistics systems this past year has been significant. The most visible leadership has come from the Government of Canada's prioritisation of CRVS within its $3.5 billion phase II Muskoka commitment. But the real progress is being seen in countries. This work began with the Bangkok Call for Partner Action at the Global Summit on CRVS in April, 2013—"We strongly believe that the time has come for the international community to seize the current momentum generated through country and regional action in order to achieve universal and effective CRVS systems in countries." WHO now reports that 51 of our 75 countries of concern have completed assessments of their CRVS systems. 28 countries have conducted comprehensive analyses that lay the foundation for a multisectoral plan. Several countries have now developed long-term investment plans. Maternal death surveillance and response is another important part of taking data more seriously. Again, WHO reports that 29 countries now require notification of a maternal death to a central authority within 24 hours. 46 countries are

implementing facility-based maternal death reviews. WHO concludes that "there is unprecedented momentum and regional action for CRVS." We agree. Global leadership and partnership to scale-up commitments have been extraordinary. UNICEF has framed CRVS as a "passport to protection" for every child (32). WHO has brought together the best practices from countries in order to establish CRVS as a public good and to provide design principles for the delivery of civil registration systems (33). WHO also convened a technical meeting in December, 2013, to identify innovative approaches to strengthen CRVS. Out of that consultation has come a set of principles and good practices to support countries in their next steps (34). In May, 2014, the World Bank published a "scaling up investment plan 2015-24." Their plan has 3 components (35). First, national CRVS strengthening. Second, international support for CRVS. And third, building the evidence case. The World Bank estimates that for 73 countries (because of their size, India and China have been excluded from their analysis) the total budget to deliver CRVS is around US$3.82 billion. The financing gap to meet that target over a 10-year period is US$1.99 billion, or US$199 million per year. The 2014 Countdown to 2015 report also highlights the importance of data, not only from CRVS but also from household surveys (3). One critical actor in the successful movement for better data are the UN Economic Commissions. For example, the UN Economic Commission for Africa is playing an important part in mobilising country action. Their goal is to have all 53 African states complete comprehensive reviews of their vital registration systems and develop national plans of action. The beginning of the post-2015 period can then be the start of a massive implementation programme across the continent. Regular events are being staged to maintain momentum—eg, a ministerial conference on civil registration, to be held in Cote D'Ivoire in October, 2014. The health sector is being promoted as a key partner in these activities. As part of the effort to position CRVS in the post-2015 agenda, the UN Statistics Division is part of a new inter-agency "Global CRVS Group", whose goals are to advocate for and accelerate action to achieve CRVS.

34. *Health indicators.* WHO reports that the 11 CoIA indicators "are used in almost all countries for tracking progress." To support their statement, WHO cites Countdown to 2015. However, in its latest report, Countdown to 2015 draws a different conclusion—"Only 8 of the 75 Countdown countries had recent data on all of these coverage indicators in 2011-2012, and 37—half the Countdown countries—had data for only one of them. The paltry number of countries able to report recent data on the full set of recommended coverage indicators is a distressing testament to data gaps in the countries where the burden of preventable maternal, newborn, and child deaths is highest. Responsibility for filling those gaps, and for defining indicators based on what it is feasible to measure well, is shared by countries and the global RMNCH community." The Countdown conclusion is best seen in Figure 7. How does one explain these discrepant interpretations of the same data? WHO's positive conclusion is because the agency is referring to countries that are using data for each of the 11 indicators. Countdown, by contrast, is referring to countries using *recent* data from 2011-12. Strictly speaking, Countdown is correct (and WHO concedes this point). The CoIA recommendation is about having up-to-date and accurate data for all 11 indicators. This is clearly not the case. That said, the spirit of the CoIA recommendation is that countries are using data for these indicators. That statement is, at least, true.

Nigeria: Civil society promotes accountability and transparency in RMNCH

This case study describes efforts to secure meaningful civil society engagement to strengthen accountability and promote transparency in accelerating progress on RMNCH in Nigeria.

Significant progress is needed to meet MDGs 4 and 5 on maternal and child health in Nigeria, where over 40 000 mothers (1) and about 1 million children (over 240 000 of them newborns) (2) die annually. Very few civil society groups in Nigeria were aware of the recommendations by the Commission on Information and Accountability for Women's and Children's Health for better national and global oversight of results and resources, in particular its recommendation that by 2012, all countries should have established national accountability mechanisms that are transparent, that are inclusive of all stakeholders, and that recommend any remedial action required.

This crucial mechanism for assessing the current situation, identifying actions needed, and helping to track progress on RMNCH was lacking in Nigeria. In order to remedy this, Evidence for Action (E4A) and the White Ribbon Alliance Nigeria (WRAN) worked with Health Reform Foundation of Nigeria and Advocacy Nigeria to ensure civil society representation in the Country Accountability Framework (CAF) regional workshop that took place in Harare, Zimbabwe, in October, 2012, alongside WHO and government delegates (3). This group also advocated for the involvement of civil society organisations (CSOs) in the follow-up national workshop in Abuja held in April, 2013, focusing on the review and finalisation of Nigeria's country accountability framework and priority actions. E4A invited CSOs to come together a day before the workshop to share evidence, conduct their own assessment of Nigeria's progress, and identify priority actions on RMNCH. The CSO contingent was thus able to agree collective goals and to prepare a highly effective strategy of engagement in advance of the national workshop. They involved themselves in all seven thematic areas of the workshop, which culminated in the development of a national roadmap. Following the CAF, the seven thematic areas were:

1. Civil registration and vital statistics
2. Monitoring for results
3. Maternal death surveillance and review
4. ehealth
5. Monitoring resources
6. Review process
7. Advocacy and outreach.

To facilitate transparency and accountability for implementing and tracking progress on the national RMNCH roadmap and plan, the CSOs proposed the establishment of an independent expert review group, which was well received. Through an existing national umbrella coalition, which brings together CSOs, health professional bodies, and the media, known as "Accountability for RMNCH in Nigeria (AMHiN)", terms of reference were drafted and a working group was convened to set up this independent mechanism.

These terms of reference guide the Nigerian Independent Accountability Mechanism (NiAM), which operates within the platform of AMHiN. Its logistical funding comes from grants secured by the member CSOs and partners of AMHiN. Information is accessed in innovative ways: involvement in government health sector review meetings, obtaining budget information from legislative assemblies, surveys, and studies, and employing social accountability strategies using scorecards to track and report progress and strategically engage in advocacy and dissemination of information.

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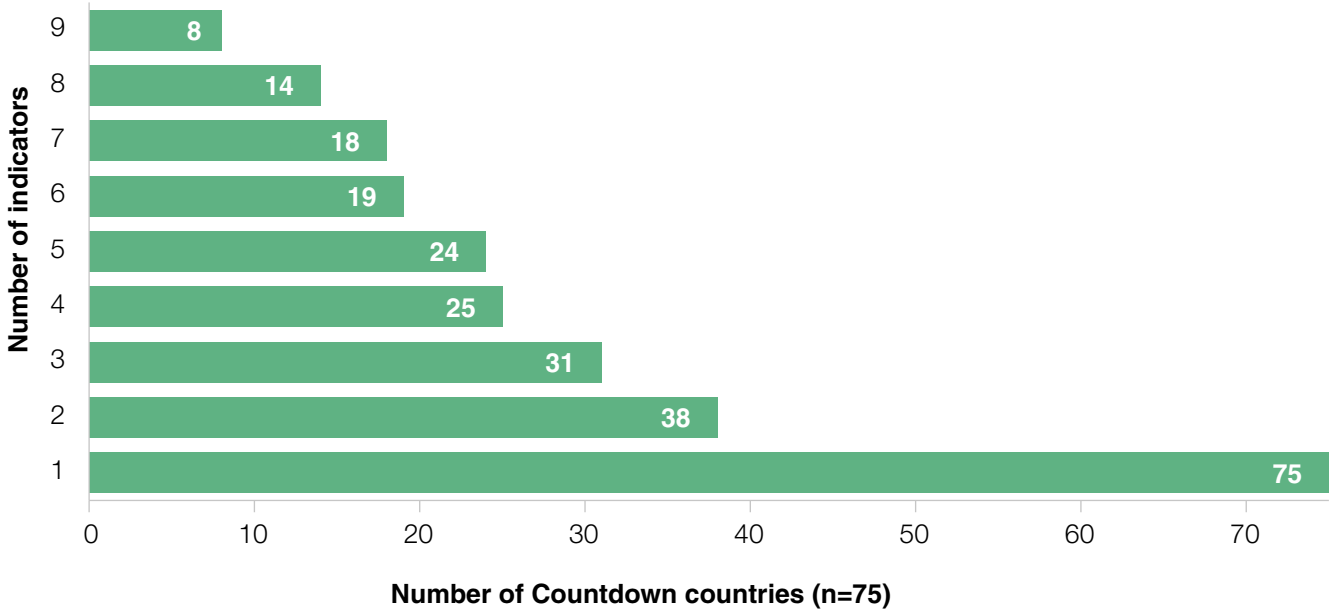
Figure 7. Half of *Countdown* countries had data for only 1 of 9 recommended coverage measures in 2011-2012

Number of Countdown countries reporting updated data from 2011 or 2012* for one or more of nine coverage indicators recommended by CoIA.**



* Includes 2013 data for Ghana and Pakistan for demand for family planning satisfied.
** Indicators include: (1) Demand for family planning satisfied, (2) Antenatal care (four or more visits), (3) Skilled attendant at birth, (4) Postnatal care for mother, (5) Postnatal care for baby, (6) Exclusive breastfeeding, (7) DTP3 vaccine coverage, (8) Careseeking for pneumonia, and (9) Antibiotic treatment for pneumonia. This list differs from the Commission list because it does not include two indicators related to HIV, counts postnatal care for mother and baby separately, and includes careseeking as well as treatment for pneumonia.

35. *Innovation.* WHO reports that 27 countries have developed and implemented national eHealth strategies linked to RMNCH. 65 countries have completed eHealth profiles that serve as a baseline for monitoring the uptake of information and communication technologies. This progress is important. The entire field of eHealth has been scarred by pilot projects that have often yielded interesting and hopeful results, but which prove unsustainable when project funding expires (36,37). In February, 2014, WHO hosted a joint inter-ministerial dialogue on eHealth standardisation and interoperability to deliver the platforms for sustainable solutions to technological improvements in the collection and use of data. We will continue to follow progress in this important area closely.

36. *Resource tracking.* 18 of 75 countries, WHO reports, track expenditure on RMNCH. Nine of these countries have data available. A further 33 countries are expected to be able to track spending on RMNCH by the end of 2015. The fulfilment of this recommendation is challenging since health accounts methodology is undergoing substantial change. A new mechanism called SHA 2011 is seen by many agencies as an important step to better resource tracking. It is this method that is now being adopted by countries. What is already clear is that although spending on RMNCH is low (between US$4-15 per capita), the proportion of the health budget allocated to RMNCH is high (at around a third of total health spending). Although these data come from only 6 countries, it is also clear that much of the burden of RMNCH expenditure (41%) falls on families. The remainder comes from development partners (37%), governments (15%), and other private sources (7%). Many families have little financial risk protection, making the quest for universal health coverage as a post-2015 goal so important.

37. *Country compacts.* WHO reports that 44 countries have a compact or partnership agreement in place. A further 9 countries are in the process of establishing such agreements. Since 2010, more than one in three of these compacts have been co-signed by civil society or non-state actors. Such agreements provide a means to formalise debate, coordination, and decision-making in countries. The principles underlying the compact are the “three ones”: one country health strategy, one results framework, and one

budget. What is now needed is not simply a measure of whether a compact is in place or not, but measures of whether the "three ones" are being adhered to. WHO describes 2014 as the year that marks the end of the first phase of implementation after publication of the CoIA report. The next phase is about ensuring that the systems now increasingly being put in place start to deliver results for women and children. The implementation of the "three ones" principle will be an important measure of whether these early commitments are being translated into action.

38. *Reaching women and children.* Currently PMNCH tracks all commitments to the Secretary-General's Global Strategy. Annex 2 shows the sources of commitments made so far to the Global Strategy (full details are available online). 58 countries report having regular national health sector reviews, although not all routinely include civil society and not all have the means to take remedial action once reviews have identified problems.

39. *National oversight.* CoIA's goal was that, by 2012, all countries would have established national accountability mechanisms that are transparent, inclusive of all stakeholders, and recommend remedial action. Countdown to 2015 makes all data fully and publicly available. Although still at an early stage of development, progress towards this recommendation is being made. Parliaments have a critical part to play, and the Inter-Parliamentary Union has been a tireless advocate for women's and children's health. In 10 African countries, parliamentarians, civil society advocates, and the media have received training to understand national budgets for women's and children's health. That said, the iERG would like to know and understand a great deal more about the variation in national accountability mechanisms. To this end, we conducted two country visits—to Malawi and Peru. We will discuss the lessons of these visits later in this chapter. The iERG also conducted a survey of countries to understand better the value of the CoIA process to their planning and decision-making. Iraq pointed to specific capacity challenges, a lesson that should be borne in mind with all new initiatives taken to countries—"The implementation of accountability requires the country to work on a number of new interventions. The current in house capacity to work on successful execution of those interventions is limited. We request the partners to assist the Ministry of Health in building the capacity of concerned departments in order to enable them to support and sustain the new accountability related interventions at all levels of the system."

40. *Transparency.* As cited above, Countdown to 2015 makes all of its data fully and freely available to all. WHO reports that 20 countries have web-based facility reporting systems. As we argued in our 2013 report, transparency is not simply about making data available. It also has to be about ensuring that all sections of society can use those data. On this question, the iERG has no detailed information to make informed judgements about country progress.

41. *Reporting aid.* OECD-DAC has agreed to improvements in its Creditor Reporting System to better capture RMNCH health spending by development partners. These changes will be implemented in the second half of 2014. We expect to be able to report data in 2015.

42. *Global oversight.* The iERG began its work in 2012. We have submitted two reports to date. After each report, a stakeholders meeting has been convened by WHO to discuss our recommendations and their prioritisation. We will discuss these responses later in this chapter. The evidence commissioned by and submitted to the iERG for this year's report is shown in Annex 3.

43. WHO concludes that their results present "a mixed but encouraging picture." We are even more optimistic. We have seen rapid scale-up in interest around accountability and the results of CoIA. Two years of continued work by all partners is finally bearing fruit. Progress is being made in almost all areas. Country Accountability Frameworks have been developed in 63 of 75 countries as a means to translate the results of CoIA into practical actions (Table 6 shows the distribution and timing of catalytic funds to countries). WHO has provided catalytic funding of US$250 000 for each country to allocate according to its own particular priorities. Accountability has now become a powerful force not only in women's and children's health, but also in global health more widely. The CoIA can take a large measure of credit for establishing accountability as a critical part of the development debate. The challenge facing country accountability mechanisms in the future is, first, the need to have more inclusive participation in these processes and, second, the need to link the systems put in place to tangible results for women and children. These challenges were reiterated in evidence submitted to the iERG by Family Care International (FCI). They describe "challenges in ensuring effective and sustainable civil society involvement in the implementation of the CAF roadmaps." FCI goes further. They charge that "the process for national reporting on the implementation of the CAF has not generally been transparent or inclusive." They argue that the catalytic funding of US$250 000 poses questions—"it is often unclear how these catalytic funds have contributed to implementation of the country roadmap, what activities

have been completed, and what progress towards improving women and children's health has been achieved as a result of these investments." Worse still, FCI claims that there is "a lack of country ownership of CAF implementation." These views were helpfully informed by country responses to a survey the iERG conducted of their experiences of the CoIA process. Egypt, for example, reported that, "The accountability framework has enabled Egypt to look more clearly at health system bottlenecks and it has enabled Egypt to strive for better data for planning, prioritisation, and monitoring and evaluation." Djibouti noted that the CoIA process "has raised the level and scope of advocacy, ensured stronger uptake of commitments and responsibilities—pushing for synergies and a common purpose to provide better results, to monitor and to address key bottlenecks and challenges. This applies to resources and data. It has spurred competitiveness between countries." Sudan said that the CoIA "has helped to ensure that more funds are committed and allocated to MCH and that they are used appropriately to support the needed interventions."

Table 6. Implementation Status of Catalytic Funds for the Country Accountability Frameworks

Countries	Distribution date	Approved amount for distribution, US$	Amount currently distributed, US$	Implementation as at 31 May 2014, US$	Implementation % as at 31 May 2014
Turkmenistan		-	-	-	0%
India		-	-	-	0%
Côte d'Ivoire		-	-	-	0%
Guinea-Bissau		-	-	-	0%
Mali		-	-	-	0%
Azerbaijan		-	-	-	0%
Uzbekistan		-	-	-	0%
Chad		-	-	-	0%
Ghana		-	-	-	0%
South Sudan		-	-	-	0%
Benin	02-Jul-12	250 000	250 000	250 000	100%
Tanzania-Mainland/ Zanzibar	04-Jul-12	350 000	350 000	110 922	32%
Lao PDR	11-Jul-12	250 000	250 000	199 412	80%
Solomon Islands	13-Jul-12	250 000	250 000	87 186	35%
Malawi	21-Aug-12	250 000	250 000	244 360	98%
Senegal	21-Aug-12	250 000	125 000	92 672	74%
Sierra Leone	20-Sep-12	250 000	250 000	207 940	83%
Togo	21-Sep-12	250 000	250 000	241 884	97%
Uganda	25-Sep-12	250 000	250 000	137 189	55%
Zimbabwe	20-Sep-12	250 000	250 000	127 908	51%
Philippines	10-Oct-12	250 000	250 000	157 514	63%
Ethiopia	16-Nov-12	250 000	250 000	194 880	78%
Madagascar	16-Nov-12	250 000	250 000	72 339	29%

Countries	Distribution date	Approved amount for distribution, US$	Amount currently distributed, US$	Implementation as at 31 May 2014, US$	Implementation % as at 31 May 2014
Viet Nam	16-Nov-12	250 000	250 000	147 155	59%
Cameroon	14-Dec-12	250 000	250 000	250 000	100%
Mauritania	26-Nov-12	250 000	250 000	144 924	58%
Papua New Guinea	26-Nov-12	250 000	250 000	186 799	75%
Dem. People's Rep. of Korea	30-Jan-13	250 000	250 000	139 427	56%
Nepal	30-Jan-13	250 000	250 000	173 469	69%
Cambodia	07-Feb-13	250 000	250 000	150 361	60%
Zambia	05-Mar-13	250 000	250 000	250 000	100%
Liberia	18-Mar-13	250 000	250 000	247 147	99%
Lesotho	26-Mar-13	250 000	250 000	167 433	67%
Bolivia	27-Mar-13	250 000	250 000	177 000	71%
Guatemala	27-Mar-13	250 000	250 000	178 000	71%
DRC	11-Apr-13	250 000	250 000	155 000	62%
Yemen	11-Apr-13	250 000	250 000	30 931	12%
Tajikistan	11-Apr-13	250 000	250 000	249 799	100%
Afghanistan	17-Apr-13	250 000	250 000	190 966	76%
Kenya	23-Apr-13	250 000	250 000	241 710	97%
Pakistan	20-May-13	250 000	250 000	244 104	98%
Myanmar	20-May-13	250 000	250 000	243 430	97%
Iraq	31-May-13	250 000	250 000	211 971	85%
Burkina Faso	17-Jun-13	250 000	125 000	125 000	100%
Comoros	17-Jun-13	250 000	125 000	125 000	100%
Guinea	17-Jun-13	250 000	125 000	130 000	104%
Nigeria	17-Jun-13	250 000	125 000	107 185	86%
Brazil	17-Jun-13	250 000	125 000	125 000	100%
Peru	17-Jun-13	250 000	125 000	125 000	100%
Kyrgyzstan	20-May-13	250 000	250 000	165 000	66%
China	03-Jul-13	250 000	125 000	12 951	10%
Rwanda	15-Aug-13	250 000	125 000	79 504	64%
Indonesia	19-Aug-13	250 000	125 000	14 995	12%
Bangladesh	20-Aug-13	250 000	250 000	124 595	50%

Countries	Distribution date	Approved amount for distribution, US$	Amount currently distributed, US$	Implementation as at 31 May 2014, US$	Implementation % as at 31 May 2014
Somalia	22-Aug-13	250 000	125 000	102 888	82%
Angola	18-Nov-13	250 000	130 000	27 108	21%
Burundi	29-Nov-13	250 000	250 000	24 444	10%
Niger	29-Nov-13	250 000	250 000	1 146	0%
Congo	15-Jan-14	250 000	125 000	30 089	24%
Gabon	15-Apr-14	250 000	125 000	-	0%
Djibouti	15-Apr-14	250 000	125 000	125 000	100%
Mozambique	01-May-14	250 000	125 000	-	0%
Sao Tome and Principe	01-May-14	250 000	125 000	-	0%
Swaziland	01-May-14	250 000	125 000	-	0%
Gambia	20-Mar-14	250 000	125 000	-	0%
Eritrea	22-May-14	250 000	125 000	-	0%
Mexico	22-May-14	250 000	125 000	-	0%
Haiti	26-May-14	250 000	125 000	-	0%
South Africa	28-May-14	250 000	125 000	-	0%
Sudan	03-Jun-14	250 000	125 000	-	0%
Egypt	05-Jun-14	250 000	125 000	-	0%
Central African Republic	05-Jun-14	250 000	125 000	-	0%
	Totals:	**15 350 000**	**12 355 000**	**7 348 737**	

44. A further crucial part of CoIA was its focus on equity. CoIA recommended that the 11 health indicators it proposed be "disaggregated for gender and other equity considerations." Countdown to 2015 takes a special interest in equity monitoring. In their 2014 report, they draw two conclusions.

- Even for interventions with high coverage, some countries reach less than half of all women and children
- Coverage for key interventions along the continuum of care is much higher for the wealthy than for the poor

Countdown gives a telling example. Stunting is 2.5 times more common among poor children than among children from wealthier families. Countdown uses two measures for its equity analyses: the composite coverage index (measuring 8 preventive and curative interventions along the continuum of care) and the co-coverage index (the proportion of mothers and children who receive 8 well-established interventions). In almost every country, coverage of 8 interventions is higher among the richest than among the poorest. And in some countries, more than a third of mothers and children in the poorest 20% of the population received zero-to-2 interventions—Nigeria, Afghanistan, Ethiopia, Central African Republic, Lao PDR, and Pakistan. We welcome Countdown's attention to equity and its focus on stunting. We hope that they and others will build on this work by extending the range of indicators for outcome equity.

45. The iERG has made 12 recommendations to accelerate progress in the delivery of *Every Woman, Every Child*. These recommendations are shown in Panel 2. Here we summarise our assessment of progress in delivering these recommendations.

46. *Strengthen global governance.* The creation of an RMNCH Steering Committee offered an opportunity to create a platform to enhance coordination between partners. The first formal meeting of the Committee took place in April, 2013. The Committee's members—which included WHO, UNICEF, UNFPA, the World Bank, GAVI, Global Fund, development partners, countries, and civil society—saw themselves as filling an important gap in the RMNCH space. Their goal was to respond to the messages of countries and work to harmonise and align RMNCH efforts at country level. In addition, they sought to identify funding gaps, coordinate donor commitments with country needs, and facilitate the development of costed plans for the UN Commission on Life-Saving Commodities. Through the creation of a Strategy and Coordination Team, identification of 8 "pathfinder countries", the use of an RMNCH Trust Fund under the auspices of UNFPA, the adoption of IHP+ principles, and the development of a country engagement process to begin work on harmonisation and alignment, the RMNCH Steering Committee provides a mechanism to address one of the most challenging issues facing countries today—how to reduce the burden of managing multiple parallel donor-driven initiatives that often violate the principle of the "three ones." As yet it is too early to say whether the Committee is delivering on its promise. The iERG is impressed by the speed with which the Committee has begun its work. We are mindful of some criticism, however—the need for greater participation of civil society, clearer definition of the precise added value the Committee will bring, and the metrics of success the Committee will adopt to judge its work.

47. *Devise a global investment framework.* The global investment framework for women's and children's health was published in November, 2013 (38). The framework estimated the effects of investment on RMNCH across the continuum of care (for 50 interventions, including family planning, for which health outcomes could be modelled) and extended the time frame to 2035. The work included an analysis of the economic and social returns on investment. Three scenarios were applied: current coverage maintained, historic trends of coverage increased, and accelerated scale-up. Not surprisingly, accelerated scale up would bring significantly more reductions in child and maternal mortality—between 2013 and 2035, prevention of 150 million under-5 deaths (including prevention of 60 million newborn deaths), averting the deaths of 5.3 million mothers, and avoiding 32 million stillbirths. These investments are large but affordable: an additional US$30 billion per year. They will also deliver substantial economic and social benefits, and yield a demographic dividend. These returns on investment are highest for low and low-middle income nations. For the first time, this investment framework has provided a guide to countries and partners about the likely costs and benefits of investing in women and children. In its annual report to the iERG, PMNCH emphasises the importance of using this global investment framework to continue to make the case for scaled-up investments. The RMNCH Trust Fund is one innovative mechanism to assume a gap-filling and catalytic role in countries. The Trust Fund was established in August, 2013, and is managed by a Trust Fund Allocation Committee made up of donors to the Trust Fund and UN implementing partners. Housed by UNFPA, it was established through a memorandum of understanding between UNICEF, WHO, and UNFPA. So far, Norway has been the only contributor to the Fund. In 2014, it is hoped that the UK will become an additional partner. The Fund's resources are small—only US$50 million annually. Investments are therefore highly targeted. Presently, only 9 countries are in receipt of funds from this source, and these countries are included as part of the follow-up to the Commission on Life-Saving Commodities—DRC, Ethiopia, Malawi, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, and Uganda. Additional countries are being or hope to be engaged— Benin, Burkina Faso, Cameroon, Ghana, Kenya, Liberia, Mali, and Sudan. This new Trust Fund complements a separate mechanism housed at the World Bank—the Health Results Innovations Trust Fund (HRITF). This Fund is a World Bank managed multidonor trust Fund created in 2007 to support results-based financing for the health-related MDGs, especially for women's and children's health.

48. *Set clear country-specific strategic priorities.* As a global oversight mechanism, judging progress in countries is almost impossible except by referral to globally available health data. To overcome this limitation to the iERG's work, we decided to test the idea of country visits by members of the iERG team to assess the nature of country accountability mechanisms for women's and children's health. In 2014, members of the iERG visited Malawi and Peru. The full reports of these visits are in Annexes 4 and 5. They will be discussed later in this chapter.

49. *Accelerate eHealth and mHealth.* The iERG has received no further reports from WHO about progress in eHealth or mHealth for women and children. Our summary of progress is confined to information and accountability (paragraph 35 on innovation).

50. *Strengthen human rights tools.* 2014 is the 25th anniversary of the ratification and accession of the UN Convention on the Rights of the Child. One of the most successful aspects of the greater attention to women's and children's health since the launch of *Every Woman, Every Child* has been the rapid strengthening of human rights tools and platforms to protect women and children. A brief recent history is worth summarising.

- In 2012, the UN Human Rights Council welcomed the "Technical guidance on the application of a human-rights-based approach to the implementation

A regional hospital

of policies and programmes to reduce preventable maternal morbidity and mortality." The Council called upon all relevant actors, including governments, regional organisations, relevant UN agencies, national human rights institutions, and civil society organisations to disseminate the technical guidance and apply it, as appropriate, when designing, implementing, and reviewing policies and evaluating programmes to reduce preventable maternal mortality and morbidity

- In September, 2014, the application of this technical guidance will be reviewed by the Council. There has been widespread dissemination, promotion, and implementation. Countries (eg, Mexico), donors (eg, Denmark), and multilaterals (eg, UNFPA and WHO), among others, have found the guidance helpful in shaping their decision-making, capacity building, planning, programming, and strategic vision
- In February, 2013, the UN Committee on the Rights of the Child adopted General Comment 15: The right of the child to the enjoyment of the highest attainable standard of health. The document was prepared in close collaboration with WHO, UNICEF, Save the Children, and World Vision
- In March, 2013, the Office of the UN High Commissioner for Human Rights (OHCHR) published a comprehensive review on "The right of the child to the enjoyment of the highest attainable standard of health", prepared in close collaboration with WHO and UNICEF
- In May, 2013, Paul Hunt and Flavia Bustreo published an important assessment: "Women's and Children's Health: Evidence of Impact of Human Rights"
- In September, 2013, the Human Rights Council welcomed a WHO study on mortality among children under 5 as a human rights concern—"The study identifies the human rights dimensions of under-five mortality in the existing international legal framework." The report was prepared by WHO, among others, at the invitation of the Council
- In September, 2013, the Human Rights Council adopted a resolution concerning "Preventable mortality and morbidity of children under 5 years of age as a human rights concern", in which it requested OHCHR, in close collaboration with WHO, to prepare "Technical guidance on the application of a human-rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age"
- In September, 2014, it is expected that the "Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age" will be discussed and adopted by the Human Rights Council

- In 2014, WHO published an important document: "Ensuring human rights in the provision of contraceptive information and services—guidance and recommendations"
- In 2014, the UN Secretary-General issued a "Report of the Operational Review of the Implementation of the Programme of Action of the International Conference on Population and Development and its Follow-up Beyond 2014." The review is firmly grounded in human rights, and contains sound recommendations on sexual and reproductive health and rights

What does this activity mean? Quite simply that there is now a comprehensive human-rights-based platform that provides a rules-based system to accelerate action to improve the health of women and children.

51. *Expand evaluation.* The research community continues to be a powerful force to bring reliable knowledge to bear on women's and children's health. They do this is various ways. First, by assembling and synthesising research to summarise what we know about the size of particular predicament and what can be done to ameliorate it (eg, the *Every Newborn Action Plan*). Second, to monitor progress in key measures of maternal, newborn, and child health (eg, new under-5, newborn, and maternal death estimates). Third, the evaluation of programmes in countries to judge their success or failure, and to learn lessons from their implementation. The iERG has seen many excellent evaluations presented and discussed during the course of the past year. Some examples include:

- Implementation and impact of National Health Accounts in Tanzania
- Partnership and accountability in Nepal
- Maternal death surveillance and response in Cambodia
- Independent accountability mechanisms for MNCH in Nigeria
- Argentina's Plan Nacer: rewarding performance to enable a healthy start to life
- A harmonised action plan to accelerate Nigeria's progress to MDGs 4 and 5
- Update on Senegal's RMNCH country engagement process
- Update on Ethiopia's RMNCH country engagement process
- Accelerating DRC's progress to MDGs 4 and 5
- Malawi's strategy to "bend the curve" to MDGs 4 and 5

These evaluations—and creating the capacity in countries to complete these evaluations—are more than simply pieces of research. They represent important components of accountability itself. A strong health research system in a country is part of a strong climate of accountability within that country.

52. The iERG's 2013 recommendations were discussed at a Stakeholder's Meeting, led by WHO, in January, 2014. At that meeting each recommendation was assigned to a specific entity for follow up. It is therefore too early to report on progress for our 2013 recommendations. However, we briefly report some evidence of movement in each of these areas.

53. *Strengthen country accountability.* We have summarised progress on country accountability in our review of CoIA recommendations. In our 2013 report, we wrote that, "we judge that half of the [CoIA] recommendations are currently off-track, meaning they will be difficult or impossible to achieve by 2015." Our view has changed substantially in this year's report. Now we conclude that almost half of the CoIA recommendations are on-track. This result is a tribute to the work countries are doing in delivering results for women and children.

54. *Demand global accountability*—assigned to the Executive Office of the UN Secretary General. We discuss the issue of global accountability for women's and children's health in the post-2015 period in Chapter 5.

55. *Take adolescents seriously*—assigned to UNFPA. There has been substantial activity to promote adolescent health since our report was published in September, 2013. WHO published a comprehensive call for action in May, 2014 (39). *Health for the World's Adolescents* for the first time brought all of WHO's policies on adolescents together in one report. WHO drew attention to the 1.3 million adolescents who die each year. Depression is the main cause of illness and disability among boys and girls aged 10-19 years. The top 3 causes of deaths in this age group are road traffic injuries, HIV/AIDS, and suicide. There is good news too. Pregnancy and childbirth-related deaths have fallen significantly since 2000. UNFPA describes substantial activity to scale-up action for adolescents. First, UN agencies have developed an action plan on youth which includes indicators on adolescents. Second, UNFPA has advocated for adolescents to be participants in country accountability mechanisms. Third, UNFPA has continued to work to implement existing technical guidance in countries. And finally, new technical guidance is being developed—for sexual and reproductive health service use, on comprehensive sexuality education, and on integrating human rights and gender equality into family planning. These are impressive commitments by global actors. But we must qualify our enthusiasm: the reality remains that progress among countries is uneven and deep inequalities exist across wealth quintiles. Furthermore, we do not believe that adolescent health is best served by assigning it only to UNFPA. There has been too little work in other agencies to address, for example, mental health,

undernutrition, overweight and obesity, and violence among adolescents.

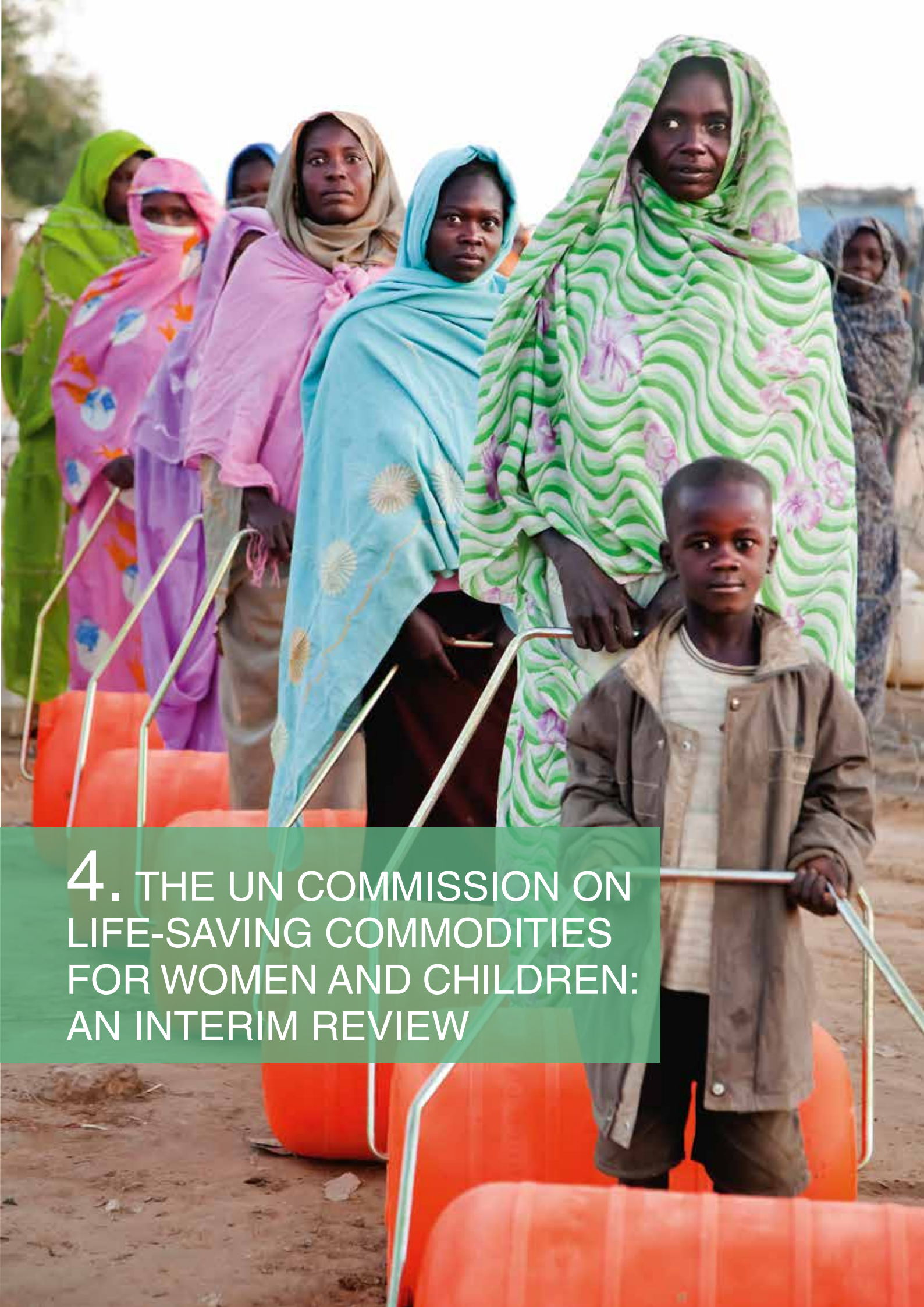
56. *Prioritise quality*—assigned to WHO. Immediately after the Stakeholder's Meeting in January, 2014, WHO made its work on quality a high-priority. The agency committed to achieve "consensus on the indicators [of quality]—definition and agreement on standards—to promote quality care, and assessment, and to move ahead on ensuring these are applied—and measured." WHO committed to get its work on definition, indicators, standards, and assessment completed in 2014. Its work began in December, 2013, with a consultation on improving maternal, newborn, and child quality of care in health facilities. This was a first meeting to bring countries together with partners to share experiences, identify possible core indicators of quality, discuss measurement challenges, and to chart a way forward. In April, 2014, WHO convened a further meeting on quality of antenatal, intrapartum, and postpartum care to examine the evidence, knowledge gaps, and priorities for action. Quality of care is far more than clinical outcomes alone. In a systematic review of qualitative studies across 17 countries presented at this meeting, the barriers to quality of care included:

- Perceptions of poor quality of care
- Distance
- Cost
- Stigma
- Social and traditional influences
- Perceptions that pregnancy is a healthy state and so does not need specific care
- Disrespect and abuse

57. *Make health professionals count*—assigned to WHO. The report we have received from WHO indicates that most efforts during the past year have focused on raising political commitment to strengthening the health workforce. The Third Global Forum on Human Resources for Health was held in November, 2013, in Recife, Brazil. The "Recife Political Declaration on Human Resources for Health" emphasised the critical importance of the health workforce to the goal of universal health coverage. But as Save the Children pointed out in their submission to the iERG, "many of these commitments lacked specific timeframe or defined outcomes." Meanwhile, WHO has begun developing health workforce educational assessment tools. We have already drawn attention to the importance of midwives and midwifery services. We are hopeful that the extraordinary burst of activity around scaling-up midwifery services can be translated into sustained action, ensuring the availability of a high-quality workforce where and when it is needed. The High Burden Countries Initiative of the H4+ may be one way to begin to do so. Despite our invitation and a promise from the H4+ to deliver, the iERG was disappointed not to receive a detailed report from the H4+ to track its progress on commitments to women and children. We will be hoping for evidence of success in 2015.

58. *Launch a new movement for better data*—assigned to the UN Statistics Division. We have already discussed the considerable progress made in advancing CRVS during the past year. We will develop this idea further in our chapter on the post-2015 period.

59. 2014 is the first year the iERG has visited countries with the goal of understanding more about their progress towards meeting the recommendations of CoIA. The teams that went to Malawi and Peru included members of the iERG and two consultants with expertise and experience in universal periodic review and human rights as applied to health. The two reports from these country visits are published in full in Annex 4 and Annex 5. There are several aspects of the reports that reveal common challenges in these two very different settings. First, there was often a general lack of awareness of the Global Strategy for Women's and Children's Health and CoIA. Second, national accountability mechanisms frequently suffered weaknesses that challenged the country's efforts to use accountability as a mechanism to advance women's and children's health. Third, transparency of data was a commonly discovered problem. And finally, health systems were often under great pressure—undergoing reform, but with limited management and health worker capacity to deliver on ambitious political goals. On the positive side, both Peru and Malawi are enjoying good economic growth, delivering considerable fiscal space for greater health investments. Both countries have ratified important international human rights treaties. Both countries have made good progress in reducing child mortality. And both countries have governments that are committed to improving the health of women and children. But these visits also showed why no single blueprint for success can simply be projected on (or parachuted into) a country. Malawi, for example, has undergone a successful transition to democracy, but still endures the twin obstacles of widespread poverty and corruption. Peru, meanwhile, is emerging from two decades of armed conflict and somehow has to manage an extremely diverse geographic space for the delivery of its healthcare. These differing political, economic, social, and environmental predicaments between the two countries all shape their health challenges and responses in unique ways. The iERG plans further visits to countries in our final year of operation.



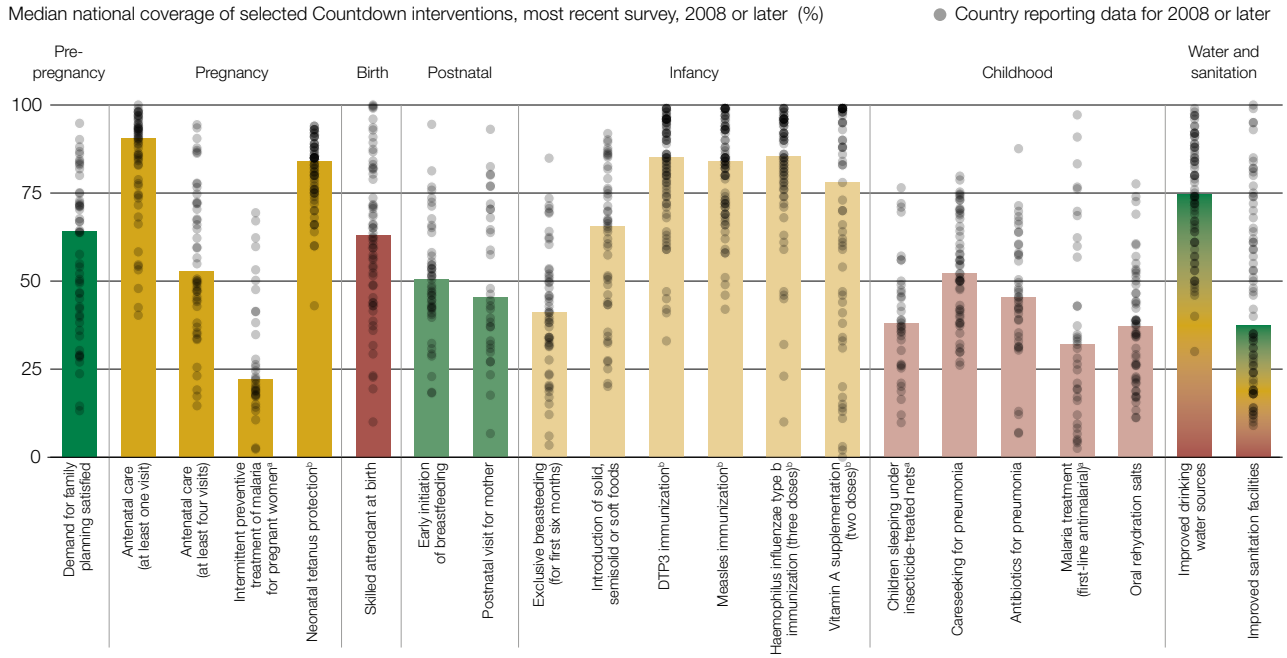
4. THE UN COMMISSION ON LIFE-SAVING COMMODITIES FOR WOMEN AND CHILDREN: AN INTERIM REVIEW

60. Interventions matter. A year ago, Jennifer Bryce, Cesar Victora, and Robert Black put it this way when considering the unfinished agenda for child survival (13):

"With regard to progress towards achievement of high, sustained, and equitable coverage for these proven interventions, the 2013 report from Countdown shows that of the 75 countries that account for more than 95% of child deaths, none has yet achieved anything close to full population coverage for even a minimum set of essential interventions. An analysis using historical trends in coverage to project under-5 mortality in 2035 shows that there would be 71% fewer deaths in that year (2.3 million rather than 7.6 million) if each Countdown country could scale up coverage at the same pace as they are in the best-performing country with a similar level of baseline coverage."

As the latest Countdown to 2015 report makes clear, coverage with some interventions remains inadequate and has barely changed for a decade—satisfied demand for family planning, skilled birth attendance, exclusive breastfeeding, improved sanitation, and appropriate care seeking and treatment for children with pneumonia or diarrhoea. The most reliable and recent data on coverage with key interventions across the entire continuum of care are shown in Figure 8 and Table 7.

Figure 8. Coverage of interventions varies across the continuum of care



61. The final report of UN Commission on Life-Saving Commodities for Women and Children, co-chaired by the President of Nigeria, Goodluck Jonathan, and the then Prime Minister of Norway, Jens Stoltenberg, was published in September, 2012 (10).
The recommendations of the Commission are shown in Panel 5. The key "overlooked" Commodities identified by the Commission are shown in Panel 6.
The Commission's recommendations are time-bound. That is, the final deadline for all recommendations to be fulfilled is the end of 2015. But the Commission was nevertheless ambitious in its vision, even over this narrow time window. If the recommendations of the Commission were fulfilled, they predicted a final under-5 mortality estimate of 5.3 million deaths per year by 2015. For maternal deaths, the Commission predicted a decline to 213 000 deaths. This was the definition of success set out by the Commission in 2012.

Table 7. National coverage of *Countdown* interventions, most recent survey, 2008 or later

Indicator	Number of countries with data	Median coverage (%)	Range (%)
PRE-PREGNANCY			
Demand for family planning satisfied	53	64	13–95
PREGNANCY			
Antenatal care (at least one visit)	58	90	40–100
Antenatal care (at least four visits)	48	53	15–94
Intermittent preventive treatment of malaria for pregnant women	34	22	2–69
Neonatal tetanus protection	67	84	43–94
BIRTH			
Skilled attendant at birth	60	63	10–100
POSTNATAL CARE			
Early initiation of breastfeeding	47	50	18–95
Postnatal visit for mother	32	45	7–93
Postnatal visit for baby	17	30	5–83
INFANCY			
Exclusive breastfeeding	51	41	3–85
Introduction of solid, semisolid, or soft foods	47	66	20–92
Diphtheria-tetanus-pertussis (three doses)	75	85	33–99
Measles immunization	75	84	42–99
Haemophilius influenzae type b immunization (three doses)	66	86	10–99
Vitamin A supplementation (two doses)	55	78	0–99
CHILDHOOD			
Children sleeping under insecticide-treated nets	36	38	10-77
Careseeking for symptoms of pneumonia	53	52	26–80
Antibiotic treatment for symptoms of pneumonia	40	46	7–88
Malaria treatment (first-line antimalarial)	35	32	3–97
Oral rehydration therapy with continued feeding	45	47	12–76
Oral rehydration salts	55	37	11–78
WATER AND SANITATION			
Improved drinking water sources (total)	72	75	30–99
Improved sanitation facilities (total)	72	38	9–100

Source: United Nations Children's Fund global databases, April 2014, based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other national surveys.

Panel 5. Recommendations of the UN Commission on Life-Saving Commodities for Women's and Children's Health

Improved markets:

1. Shaping global markets: By 2013, effective global mechanisms such as pooled procurement and aggregated demand are in place to increase the availability of quality, life-saving commodities at an optimal price and volume.

2. Shaping local delivery markets: By 2014, local health providers and private sector actors in all *Every Woman, Every Child* countries are incentivised to increase production, distribution and appropriate promotion of the 13 commodities.

3. Innovative financing: By the end of 2013, innovative, results-based financing is in place to rapidly increase access to the 13 commodities by those most in need and foster innovations.

4. Quality strengthening: By 2015, at least three manufacturers per commodity are manufacturing and marketing quality-certified and affordable products.

5. Regulatory efficiency: By 2015, all *Every Woman, Every Child* countries have standardised and streamlined their registration requirements and assessment processes for the 13 live-saving commodities with support from stringent regulatory authorities, the WHO and regional collaboration.

Improved national delivery:

6. Supply and awareness: By 2015, all *Every Woman, Every Child* countries have improved the supply of life-saving commodities and build on information and communication technology (ICT) best practices for making these improvements.

7. Demand and utilisation: By 2014, all *Every Woman, Every Child*d countries in conjunction with the private sector and civil society have developed plans to implement at scale appropriate interventions to increase demand for and utilisation of health services and products, particularly among under-served populations.

8. Reaching women and children: By 2014, all *Every Woman, Every Child* countries are addressing financial barriers to ensure the poorest members of society have access to the life-saving commodities.

9. Performance and accountability: By the end of 2013, all *Every Woman, Every Child* countries have proven mechanisms such as checklists in place to ensure that health-care providers are knowledgeable about the latest national guidelines.

Improved integration of private sector and consumer needs:

10. Product innovation: By 2014, research and development for improved life-saving commodities has been prioritized, funded and commenced.

Panel 6. Life-Saving Commodities

Commodity by life stage	Examples of key barriers	Recommendations	Potential 5-year impact
Maternal health commodities			
1. **Oxytocin** – post-partum haemorrhage (PPH)	Often poor quality	1, 4, 5	
2. **Misoprostol** – post- partum haemorrhage	Not included in national essential medicine lists	5	15 000 maternal lives saved
3. **Magnesium sulfate** – eclampsia and severe pre-eclampsia	Lack of demand by health workers	1, 9, 10	55 000 maternal lives saved
Newborn health commodities			
4. **Injectable antibiotics** – newborn sepsis	Poor compliance by health workers	1, 9, 10	1.22 million neonatal lives saved
5. Antenatal **corticosteroids (ANCs)** – preterm respiratory distress syndrome	Low awareness of product and impact	9	466 000 neonatal lives saved
6. **Chlorhexidine** – newborn cord care	Limited awareness and demand	2, 5	422 000 neonatal lives saved
7. **Resuscitation devices** – newborn asphyxia	Requires trained health workers	1, 9, 10	336 000 neonatal lives saved
Child health commodities			
8. **Amoxicillin** – pneumonia	Limited availability of child-friendly product	2, 7, 9, 10	1.56 million lives saved
9. **Oral rehydration salts (ORS)** – diarrhoea	Poor understanding of products by mothers/caregivers	2, 5, 7, 9, 10	1.89 million lives saved
10. **Zinc** – diarrhoea			
Reproductive health commodities			
11. **Female condoms**	Low awareness among women and health workers	1, 7	Almost 230 000 maternal deaths averted
12. **Contraceptive implants** – family planning/ contraception	High cost	1, 7	
13. **Emergency contraception** – family planning/ contraception	Low awareness among women	2, 7	

62. As can be seen from the Panels, 3 of the Commission's recommendations were to have been fulfilled by the end of 2013—on shaping global markets, innovative financing, and performance and accountability. By the end of 2014, a further 4 recommendations should be fulfilled—on shaping local delivery markets, demand and utilisation, reaching women and children, and product innovation. By any standards, these were exceptionally ambitious objectives.

63. One way to look at the Commission's recommendations is as a list of 10 mutually exclusive items. This is the way the original Commission report seemed to set out its hopes. We have preferred to see the Commission's goals as a sequence of steps with the ultimate aim of getting life-saving commodities to the women and children who need them most of all. Here is an alternative model we have constructed, with adjusted timelines.

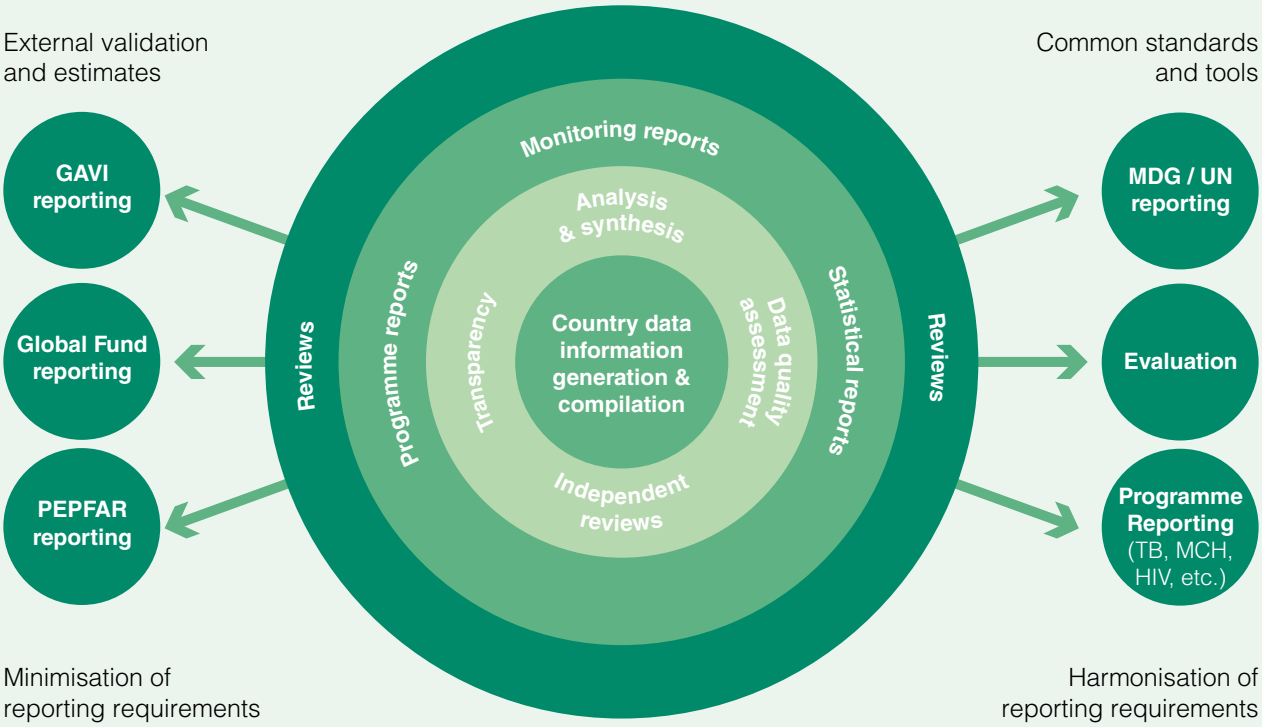
IHP+: Improving accountability and focusing on results by jointly measuring fewer things better

The International Health Partnership (IHP+) (1) is a group of partners committed to improving the health of citizens by mobilising collective support for national health plans, priorities, and systems. IHP+ encourages inclusive ways of working: governments, civil society organizations (CSOs), parliaments, the private sector, and international development partners all have a role to play.

Mutual accountability for results has been central to IHP+ since it began in 2007. An IHP+ Technical Working Group involving partner countries, development agencies, and CSOs agreed the principles for developing strong country led platforms for information and accountability (2) (see figure below). Furthermore, IHP+'s approach to Joint Assessment of National Strategies and Plans (JANS) includes an assessment of the strengths and weaknesses of a country's monitoring and accountability framework (3). Finally, IHP+ has developed methodologies for periodically monitoring mutual accountability in terms of partners' implementation of commitments to support national strategies and other agreed principles of development effectiveness (4).

In the follow-up to the Commission on Information and Accountability agreement, it was decided to utilise its momentum not only to strengthen monitoring of women's and children's health but to strengthen the whole health monitoring system based on the framework and principles developed under IHP+. Efforts to implement the framework are now underway in over 70 countries.

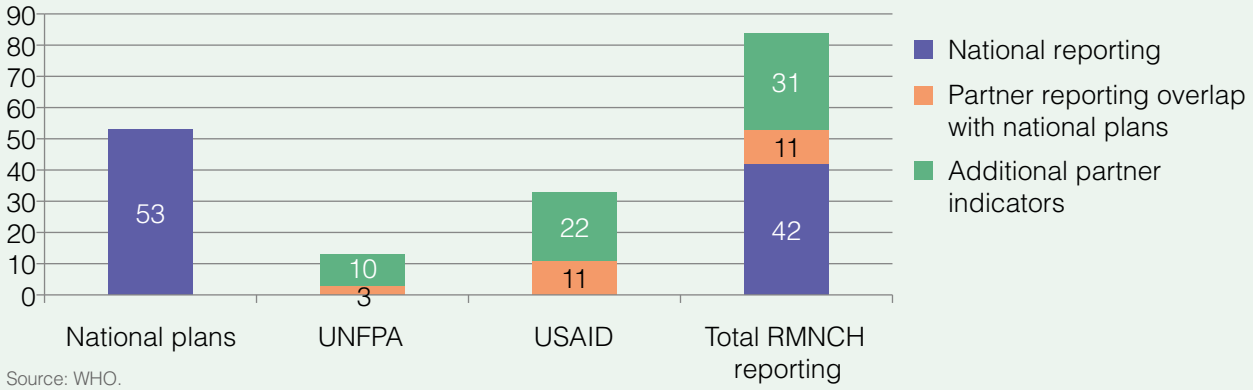
Figure 1. Monitoring and review of national health strategies: one country platform for information & accountability



The 2012 IHP+ Results report found that, while there is indeed more attention to national plans, countries had moved further than development partners in putting other principles of effective development cooperation into practice. In September, 2012, IHP+ obtained renewed political commitment to action by global health agency leaders, led by World Bank President Jim Yong Kim and WHO Director-General Margaret Chan. Agency leaders committed themselves to act on seven behaviours (5), one of which is "joint monitoring of progress and results, based on one information and accountability platform". In September, 2013, global health agency leaders

established a working group chaired by Margaret Chan to take stock of global reporting requirements with the goal of reducing the burden on countries. A rapid assessment of the burden of indicators and reporting for health (6) documented how global investments in disease- and programme-specific monitoring and evaluation has resulted in very large numbers of health indicators (for some countries, over 600), fragmented data collection (see example in figure on RMNCH indicators in Nigeria, below), and uncoordinated efforts to strengthen country institutional capacity, imposing unnecessary reporting burdens on countries as well as inefficiencies, and hampering overall analysis and decision-making. Based on these findings, work is progressing on agreeing on a core set of indicators with the aim of reducing the number on which countries have to report by at least 50%.

Figure 2. RMNCH indicators, Nigeria, 2014



Source: WHO.

Last but not least, under the umbrella of IHP+, ways to advance the principle of joint and aligned investment in country data systems will be developed and promoted. Such investments would include births, deaths and their cause, harmonised regular surveys, facility and administrative data reporting systems, and strengthening of institutional capacity for measurement, analysis, and communication of results.

The ultimate goal of all these efforts is to improve monitoring of sector performance and increase the focus on results by measuring fewer things better in a robust national system for information and accountability with which all partners are aligned.

This case study illustrates the hopeful advantage of linking efforts to improve women's and children's health to broader sector strategies and systems, creating a win-win situation.

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2012-15		2013-15		2015
Address upstream determinants	→	**Create delivery systems**	→	**Reach Women and Children**
Global markets (1)		Local markets (2)		Financial barriers (8)
Quality/regulation (4,5)		Supply chains (6)		Access and use (8)
Financing (3)		Implementation plans (7)		
Product innovation (10)		Education/monitoring (9)		

Our model takes account of the importance of appropriate sequencing of the Commission's recommendations. For example, the Commission put quality strengthening and regulatory efficiency as targets to be completed by 2015. But these important upstream measures must be in place *before* safe and effective commodities can be delivered to women and children, a recommendation that the Commission set to be completed in 2014.

64. In evidence submitted to the iERG by the Commission, each recommendation is marked according to whether it has been completed, partially completed, or not commenced. We publish the Commission's own assessment of its progress in Table 8. Note that the Commission seems to report an important signal of concern—work on Reaching Women and Children has not yet commenced. For an objective that was supposed to have been completed by the end of 2014, this would seem to be a serious failure. But if one sets this judgement against the sequence outlined in Paragraph 63, it is neither surprising nor to be expected that the Commission has yet delivered or even started to deliver on its ultimate goal—getting life-saving commodities to women and children.

Delivery bed, ready for use

Table 8. Progress against UN CoLSC milestones

Recommendation	Year of completion	Specified milestone	Completed	Partial	Not commenced
1 Shaping Global Markets	2014	Sign volume guarantee with at least one manufacturer of contraceptive implants, if appropriate pricing and volume terms can be agreed upon	x		
	2013	Aligning the market data collection efforts being undertaken by various groups (including CHAI, USAID, WHO, and the commodity TRTs) and consolidating this data in a web-based portal	x		
	2014	Evaluate the increase in availability and affordability of contraceptive implants	x		
	2013	Working with the commodity TRTs and other groups engaged in generating demand forecasts to consolidate this information at the global-level		x	
2 Shaping Local Delivery Markets	2014	Develop toolkits for a portfolio of interventions to engage private sector suppliers (manufacturers and distributors) to produce, distribute, and promote appropriate products	x		
	2013	Identify appropriate supply interventions and begin implementing select supply side interventions for relevant life-saving commodities in targeted countries	x		
	2014	Expand implementation of supply interventions and supply side communication to regional initiatives (such as pooled procurement and local manufacturer engagement)	x		
3 Innovative Financing	2012	Agree on the host of a results-based funding mechanism for life-saving commodities	x		
	2013	At least 10 EWEC countries enter into an agreement with the funding mechanism to increase access to life-saving commodities		x	
	2014	Guidance developed for countries to implement in-country RBF-approaches to strengthen access to life-saving commodities at all levels		x	
4 Quality Strengthening	2012	Expert Review Panel for dispersible amoxicillin	x		
	2012	Development of optimal quality assurance for zinc (e.g., market surveillance approach Expert Review Panel)	x		
	2013	Expert Review Panel for chlorhexidine	x		
5 Regulatory Efficiency	2013	WHO-EML includes all 13 life-saving commodities	x		
	2013	Joint inspections or dossier reviews are implemented for at least 3 life-saving commodities	x		
	2013	Regulators in pathfinder countries agree on a common pathway for at least 5 life-saving commodities	x		
6 Supply and Awareness	2013	Briefs/guidance and/or reference documents published on a range of supply chain topics		x	
	2013	Quantification and forecasting guidance for all life-saving commodities available to countries (including harmonized definitions of forecasting and quantification and forecasting algorithms)	x		
	2013	Toolkit for private sector engagement in supply chain functions available	x		
	2014	Commodity-related functionality for an open source Logistics Management Information System (LMIS 1.0) developed, and pilot integration with HMIS in at least one country	x		

Recommendation	Year of completion	Specified milestone	Completed	Partial	Not commenced
7 Demand and Utilization	2013	Global demand generation implementation kit developed with adaptable communication strategies for at least 9 priority commodities	x		
	2014	Country-specific communication strategies developed in at least two pathfinder countries that incorporate life-saving commodities from at least one health area (e.g. family planning)		x	
	2014	Demand generation programs implemented in at least 4 pathfinder countries that incorporate life-saving commodities from at least one health area (e.g. family planning)		x	
8 Reaching Women and Children	2013	Eight EWEC countries have financial protection programmes with a commodity focus			x
	2014	Evaluate the increase in use of (a sub-set of) life-saving commodities in concerned countries			x
9 Performance and Accountability	2014	The status of national availability and use of the 13 commodities and available guidelines (including m-applications) in 8 pathfinder countries for their use have been analyzed	x		
	2013	Development of generic checklists for implants and safe birth, including use of MgSO4, has begun		x	
	2014	Training and scalable strategies for checklist use including e- and m-learning have been developed and deployed		x	
	2014	Feasibility assessments on the use of social audits to improve accountability have been carried out in 10 countries			x
10 New Product Innovation	2014	Form a coordinating group to lead reviews, prioritization and monitoring of product improvements/innovations	x		
	2014	Prioritize four product improvement/ innovation areas		x	
	2014	Secure commitments including donor and private industry earmarks for innovation and research and development		x	

65. The areas where only partial completion has taken place are in aspects of shaping global markets, innovative financing, supply and awareness, demand and utilisation, performance and accountability, and new product innovation. We want to highlight 4 areas of concern.

- *Financing*: Successful financing of commodities is an essential prerequisite for their sustainable distribution to women and children. The fact that there has been only partial success so far in reaching agreements, including results-based financing mechanisms, between countries and funders to increase access to life-saving commodities is a cause for serious concern. This is especially so since the target the Commission subsequently set itself—achieving agreements in only 10 countries—is a very low bar to achieve.
- *Product innovation*: Investment in global public goods for women and children will become an increasing part of official development assistance in the future. Based on historical experience, the continuous improvement of these technologies will be important if the mortality and morbidity endured by women and children are to be diminished. The finding that securing commitments from donors and the private sector for research and development is only partly complete is a matter of concern.
- *Implementation plans*: A necessary step in making quality interventions available and accessible to women and children is the creation of an implementation plan. It is worrying that with only one full year to go before the final deadline

of recommendations from the Commodities Commission, the very low expectation of communication strategies in just 2 countries and demand-generation programmes in just 4 countries is only partially complete. If this is the extent of success in such a small number of countries, it is reasonable to be extremely concerned about progress in over 70 other countries with high burdens of maternal, newborn, and child mortality.
- *Accountability*: The CoIA saw accountability as a critical lever to improve performance. It is therefore of concern to the iERG that 3 of the 4 specified milestones set by the Commission have not so far been fully reached (or even commenced).

66. The UN Commission's recommendations are being taken forward by an RMNCH Strategy and Coordination Team, comprising representatives from WHO, UNICEF, and UNFPA. This team: facilitates the work of Technical Resource Teams whose responsibility is to facilitate technical assistance to countries through established partners and to catalyse action globally; tracks the status of commodities; and administers a Trust Fund that provides catalytic investments to support national RMNCH plans. Key progress to date includes:

- Creation of the Technical Resource Teams
- Development of a commodity tracking platform
- Provision of catalytic support to national RMNCH plans for 8 "pathfinder countries" (DRC, Ethiopia, Malawi, Nigeria, Senegal, Sierra Leone, Tanzania, and Uganda)
- Inclusion of all 13 life-saving commodities on the WHO Essential Medicines List
- Global price reductions have been negotiated for implantable contraceptives
- Efforts to fast-track national registration of life-saving commodities are underway

67. The Strategy and Coordination Team is frank about the challenges it faces:

- Translating global learning into country responses
- Misalignment in countries between WHO recommendations, essential medicines lists, treatment guidelines, and approved life-saving commodities
- Providers not being required to administer commodities where they could have the greatest impact
- Supply chain bottlenecks
- Health workers not yet fully prepared for the latest treatment protocols

68. Over the next two years, the work of the Commission will focus on addressing these shortcomings. First, the Technical Resource Teams are being reorganised around commodity themes (reproductive, maternal, newborn, and child, with product innovation contributing to each). Those Teams dedicated to delivering the recommendations of the Commission will be organised into 3 groups—on global markets, regulation, and quality; on local markets and supply chain; and on demand, access, and performance. These groupings broadly mirror the sequencing we set out earlier in this chapter. Second, there will be a renewed country-level focus by the Technical Resource Teams. Third, an expanded RMNCH Country Engagement Strategy will be implemented. Since its launch in late 2013, this Strategy has already engaged 17 countries, with five more at an advanced stage of discussion. We believe this reconfiguring of the post-Commission work makes good sense. However, the final test of the Commission will be the delivery of high-quality, safe, and affordable commodities to those women and children who need these interventions most of all. We note with concern one sentence from the RMNCH Strategy and Coordination Team's submission to the iERG: "where levels of coverage with life-saving commodities have been assessed, they remain disconcertingly low." And yet this outcome is the end-point on which the work of the Commission will finally be judged.

69. One group of commodities, perhaps strangely, that is not part of the remit of the UN Commission is vaccines. We consider vaccines as part of the overall goal to get life-saving interventions to those women and children in greatest need. In its evidence to the iERG, the GAVI Alliance reported unprecedented demand for vaccines. 41 introductions of new vaccines took place in 2013 (the figure was 30 in 2012). Since the inception of GAVI in 2000, the Alliance has supported the immunisation of 440 million children and contributed to the prevention of 6 million deaths. In 2013, 14 countries introduced pneumococcal vaccine and 6 countries introduced rotavirus vaccine. The pentavalent vaccine, which protects against Hib type b, hepatitis B, diphtheria, tetanus, and pertussis, has now been introduced into almost all GAVI-supported countries. 23 countries have now been approved for Human Papillomavirus Vaccine support. And 4 countries conducted measles-rubella campaigns in 2013. HPV and measles-rubella vaccines are important interventions to protect the health of women. GAVI continues to support routine meningitis A and yellow fever campaigns. In 2013, GAVI opened a funding window for inactivated polio vaccine. 26 countries had applied for IPV by May, 2014—indicating strong demand by countries to be part of the polio endgame strategy.

70. GAVI does identify important challenges. One in 5 children remains unvaccinated. Demand is outstripping supply for some vaccines and in some countries. Health systems are often pervasively weak. And data about vaccine needs and use are frequently poor or absent. Indeed, WHO now argues that "improvement in data quality has to become the highest priority for all stakeholders"—especially immunisation coverage and vaccine-preventable disease surveillance data. In its report to the World Health Assembly in 2014, WHO summarised progress on its Global Vaccine Action Plan.

- Immunisation coverage has remained low, stagnant, or is decreasing in some countries (see Tables 9-11)
- Only 59 countries have met the coverage target of at least 90% nationally (and 80% in every district) with 3 doses of DTP3 in children below 12 months of age
- In the final phase of polio eradication, challenges to achieve success have increased: failure now would represent failure not only for the immunisation community but also for public health
- The goal of neonatal tetanus elimination remains delayed
- Measles elimination: this goal has been achieved in the Region of the Americas, and is on track to do so in the Western Pacific Region. All other regions are not on track

Table 9. List of iERG countries not sustaining DTP3 national level coverage ≥ 90% in the last three years, 2010-2012

Country	DTP3 2010	DTP3 2011	DTP3 2012
Afghanistan	66	68	71
Angola	91	86	91
Azerbaijan	75	77	75
Benin	83	85	85
Bolivia (Plurinational State of)	80	82	80
Cameroon	84	82	85
Central African Republic	45	47	47
Chad	39	33	45
Comoros	74	83	86
Congo	90	90	85
Côte d'Ivoire	85	62	94
Democratic Republic of the Congo	60	74	72
Djibouti	88	87	81
Equatorial Guinea	33	33	33
Ethiopia	63	65	61
Gabon	67	75	82
Guatemala	94	88	96
Guinea	64	59	59
Guinea-Bissau	80	80	80
Haiti	60	60	60
India	72	72	72
Indonesia	62	62	64
Iraq	74	79	69
Kenya	83	88	83
Lao People's Democratic Republic	74	78	79
Lesotho	83	83	83
Liberia	70	77	77
Madagascar	85	89	86
Mali	76	72	74

Country	DTP3 2010	DTP3 2011	DTP3 2012
Mauritania	64	75	80
Mozambique	74	76	76
Myanmar	90	86	85
Nepal	82	92	90
Niger	70	75	74
Nigeria	54	45	41
Pakistan	86	80	81
Papua New Guinea	56	61	63
Philippines	79	80	86
Senegal	89	92	92
Sierra Leone	84	84	84
Solomon Islands	79	88	90
Somalia	45	41	42
South Africa	66	72	68
Swaziland	89	91	95
Togo	86	92	84
Uganda	80	82	78
Yemen	87	81	82
Zambia	83	81	78
Zimbabwe	89	89	89

A hospital in a capital city

Table 10. List of iERG countries that have never reached DTP3 national level coverage ≥ 90% in the last three years, 2010-2012

Country	DTP3 2010	DTP3 2011	DTP3 2012
Afghanistan	66	68	71
Azerbaijan	75	77	75
Benin	83	85	85
Bolivia (Plurinational State of)	80	82	80
Cameroon	84	82	85
Central African Republic	45	47	47
Chad	39	33	45
Comoros	74	83	86
Democratic Republic of the Congo	60	74	72
Djibouti	88	87	81
Equatorial Guinea	33	33	33
Ethiopia	63	65	61
Gabon	67	75	82
Guinea	64	59	59
Guinea-Bissau	80	80	80
Haiti	60	60	60
India	72	72	72
Indonesia	62	62	64
Iraq	74	79	69
Kenya	83	88	83
Lao People's Democratic Republic	74	78	79
Lesotho	83	83	83
Liberia	70	77	77
Madagascar	85	89	86
Mali	76	72	74
Mauritania	64	75	80
Mozambique	74	76	76
Niger	70	75	74
Nigeria	54	45	41
Pakistan	86	80	81
Papua New Guinea	56	61	63
Philippines	79	80	86
Sierra Leone	84	84	84
Somalia	45	41	42
South Africa	66	72	68
Uganda	80	82	78
Yemen	87	81	82
Zambia	83	81	78
Zimbabwe	89	89	89

Table 11. List of iERG countries showing a decreasing trend in DTP3 national level coverage for the last 3 years (DTP3 national level coverage in 2012 < 2011 or 2012 < 2010)

Country	DTP3 2010	DTP3 2011	DTP3 2012
Brazil	98	99	94
Burkina Faso	91	91	90
Congo	90	90	85
Djibouti	88	87	81
Egypt	97	96	93
Ethiopia	63	65	61
Iraq	74	79	69
Myanmar	90	86	85
Nigeria	54	45	41
Togo	86	92	84
Uganda	80	82	78
Zambia	83	81	78

71. Given these multiple initiatives to get high-value interventions to women and children, and on the background of a now very limited time window until the end of 2015, what more can be done to accelerate progress? In May, 2014, at the RMNCH Steering Committee held on the margins of the World Health Assembly, a draft "Roadmap and Call to Action to Achieve MDG-5 and Accelerate Newborn Survival to Reach MDG-4" was presented. It was an exciting document. In it, a plan was set out to save an additional 250 000 newborn lives and 140 000 maternal lives in 2015. Achieving these numbers would not only enable the global MDG-4 and MDG-5A targets to be met, but would also provide valuable momentum to continue to accelerate progress beyond 2015. The core idea in the Roadmap was to focus on the day of childbirth and the few days following. This moment is when the greatest impact on saving mothers and newborns could be made. Priority actions would include: scaling up access to key life-saving commodities, expanding midwifery care, using antenatal care platforms as the vehicle to more fully protect women and their newborns, increasing access to modern contraceptives, and implementing results-based financing for maternal and newborn health. The Roadmap goes on to argue that this acceleration plan should not only focus on priority initiatives, but also on the countries where most deaths can be prevented, such as India, Nigeria, DRC, and Pakistan. It was launched at an MDG Advocates meeting in July, 2014, in Kigali. In addition, we recommend that any further actions to accelerate progress use and strengthen existing country plans.

72. Enthusiasm for a commodity or intervention approach to women's and children's health needs to be tempered by several cautionary notes. First, counterfeit medicines. The prevalence of substandard or counterfeit medicines is alarmingly high—as high as 29% in one systematic review (40). The commonest category of counterfeits or substandard medicines is antimicrobials. Prevalence was highest when medicines were purchased from unlicensed outlets. The prevalence was even higher for particular types of antimicrobials—antimalarial drugs, for example (41). A first step to address counterfeits and substandard medicines is to recognise the size and scale of the problem. There are several notable examples of countries that have done so (42,43). But the likely solution to counterfeits is going to require stronger global governance, requiring collaboration between public health, law enforcement, and international crime prevention (44).

73. There is, perhaps, an even deeper challenge. Technological solutions to health problems are likely to fail unless equal attention is paid to the quality of delivery of those solutions, and even to the quality of healthcare overall. In a study whose implications were deeply disturbing, João Paulo Souza and colleagues found that high coverage levels with life-saving maternal interventions, such as oxytocin, magnesium sulphate, and antibiotics, did not correlate with outcomes for mothers (45). Furthermore, the success of an intervention goes even beyond the quality of healthcare. For example, Zubia Mumtaz and colleagues point to poverty and caste as being two critical but neglected determinants of access to maternal health services in Pakistan (46).

The importance of social and economic exclusion must be taken into consideration when planning the delivery of services, even services that would seem to be about the straightforward provision of health technologies. And finally, advocates, funders, programme managers, and health professionals should think more than some do about the context of the local community in which they are working. In a recent study of immunisation polices and practices, emphasis was placed on knowing and understanding the local communities in which vaccines will be introduced (47). We end this chapter by quoting these thoughtful reflections, which apply well beyond the field of vaccines (47):

"We would like to see [commodity-based] programmes rescued from the strategic interests that have come to define global health. We would like to see them not just 'evidence-based', but 'knowledge-based', where 'knowledge' includes acknowledgement of the relevance of wisdom born of living in a particular community, culture, or environment. We would like to see [commodity-based] programmes in poor countries (re)integrated into processes of community development. We would like to see the health and well-being of children, rather than the optimum deployment of health technology, as the ultimate measure of progress."

Commodities certainly have a vital part to play in any future vision for women's and children's health. But an intervention-led strategy alone, one that places the overall life and wellbeing of a woman and child as a secondary consideration, is unlikely to deliver either a sustainable or a just future for the most threatened communities in the poorest countries.

5. A SUSTAINABLE POST-2015 VISION FOR WOMEN AND CHILDREN

74. This year's iERG report is published at a crucial moment in planning for the post-MDG era. The Open Working Group on Sustainable Development Goals has submitted its final report to the UN Secretary-General. At the time of writing, the Open Working Group has identified 17 SDGs. SDG-3 is: Ensure healthy lives and promote wellbeing for all at all ages. There are 9 sub-goals and 4 proposals for means of implementation:

3.1. By 2030 reduce the global maternal mortality ratio to less than 70 per 100 000 live births
3.2. By 2030 end preventable deaths of newborns and under-five children
3.3. By 2030 end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-born diseases, and other communicable diseases
3.4. By 2030 reduce by one-third premature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and wellbeing
3.5. Strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
3.6. By 2020 halve global deaths and injuries from road traffic accidents
3.7. By 2030 ensure universal access to sexual and reproductive health services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
3.8. Achieve universal health coverage (UHC), including finacial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all
3.9. By 2030 substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination
3.a Strenghten implementation of the Framework Convention on Tobacco Control in all countries as appropriate
3.b Support research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration which affirms the right of developing countries to use to the full the provisions in the TRIPS agreement regarding flexibilities to protect public health and, in particular, provide access to medicines for all
3.c Increase substantially health financing and recruitment, development and training and retention of the health work force in developing countries, especially in LDCs and SIDS
3.d Strenghten the capacity of all countries, particularly developing countries, for early warning, risk reduction, and management of national and global health risks.

At least one issue needs to be reflected on further when one considers these proposed goals. With a new era of sustainable development, the number of goals, and therefore indicators, will increase substantially compared with the MDG era. This expansion in number of indicators will pose significant challenges for monitoring capacity in countries.

75. The process by which these goals are being finalised is being led by governments, not technical agencies or related entities, such as the iERG. However, we want to use this year's iERG report to set out our vision for the post-2015 period. We could make two specific contributions—first, on the health of woman

A pharmacy as part of the regional hospital's services

and children; and second, on accountability. Both of these issues have already been taken up by the health community. In April, 2013, a multi-agency and multi-stakeholder group published the final results of a global consultation on "Health in the Post-2015 Agenda" (48). That report proposed a development goal focused on "sustainable wellbeing for all", with a specific health goal divided into 4 broad areas—accelerate the MDG agenda, reduce the NCD burden, ensure universal health coverage and access, and include contributions of other sectors to health. That framework was subsequently developed further by WHO. At the 2014 World Health Assembly, WHO published a more detailed version of this proposal. It is shown in its updated form in Panel 7. We have more to say about this proposal shortly. But the question might be asked: what can the iERG substantively add to this considerable body of work?

Panel 7. WHO's vision for the post-2015 era

OVERARCHING HEALTH GOAL	**Ensure healthy lives and universal health coverage at all ages**
SUB-GOALS:	**1. Achieve and exceed the health-related Millennium Development Goals (MDGs)** **2. Address the burden of noncommunicable diseases, injuries, and mental disorders** **3. Achieve Universal Health Coverage including financial risk protection** **4. Address the social and environmental determinants of health**
SUB-GOAL 1: Improve reproductive, maternal, and child health and reduce the burden of communicable diseases (achieve and exceed the MDGs)	
	Selected possible minimal targets for 2030 (baseline 2010)
• End preventable child deaths • End preventable maternal deaths, and improve reproductive health • End the epidemics of HIV/AIDS, tuberculosis, malaria and other communicable diseases	• Under-5 mortality 25/1000 live births, newborn mortality 12/1000, in all countries • Maternal mortality ratio (MMR) less than 70/100 000 (no country with MMR>140); achieve universal access to reproductive health • Reduce new adult HIV infections and deaths by 90%; eliminate new infections among children • Reduce TB incidence rate by 80% and number of TB deaths by 90% • Reduce malaria incidence and death rates by 90%; eliminate malaria from 20+ countries; 80% coverage of NTD interventions; reduce viral hepatitis incidence/ mortality
SUB-GOAL 2: Reduce the burden of noncommunicable diseases, injuries, and mental illness	
	Selected possible minimal targets for 2030
• Reduce preventable deaths from non-communicable diseases • Reduce deaths and disabilities from injuries and mental disorders	• Reduce mortality from cardiovascular diseases, cancer, diabetes, chronic respiratory disease by one-third (age 30-70) • Reduce road traffic deaths by 50%
SUB-GOAL 3: Achieve Universal Health Coverage including financial risk protection	
	Selected possible minimal targets for 2030
• Financial risk protection • Universal coverage of quality health services (including and exceeding MDG coverage targets for reproductive, maternal, and child health and communicable diseases)	• No one pushed into poverty or further into poverty due to out-of-pocket health payments • Minimum 80% coverage of services in all population groups: - promotion/prevention: immunization, ante-and postnatal care, family planning and contraceptives; sexual and reproductive health; non-use of tobacco; safe water and sanitation; insecticide-treated nets - treatment/rehabilitation/palliation: skilled birth attendance; detection and treatment of HIV, TB, malaria, NTDs, viral hepatitis, hypertension, diabetes and severe mental disorders; assistive devices for persons with disabilities; palliative care; access to basic technologies and essential medicines; emergency health care
SUB-GOAL 4: Address the social and environmental determinants of health	
	Targets for 2030
• Reduce exposure to environmental risk factors	• Improved water sources, adequate sanitation; household use of modern fuels for cooking/heating/lighting; improved indoor air quality; cities with lower mean PM 2.5; disaster risk management
• Improve nutrition	• Reduce child stunting by 50%, reduce child wasting to 5% , reduce anaemia in women of reproductive age by 60%, low birth weight by 30%; reduce child overweight by 25%; at least 50% exclusive breastfeeding 0-5 months
• Promote health security	• Reduce mortality due to disasters by 30%; implement International Health Regulations

76. Indeed, there are already many visionary contributions to the post-2015 debate. In a review of the impact and future of an agenda launched in Cairo in 1994 at the International Conference on Population and Development, a renewed vision of a world in which "the respect, protection, promotion, and fulfilment of human rights are necessary preconditions to improving the development, dignity, and wellbeing of all people" was advanced (7). The Women Deliver global advocacy organisation has invited decision-makers to, "Imagine a world where no woman dies giving life, where no baby is born with HIV, where every girl is able to attend school and receive a quality education, and where everybody—including girls and women—has the opportunity to fulfil their potential. That world is within reach—if we want it." And the *Global Health 2035* initiative argued that, "A unique characteristic of our generation is that collectively we have the financial and the ever-improving technical capacity to reduce infectious, child, and maternal mortality rates to low levels universally by 2035, to achieve a 'grand convergence' in health" (11).

77. The vision offered by the UN Secretary-General's Office is more prosaic, but nevertheless still important. Their goal is simply to ensure that women's and children's health is included in the post-2015 agenda. As Ban Ki-moon's office puts it, moving into the post-2015 period, there will be "a strong focus on delivering and reporting on results, addressing the most vulnerable and hardest to reach, mobilising new partnerships and sustainable financing, together with strategic positioning and advocacy for *Every Woman, Every Child* within the post-2015 development framework."

78. These visions are important to motivate and inspire action. But they need to be seen in the context of what will be a very different world as the 21st century moves on. For example, demographic change will dramatically alter the prospects for children and adolescents in the era of sustainable development (49):

- The world's under-18 population will only modestly increase between 2015 and 2025, but its composition and concentration will change markedly
- The share and numbers of children living in the world's poorest regions and countries will continue to grow rapidly
- The child population in sub-Saharan Africa is burgeoning: by mid-century, 1 in every 3 births—and almost 1 in every 3 children under 18—will be African
- Among countries, there will continue to be an increasing concentration of under-5 deaths in sub-Saharan Africa, in pockets of poverty and marginalisation within populous lower-middle-income countries, and in the least developed nations
- Within countries, there is likely to be an increasing concentration of under-5 deaths in poor provinces, households, and social groups
- With a growing old-age dependency ratio, one of the biggest risks to children is a transfer of essential resources away from them, as increasing total dependency ratios stretch government and family resources ever thinner
- Given these shifts, it is vital that government services take into account projected demographic shifts when planning essential social services for children

79. It is not only demographic shifts that need to be taken into account post-2015. There are also several major health transitions to note. One is the rising trends of obesity across all sectors of the population (50). Between 1980 and 2013, the proportion of adult women with a body mass index over 25 kg/m^2 rose from 29.8% to 38%. The prevalence of overweight and obesity has risen substantially in children and adolescents too. In high-income countries between 1980 and 2013: for boys, increasing from 16.9% to 23.8% in overweight or obesity; for girls, the figures have increased from 16.2% to 22.6%. In low and middle income countries, the same trends are apparent, albeit from much lower baselines: for boys, from 8.1% to 12.9%; for girls, from 8.4% to 13.4%. The sheer scale of the problem in young women is truly alarming. Over half of countries have a fifth or more of their young (under 20 years) population who are overweight or obese. If we are serious about addressing the health and wellbeing of women and children, tackling obesity must be a central concern post-2015.

80. As must be mental health. The global burden of mental health disorders frequently loses out politically. But if one examines the human effects of mental ill-health it is impossible not to be shocked both by the importance of the issue and the negligence of the international community in terms of the attention it has paid to mental health. Mental and substance use disorders are the leading cause of years of life lived with disability (51). Depressive disorders account for 40% of all disability-adjusted life years caused by mental and substance abuse disorders. Anxiety disorders account for a further 15%, illicit drug use disorders 11%, alcohol use disorders 10%, schizophrenia 7%, bipolar disorder 7%, pervasive developmental disorders 4%, childhood behavioural disorders 3%, and eating disorders 1%. The highest rates of disability occur in young people aged 10-29 years. Thanks to population growth and ageing, the burden of these illnesses has risen by a vast 38% between 1990 and 2010.

81. A further risk for women's health is tobacco consumption (52). Table 12 shows the prevalence of tobacco use among young and adult women in selected iERG countries (where reliable data are available). The most striking aspect of these data is that the figures are so low. Aside from isolated examples (Bangladesh, Brazil, India, Mexico, Myanmar, and Nepal), most countries have prevalence rates below 10%. Overall, the age-standardised global prevalence of daily tobacco smoking declined among women from 10.6% in 1980 to 6.2% in 2012. This evidence should be seen as encouraging. But in many of these countries, the male prevalence of tobacco use is high, often well above 60%. And, as recent data from the Institute for Health Metrics and Evaluation have shown, the global tobacco market has grown by 26% from 1980 to 2012. Total numbers of female smokers have *increased* by 7% during this period. And, since 2006, declines in tobacco use among women have slowed considerably. Women therefore live on a precipice. Many women currently have low, or even very low, smoking prevalence rates. But they remain at high risk of adopting the same tobacco behaviour as their male counterparts. The absolute global burden of tobacco use among women is increasing. The fight against tobacco in all sectors of the population must continue to be strengthened.

Table 12. Prevalence of tobacco use among young and adult women in selected iERG countries

Country	Youth		Adult	
	Current cigarette smoking	Current users of smokeless tobacco	Current cigarette smoking	Current users of smokeless tobacco
Bangladesh	1.1	4.3	0.2	32.6
Brazil	6.3	…	13.0	0.3
China	…	…	2.3	…
Egypt	1.4	…	…	0.3
India	2.4	6.0	0.9	18.4
Indonesia	3.5	2.3	2.7	2.0
Mexico	12.9	3.9	7.5	0.3
Myanmar	0.5	4.0	…	16.1
Nepal	0.8	12.9	8.7	6.0
Nigeria	1.3	6.8	0.2	…
Pakistan	1.0	7.4	…	…
Philippines	5.3	3.3	8.7	1.2
Viet Nam	1.2	…	1.2	2.3

82. We have already set out the various goals for women's and children's health offered by the Open Working Group and WHO. These goals are not meant to be exhaustive. Other development goals will have important health-related elements to them—for example, on malnutrition, violence against women, child marriage, female genital mutilation, girls' education, water and sanitation, safe housing and transport, inequality, and even climate change. The goal and sub-goals set by the Open Working Group are good—they are specific and aggressive; they include vertical and horizontal measures (including universal health coverage, which we fully support and endorse as its own separate sub-goal); they include universal access to reproductive health services; and they include universal access to essential medicines. Three aspects could be strengthened—an acknowledgement of the importance of maternal, newborn, child, and adolescent morbidity as well as mortality; the inclusion of a rights dimension to sexual and reproductive health services (sexual and reproductive health *and rights)*; and the addition of key risk behaviours. We also endorse the WHO statement. There are particular strengths to this document over that of the Open Working Group. WHO is more specific in its maternal, newborn, and child health targets. And WHO includes stillbirths. Universal health coverage is rightly given a strong central role in WHO's narrative for the future of health. But reproductive health was strangely and scandalously omitted from their sub-goal of achieving the MDGs in the original version of their proposal, and when it was mentioned (under universal health coverage), the universal target was reduced to "at least 80% coverage." Both sets of goals omit equity, a serious exclusion, and it is disappointing to see that neither set adopts a goal for CRVS (note that WHO had made a commitment to do so in the past, which we cited and welcomed in Appendix 6 of our 2013 iERG report).

Tanzania: tracking resources for health and RNMCH

Financial resources are an essential input in the production of health care. As countries work to improve their citizens' health, information on health-sector financing is needed in order to: allocate resources appropriately, identify inequities in the health system, analyse provider efficiency, and more importantly to improve accountability for the use of resources. For the past decade, Tanzania has made significant efforts to strengthen resource tracking initiatives in the country. Health accounts (HA), public expenditure reviews (PER), and national AIDS spending assessments (NASA) have been used progressively, and found to be useful tools for tracking both general health and disease/condition-specific expenditure. However, until recently the process was manual, and therefore both cumbersome and expensive (1). Another challenge has been the absence of any information storage system in the Ministry of Health and Social Welfare (MoHSW). Generally, the system depended largely on personal memory; there was no institutional memory.

The creation of the Commission on Information and Accountability (2) catalysed efforts to strengthen systems for tracking resources. Although the Commission's ten recommendations specifically emphasised tracking resources for women's and children's health, their implementation has had spillover effects into the tracking of health expenditure on all diseases and conditions in the country.

A number of methodologies are currently being used to track resources, both internationally and locally. Tanzania has adopted HA methodology to track health expenditures in the country (3) and has so far held four rounds of national health accounts (NHA): in 2002/03 (4), 2005/06 (4), 2009/10 (5), and 2011/12 (6). HA reports have substantially strengthened the evidence base which informs the operationalisation of the 2007 Health Policy and strategies such as the Health Sector Strategic Plan (HSSP III) and Primary Health Services Development Plan.

The tracking of resources is very important to all stakeholders in the sector. In particular, Government and development partners are required to monitor progress on their commitments to meet health sector financial needs. Such monitoring is undertaken according to internationally agreed commitments, most notably those set out in the Abuja Declaration. In order for a country to make the necessary progress in tracking resources for health, both generally and for specific priorities, competent human resources are required, in sufficient numbers and with the required skill mix. Understanding this, the Tanzanian Government, jointly with partners, has trained health accountants. About 10 economists in the MoHSW have been trained in tracking resources. In order to ensure a continuing supply of properly educated staff, the Ministry in collaboration with USAID established a course in 2013 on health expenditure tracking at the University of Dar es Salaam. This will enable trained staff to track resources for general health expenditure and for specific categories such as women's and children's health.

In order to reduce paperwork and manual processes, the Ministry has started to automate data collection, collation, and analysis. The use of simple software has enabled the linking of accounting data and budget data. The automated process reduces the errors inherent in manual data management. It has also reduced the time required to process the data into useful information.

In collaboration with partners, the MoHSW has developed tools to collect information for various purposes, such as NHA, PER, NASA, and RMNCH analysis. The integration of data collection processes in Tanzania is helping to bring consistency to the data and to reduce the inefficiencies of multiple data collection efforts.

Resource tracking exercises in Tanzania are overseen by a single Steering Committee. This oversight committee is responsible for providing overall guidance on issues relating to the country's health financing. The Steering Committee is comprised of representatives from the Ministries, development partners, the private sector, and civil society. Feedback loops allow the Steering Committee to provide input into the whole process, allowing communication and feedback between stakeholders.

Like many other countries in sub-Saharan Africa, Tanzania has embraced the new methodology introduced by WHO (7) which helps to provide detailed sub-analyses for all diseases and conditions, including RNMCH. This is a great improvement on the old methodology which only allowed sub-accounts for a limited number of conditions (the highest number produced in Tanzania was just five). By employing a consistent

methodology, it ensures that expenditures for various diseases can be compared; the sum of expenditures for all diseases becomes the estimate of current health expenditure.

Simultaneously, WHO introduced the Production Tool, which is a convenient way of producing NHA tables automatically (8). Tanzania used the Production Tool for its NHA 2011/12. It has enabled the technical team to produce reports faster and more cheaply. WHO also introduced a Health Accounts Analysis Tool for data analysis according to need and matched with health status (9). This tool helps to analyse data in a more meaningful way.

By deploying all these initiatives, the Ministry is now able to produce health expenditure data annually, on all diseases and conditions for which there are data in the Health Management Information System. Integration has started and is a stepwise process. Insights from the production of NHA, PER, and NASA in Tanzania have informed policy; health expenditure data also stimulate debate in the Annual Joint Health Sector Review meetings. RMNCH expenditure data provide insights into Tanzania's progress on its commitment to track resources for RMNCH and allow the use of resources to be compared with results, thereby enhancing the accountability of leaders.

In sum, sustained tracking of health resources and a sustained focus on capacity building for a wide range of stakeholders have helped to deliver answers to key policy questions in Tanzania. Using data for decision-making is an iterative process, requiring ongoing dialogue and feedback. It is not without challenges. However, Tanzania has made significant progress in producing enhanced expenditure data.

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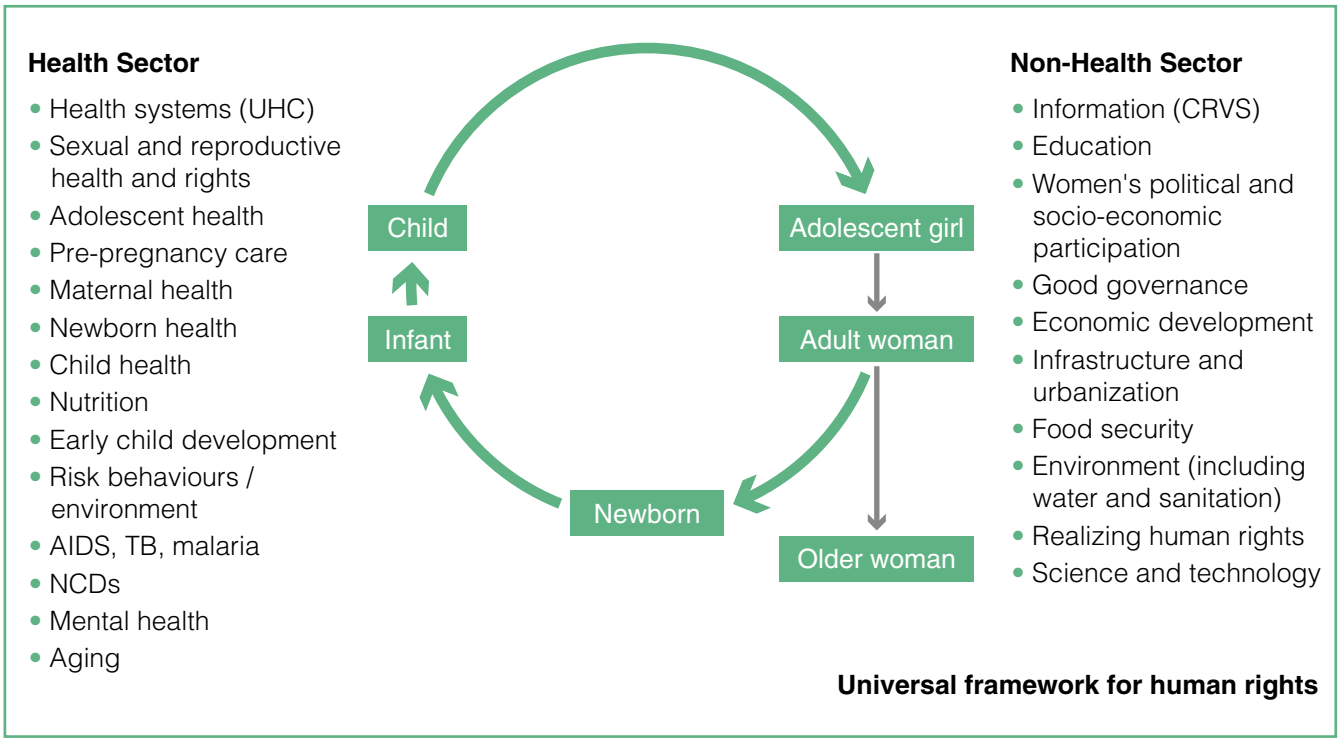
83. What is our vision? First, we wish to construct and use a foundation that neither the Open Working Group nor WHO adopts—namely, a comprehensive framework of human rights instruments and commitments. This framework now exists, as we have discussed earlier—technical guidance on the application of a human-rights-based approach to reduce maternal morbidity and mortality, similar technical guidance on a human-rights-based approach to reduce and eliminate preventable child mortality and morbidity, and General Comment 15 (the right of the child to the enjoyment of the highest attainable standard of health). These three documents make up an intergovernmental platform for accelerated action on women's and children's health. They underline the fact that we see health for women and children as a right and not a privilege. We believe that these human rights instruments, together with the mechanisms of universal periodic review and the human rights treaty bodies, provide a powerful force to reveal breaches of the universally agreed commitments to improve women's and children's health.

Figure 9. A proposed new framework for women's and children's health in an era of sustainable development (from the continuum of care to a cycle of wellbeing)



84. Once this human rights framework has been agreed, we fully endorse the efforts of partners so far to set time-bound, ambitious, and specific goals and targets to motivate action to reduce mortality and morbidity among women and children. This much is a continuation and strengthening of the goals and targets set during the MDG era. But such a "business as usual" approach is insufficient. We need to reframe women's and children's health for a new time, politically as well as technically. Furthermore, we need to translate that new frame of reference into new approaches for educating health workers.

85. We propose to expand the well-established idea of a continuum of care and embed women's and children's health in a fuller life course perspective. Such a life course approach would begin with the reproductive, maternal, and newborn care, include new attention to early child development, continue through child and adolescent health, and then move to a broader appreciation of adult health for women (including the increasing burdens of heart disease, cancer, diabetes, and mental ill-health, among other dangers), and finally ageing. A model for this life course approach is shown in Figure 9 (we have called this a shift from the continuum of care to a cycle of wellbeing). The advantage of this approach is that it disrupts the linear and overly narrow frame of RMNCH or even, with the addition of the adolescent, RMNCAH. Our model gives a fuller view of the life of a woman and her child. It sets those lives within the framework of human rights. It acknowledges the importance of non-health, as well as health, determinants. And it is better adapted to a future and more complex era of sustainable development.

World Bank lending for reproductive, maternal, newborn, and child health: 2000-2013

World Bank resources for health, nutrition, and population (HNP) are provided for low-income countries in the form of grants and credits from the International Development Association (IDA) and for middle-income countries by loans from the International Bank for Reconstruction and Development (IBRD). Since lending for RMNCH is not tabulated in standard World Bank data sets, the data provided below had to be prepared in a separate exercise.

When the World Bank agrees a lending programme with a recipient country, the Bank commits specific resources for the programme over a time period, typically of five to seven years. The commitments may or may not be fully disbursed, depending on many factors, including the speed of implementation of the programme, changes in programme content, country factors, etc. (By way of example, IDA commitments were about 14% greater than IDA disbursements during FY2000-13.) In determining actual resource flows for RMNCH, it is therefore preferable to track disbursements rather than commitments, and disbursement data are used in this case study.

Commitments and disbursements can vary widely from one year to another. For example, a large loan committed on January 1, rather than December 31, can alter year-on-year commitment numbers considerably. Similarly, a few large disbursements at the end of a fiscal year can do the same for disbursement numbers. Therefore, annual data for resource flows are presented as three-year rolling averages, to even out possible year-on-year variations.

There is a second, more significant problem in determining World Bank resource flows for RMNCH. Within HNP, the Bank tracks resource flows by coding portfolio data to various themes, including RMNCH, communicable and non-communicable diseases, and health system performance. Health system performance investments that include components supporting RMNCH, such as training midwives or upgrading a neonatal intensive care unit or maternity ward, are included in the RMNCH data presented below. However, contributions to RMNCH from other health sector interventions, such as for infectious or non-communicable diseases, hospital management, or nutrition, that also (largely) benefit women and children are not coded under RMNCH.

Therefore the specific data for RMNCH presented in Table 1 and Figures 1-3, derived from World Bank RMNCH coding, underestimate World Bank resource flows to RMNCH. Coding data do not permit a more precise estimate of resource flows, but it would be reasonable to assume that 75% of World Bank resources for HNP are used in ways that support RMNCH. The re-estimated World Bank resource flows for RMNCH, using this assumption, are shown in Figure 4. Finally, in addition to general budget support, the World Bank funds operations in water and sanitation, education, social protection, transport, and energy (e.g. indoor air pollution) which, the evidence suggests, may also have major beneficial impacts on RMNCH. Unfortunately, the Bank's current coding system does not allow estimates of these indirect resource flows, but it is clear that World Bank support for RMNCH may be considerably higher than is demonstrated by the available data.

Total disbursements for RMNCH and for HNP between FY2000 and FY2013, divided between IDA and IBRD, are shown in Table 1.

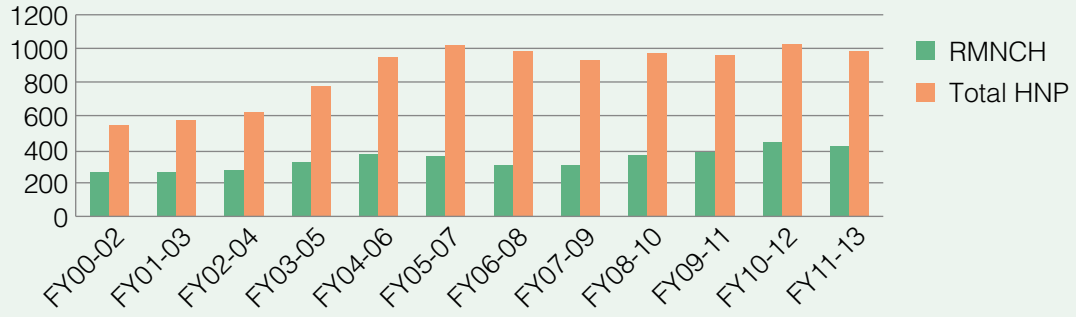
Table 1. World Bank total disbursements for RMNCH and HNP, FY2000-2013 (US$ billions)

Total IDA RMNCH	Total IDA HNP	Total IBRD RMNCH	Total IBRD HNP	Total RMNCH IDA+IBRD	Total HNP IDA+IBRD
4.74	11.82	4.13	11.93	8.87	23.75

Figures 1-3 below show annual disbursements by three-year rolling averages for the period FY2000-13 for RMNCH and HNP.

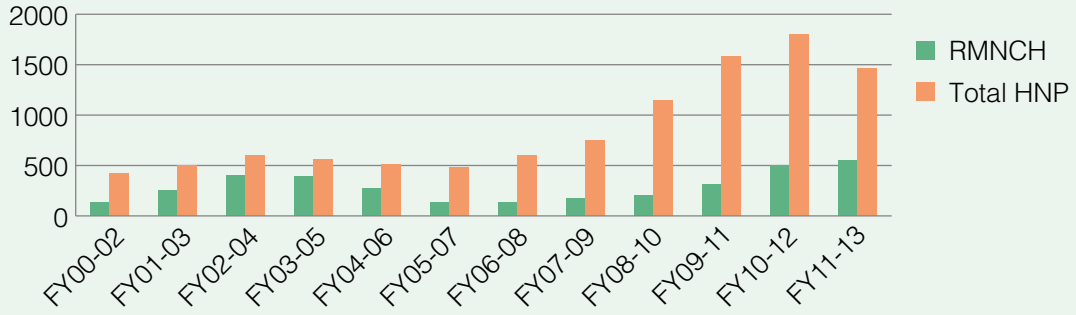
IDA disbursements for RMNCH increased from an average of US$266 million per annum over FY2000-05, to an average of $414 million per annum in FY2009-13, an increase of 56% (Figure 1).

Figure 1. IDA RMNCH and HNP annual disbursements (US$m)



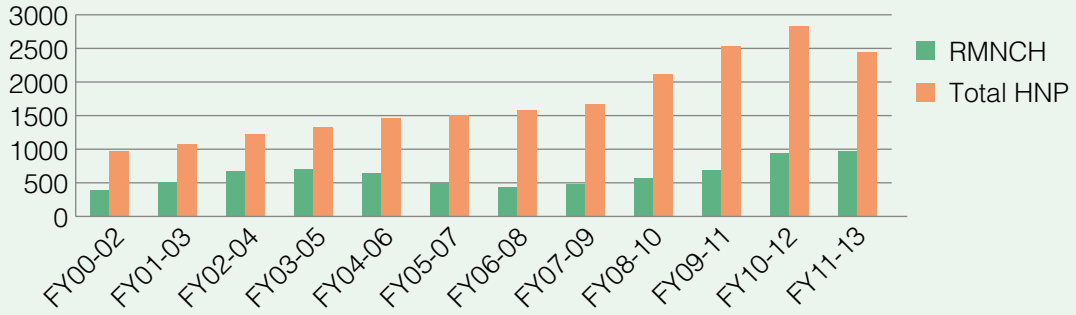
IBRD disbursements for RMNCH have fluctuated during the past decade, from a low of US$131 million during the FY2005-07 cycle, to a high of $553 million in the FY2011-13 period (Figure 2).

Figure 2: IBRD RMNCH and HNP annual disbursements (US$m)



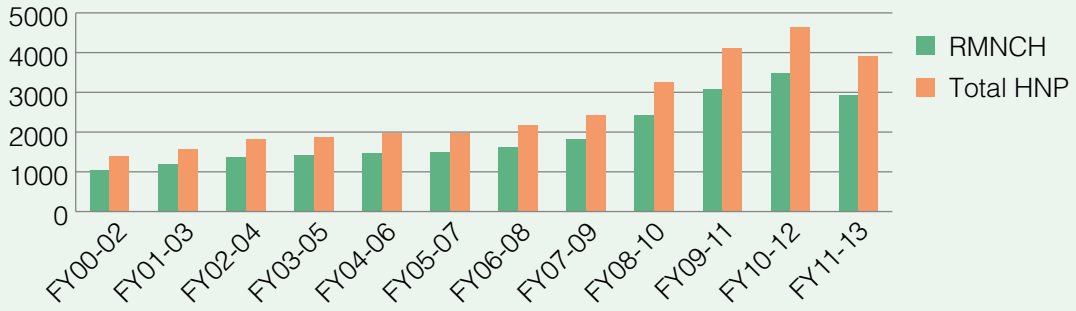
Total World Bank disbursements (IDA plus IBRD) for RMNCH have also fluctuated in the past decade, with a rising trend since FY2006-08. FY2011-13 disbursements were 120% greater than in FY2006-08 (Figure 3).

Figure 3. Total World Bank annual disbursements for RMNCH and HNP (US$m)



As noted above, these data underestimate World Bank resource flows for RMNCH. Data do not allow a precise estimation of the indirect and direct resource flows to RMNCH from the "non-RMNCH" World Bank lending for health, but it would be reasonable to assume that as much as 75% of all World Bank resource flows for HNP, including those currently coded as RMNCH, would fall in this category. Figure 4 recalculates the data in Figure 3 to represent total estimated World Bank RMNCH resource flows, based on that 75% share. Under this scenario, total IDA resource flows for RMNCH in FY2010-12 reached US$768 million, while total World Bank resource flows to RMNCH reached $3474 million during the same period.

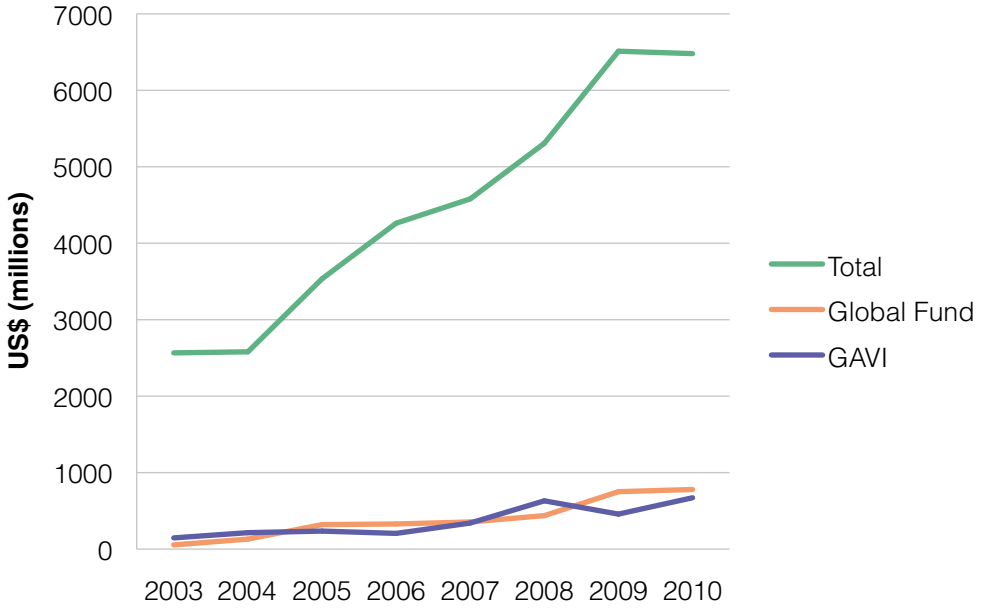
Figure 4. Total World Bank annual disbursements for RMNCH at 75% of total HNP disbursements



Because the World Bank coding system does not allow for an estimate of resource flows to RMNCH from a number of operations that clearly benefit RMNCH, actual resource flows are almost certainly higher than the World Bank data coding system demonstrates. This may have contributed to a persistent under-estimation of the priority the World Bank has attached to RMNCH over the past decade. In addition, multi-sector contributions to RMNCH, which are increasingly recognised as important for women's and children's health, are also not measured in the current data sets. Taken together, it appears that the World Bank provides significant resources for women's and children's health.

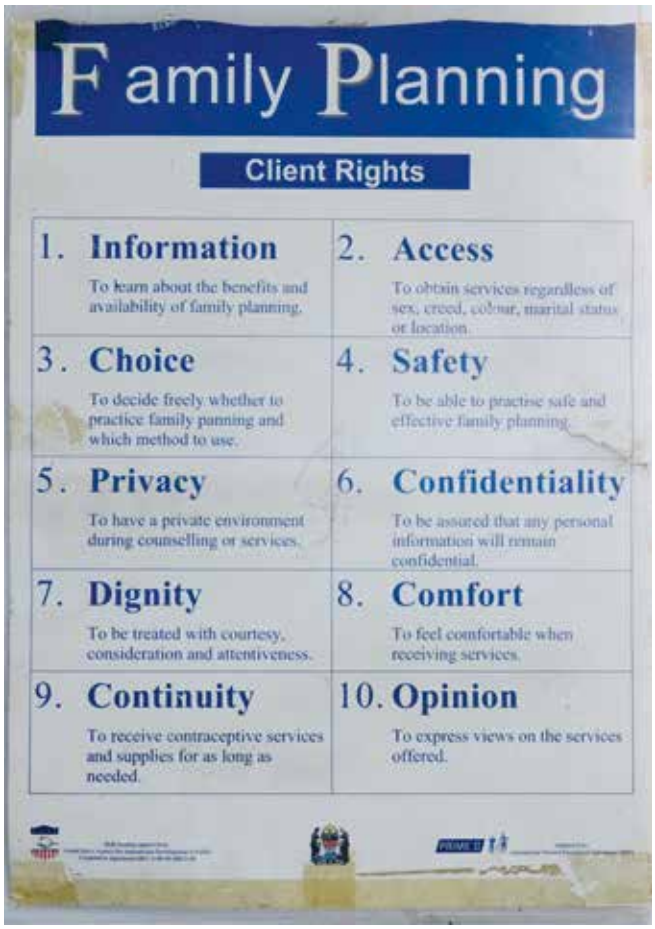
86. It will be increasingly important post-2015 to build stronger and more visible linkages with other sectors of global health. This repositioning of women's and children's health will require courageous leadership. We are already seeing such leadership in key areas. In April, 2014, the Global Fund to Fight AIDS, TB, and Malaria (GFATM) and UNICEF agreed to coordinate efforts in reducing the burden of these three diseases among mothers, newborns, and children. The goal of their memorandum of understanding is to integrate the efforts of both agencies in countries—specifically, "to jointly identify countries where HIV and malaria investments for mothers and children could be better aligned with investments in basic maternal, newborn, and child health." Both the Global Fund and UNICEF will encourage governments to apply for GFATM grants that align HIV, TB, and malaria programmes with broader maternal, newborn, and child health goals. In evidence submitted to the iERG by the Global Fund, one can see a remarkable picture beginning to emerge. The Global Fund is evolving incrementally, but consciously and deliberately, from being a Global Fund for only 3 diseases to becoming a Global Fund for Health. Here is the evidence for such a radical shift in mandate. Between 2003 and 2010, the Global Fund contributed around US$3.1 billion to maternal, newborn, and child health (Figure 10). An independent assessment of the impact of that investment found that GFATM financing was associated with reduced maternal and child mortality. These effects were most likely mediated through antiretroviral therapy, prevention of mother-to-child transmission of HIV, and the provision of insecticide-treated bed nets. Based on this experience, the Global Fund is now making an even more concerted effort to ensure that its investments make a difference for much broader segments of the population. The Fund is now more engaged in technical support for policymaking in countries. It is actively seeking to "break down… vertical programming" by direct investments in integrated systems of care. The Fund is integrating PMTCT and malaria services into antenatal care, and family planning into HIV services. And by investing in health worker training, key commodities, and community mobilisation, the Fund is scaling up action to treat key childhood illnesses (Figure 11). The Global Fund anticipates that its New Funding Mechanism will accelerate these commitments to women's and children's health still further. There will be specific allocations of money for health systems strengthening. The goal will be to achieve outcomes that explicitly include benefits for women and children. Countries are being strongly encouraged to request funding for these broader mandates. A new RMNCH/HSS team has been created within the Fund to support countries in their efforts to use the Fund's resources to have a greater impact on women's and children's health. The evolution of the Global Fund into a financing facility for women's and children's health is real and demonstrable. It is an extremely welcome development.

Figure 10. Official Development Assistance to MNCH for the 74 Countdown Priority Countries, 2003–2010



Source: Graph based on data from Hsu et al., 2012 [4]

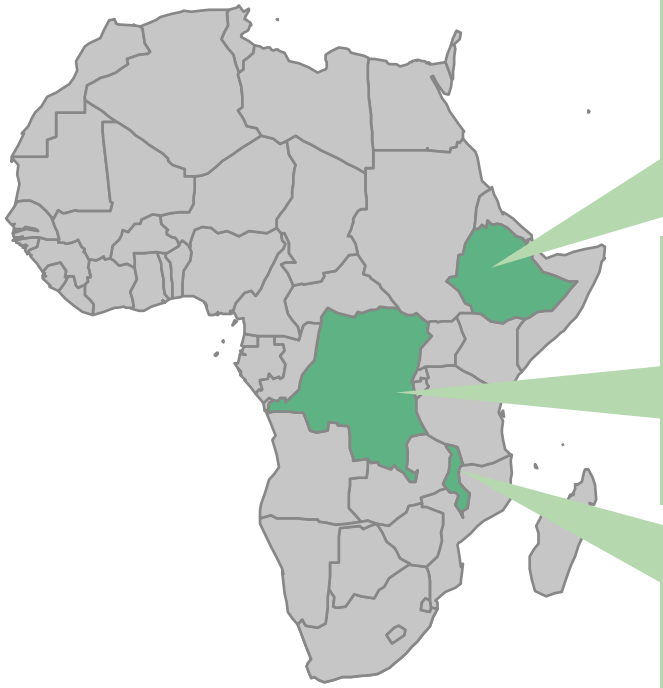
87. A stronger alliance between the RMNCH and the AIDS communities is, indeed, essential for the future success of both movements. Evidence submitted to the iERG by UNAIDS presents an alarming picture of the intersection between HIV and women's and children's health. 3.2 million children are living with AIDS globally—2.6 million of those children live in 21 priority countries, countries targeted by the Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive. These 21 countries are in sub-Saharan Africa. The remaining country in the Global Plan is India, for which, at the time of writing, data were not available. Of those 2.6 million children only 23% are receiving treatment for their HIV infection. UNAIDS rightly concludes that "we are failing children living with HIV." The Global Plan has a goal to reduce the number of new HIV infections among children by 90% by 2015. At current rates of progress, that target will not be met—there is likely to be only a 46% reduction in new HIV infections among children by 2015. Mothers are also being let down. According to UNAIDS, "there is already stagnation in the number of HIV+ pregnant women receiving antiretroviral medicines. Currently, one in 3 pregnant women living with HIV do not have access to ARVs.



Poster in the examination room

Figure 11. Global Fund support for iCCM in sub-Saharan Africa

To date, Global Fund investments in malaria and HSS have played an important role in supporting the iCCM platform



ETHIOPIA
(Round 5)
Deployed 30,000 health extension workers (HEWs) who supported not only HIV, TB, and malaria services, but also community case management of malaria, pneumonia, and diarrhoea, especially in rural areas.

DEMOCRATIC REPUBLIC OF CONGO
(Global Fund Interim Funding)
Covering 219 out of 515 Health Zones in supporting community case management of malaria, pneumonia, and diarrhoea. UNICEF is funding pneumonia and diarrhoea commodities as well as provision of family kits.

MALAWI
(Global Fund HSS, Round 5)
Reinforced its human resources for health (HRH) with >10,000 health surveillance assistants who also provide community-based maternal, newborn, and child health care in hard-to-reach areas.

88. Tuberculosis also remains neglected by the women's and children's health community. Although most TB deaths are among men, TB is one of the top 3 killers of women worldwide. 410 000 women are estimated to have died from TB in 2012 (53). 2.6 million women are estimated to have become infected with TB in 2012. TB is also a killer of children—74 000 children died from TB in 2012, and 530 000 became infected. But children with TB, at risk of TB, or with multidrug-resistance to treatment have typically been left behind by both the TB and children's health communities (54,55). That indifference must end in the post-2015 era. Malaria is a different story. WHO estimates that between 2000 and 2012, estimated malaria mortality rates fell by 42% in all age groups and by 48% in children under 5 years (56). Decreases in malaria deaths have contributed substantially to improvements in child survival. 90% of 3.3 million malaria deaths averted between 2001 and 2012 were in children under-5. These successes must be sustained and accelerated post-2015.

89. A specific note about universal health coverage is needed. We believe that universal health coverage has special importance for women's and children's health. As Jonathan Quick and colleagues have argued, "UHC has proven a powerful driver for women's health in low and middle income countries… It is the one approach that reduces inequitable access and addresses the full range of women's health issues with the full spectrum of health services" (57). Universal health coverage must work for women and children. That means ensuring women and children have access to care, that services are designed with women and children in mind, and that women and children are assured of financial risk protection. When designing indicators to monitor progress towards any SDG sub-goal of universal health coverage, we recommend that those indicators include women-and-children specific metrics (58).

90. The second area we wish to offer some reflections on concerns accountability. In its report to the iERG, PMNCH made the recommendation to, "Initiate and announce a major Global Strategy accountability reporting session at the UNGA in September, 2015." The Open Working Group recognises that "we need an accountability mechanism for all." In preparation for work to define the mechanism of accountability post-2015, the Executive Office of the UN Secretary General

has launched a review of the accountability work for women's and children's health. One of the strategic objectives of the next phase of the *Every Woman, Every Child* movement is, "In 2015-2016, launch *Every Woman, Every Child* for the post-2015 era as a recognised platform to place the most vulnerable—women, children, and adolescents—at the centre of sustainable development and cutting across future goals, **with a functioning and recognised accountability mechanism at its core** (our emphasis)**.**" Indeed, the UN Secretary-General's Office sees the *Every Woman, Every Child* accountability mechanism as "a pathfinder" for other sectors in the post-2015 framework.

Brazil's new strategy to improve quality of care: the active ombudsman

The Brazilian public health-care system (Sistema Único de Saúde, SUS), created in 1990, is universal, although currently 30% of the population also has health insurance. The Ministry of Health (MoH) estimates that in 1990 there were 141 maternal deaths per 100 000 live births (1) and 62 under-5 infant deaths per 1000 live births (2).

The main problems were access to care and its quality: in 1995, there were 1.2 prenatal care visits per SUS birth (3), and in 1996, about 90% of all births were institutional (4). From 1998 onwards the MoH launched measures to improve care: by 2006, 98.4% of all births were in hospitals (5), and by 2009, there were 10.2 visits for each SUS birth (3). In order to reduce great regional disparities, in 2009 the MoH proposed the Programme to Qualify Maternity Services (PQM) in the Northeast and the Legal Amazon regions, focused on the reference maternity facilities where 50% of all infant deaths in these regions occurred.

Learning from the experience of the PQM, the Stork Network, a programme to reorganize health care was launched in 2011. It faced the challenges of changing countrywide the interventionist and non-evidence based model of care, in favour of a multi-professional humanised approach that adopts scientifically based and respectful practices. Among its tasks was organising the health-care network in order to eliminate the antenatal pilgrimage for a hospital bed, when pregnant women in labour have to go to more than one hospital, sometimes five or six, before they are admitted.

With 3337 health-care establishments assisting between one and 10 000 births per year, of which 42.4% (1416) attend over 200 births per year, representing 93% of all SUS births, and given the continental size of the country, the need to monitor the development of the changes became evident.

Usually Ombudsmen deal with complaints sent to them. By contrast, the office of the Active Ombudsman for the Health System was conceived in 2012 in order to check proactively with SUS users how care is being delivered. Since February 2012, all birth records must include a telephone number in order to facilitate a telephonic survey. Trained telemarketing researchers administer a 38-point questionnaire developed jointly by the Ombudsman and the MoH's Women's Health Coordination Area.

From May, 2012, to June, 2013, out of 665 571 records, 431 629 had valid telephone numbers and 103 905 women responded to the questionnaire. The analysis focused on: (a) all respondents; (b) the 408 maternity facilities receiving federal investment; and (c) the 32 facilities with higher MMRs — the ones that had 15 or more maternal deaths during the period 2010-2012. The MoH chose the last of these as a priority for intervention, on the assumption that reducing the MMR in these establishments would have the greatest effect on the national MMR.

Hospitalisation is still not guaranteed for women giving birth: 39% of all respondents did not know where they would give birth, and 18% were not admitted at the first facility where they sought care. Law No. 11 108/2005 (6) guarantees the mother's right to have a companion of her choice present at childbirth. Of the 66% without a companion, 54% said they were not allowed one, and 17% did not seek to exercise that right. 53% had a vaginal birth, of which 95% in supine position. 13% reported incidences of disrespect or abuse, 75% of these being negligence. Only 59% reported immediate skin-to-skin contact with the baby. Moreover, 1% reported that the facility or physician charged them additional money.

Data for the 408 hospitals receiving federal funding were very similar, but for the 32 maternity facilities with higher MMRs the data were worse, suggesting

an association between maternal mortality and the process of care, as measured by those items. The MoH communicates these results to the Stork Network Conducting Group of the states and municipalities, so they can plan and implement the standard of care in their hospitals.

However, for the 32 maternity facilities with higher maternal mortality rates, the MoH is providing considerable technical support to enable them to introduce and maintain changes in their care. The MoH funds one technical supporter for each of these maternity facilities. One of their first steps was to organise a collegiate board to formulate an Action Plan. Their role is to facilitate the changes needed, helping to implement the Action Plan. In addition, each of these hospitals is required to file a daily report; these are analysed by the MoH team weekly, and their feedback helps reorient the Action Plan and practices. Hospital professionals hold weekly meetings to discuss the process of change. They also monitor their maternal deaths.

All 32 maternity facilities and their technical supporters participate in a monthly videoconference with the MoH team, where they present their actions, achievements, and problems, and exchange strategies to deal with them, each learning from the others.

To illustrate preliminary results, an important facility in a Northeast state had 76 maternal deaths in the period 2010-2012 (about 25 per year). Their programme was launched in March, 2013, and in the same year their maternal deaths were reduced to 17. Another example is a group of six maternity facilities in Rio de Janeiro working together and supporting each other in the process of change. One of them, where 11 maternal deaths occurred every year, managed to reduce that number to three in 2013.

An interesting consequence of this process is that the hospital professionals are becoming aware of the importance of networking with other cadres of care providers. They have instigated dialogue with prenatal professionals from primary care units, as well as with high-risk services.

The survey will continue to be used to monitor these process indicators, as well as the outcomes. The results will be published in reports: every three months for the 32 maternity facilities with higher MMRs, every six months for the 408 facilities receiving federal funding, and annually for the remaining facilities.

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Bench in the maternity ward

91. But although accountability is popular in global health today, there is very little reliable evidence to guide us as to the appropriate mechanism of accountability to adopt. There are many models of accountability to draw on. Some models focus on monitoring only, and so devote large efforts to gathering better data—we see this emphasis in the many calls for repositioning data as the central focus of the post-2015 agenda (59). Other models focus on institutions as the means to gather the data—eg, the African Health Observatory (60). IHP+ is about a partnership and a set of principles to streamline the actions of global agencies—one national plan, one monitoring and evaluation platform, and shared accountability for results. New initiatives that have large amounts of new financing (eg, FP2020) have preferred to construct their own unique and non-overlapping performance, monitoring, and accountability processes. Civil society organisations may hold global agencies accountable for their promises (eg, IPPF's scorecard to monitor the implementation of the World Bank's 2010 Reproductive Health Action Plan) (61). In countries, parliaments have a special place in delivering accountability (the Inter-Parliamentary Union has been an energetic advocate for strengthening parliamentary accountability mechanisms). And country-based civil society organisations, as World Vision showed us in evidence submitted to the iERG, have an important part to play in monitoring and reviewing the commitments and actions of governments (62). Even the media have an accountability function (62). There is no single perfect accountability mechanism that one can choose. The truth is that a pluralistic array of overlapping accountability processes may be the only practical way forward. Indeed, a pluralistic approach may have distinct advantages over a single large UN centred mechanism, as suggested by the High Level Panel—each mechanism could contribute a different emphasis and style to the practical meaning of accountability. We have one caveat to our endorsements of pluralism. We believe that an officially legitimised (via the UN) independent accountability mechanism reporting directly to the UN Secretary-General is an essential component of global accountability. This globally configured entity gives accountability a powerful platform and convening point for advocacy and influence. Multiple actors alone—all engaging in mutual accountability—risk creating an unruly cacophony of voices with diminished impact.

92. There are lessons that can be learned, however. The iERG has synthesised its reflections about its work in a submission to the UN Secretary-General's Office (see Annex 6). We have found our partners in the *Every Woman, Every Child* movement extremely collaborative and responsive to the work of the iERG. As a new entity, we had no track record of legitimacy or success. But our emergence from the CoIA process gave us the independence and permissibility to work according to our terms of reference. CoIA also gave us a clear framework to operate within—time-bound recommendations, specified indicators, and a monitor-review-action accountability model, all within an overall Global Strategy that had clearly articulated objectives. We have discovered our own challenges—time, technical resources, availability of data, engagement of countries, monitoring our own recommendations, and evidence of impact. We have seen the global RMNCH community prioritise our recommendations and work to respond to those it sees as most important to women's and children's health. The recommendations we have made, especially regarding an investment framework for women's and children's health, better governance, use of human rights tools, advocacy for global accountability post-2015, taking adolescents more seriously, and quality have been followed up in various ways that we hope have been helpful. We believe that the country visits we have made this past year have been a valuable way to bring country experiences more to the centre of our understanding of accountability. But we also recognise that the iERG is not a panacea. In the survey we conducted of countries to understand the value of the CoIA process, Norway observed that, "Norway supports the iERG, but does not believe that alone it constitutes a sufficient accountability structure for MDG 4&5. Norway believes there is a need for an explicit consideration of measurement and accountability structures for the post 2015 goals and the iERG experience can inform future architecture in this field." We agree with that view.

93. One particular gap, one that was strongly reinforced and crystallised during our consultation with civil society, concerned the lack of a global policy space to discuss the broad issues that groups such as civil society (and accountability mechanisms, such as the iERG) raise. The World Health Assembly is one opportunity in the calendar to bring government ministers together with policymakers, funders, technical experts, health workers, civil society, and the private sector to discuss the results and opportunities for improving the health of populations worldwide. However, the official programme of intergovernmental and interministerial sessions at the Assembly precludes inclusive discussions with other key actors in global health. It is true that there is an increasingly diverse and vigorous programme of side-events at the Assembly. But this programme is informal and fragmented. The lack of a more formal "policy space" is extremely disabling for global health (63). The need to create additional policy space through the presence of a "shadow meeting" in parallel with the official World Health Assembly programme is becoming more urgent every year. There have been several attempts to introduce innovations into the global health calendar to create such a space—webcasts of the official WHA programme, the notion of a "Committee C" at the Assembly itself, a WHO Forum at a different time of the year, and alternative events, such as the World Health Summit, held annually in Berlin and now regionally. However, none of these efforts have either been fully realised or achieved their desired result. The creation of a Civil Society Forum at the World Health Assembly seems to be an idea waiting to happen. Clearly, such an idea poses many questions. Who would finance such a Forum? What would be its official or unofficial relationship with the Assembly itself? How would its outputs be inputted into the Assembly? These questions should, however, not obscure the fact that such a Forum is needed to promote a more inclusive dialogue around global health decision-making—and to enhance global accountability.

94. Finally, what does it mean to talk about sustainable development for women and children? The traditional model of sustainability is tripartite—social, economic, and environmental. There are important ideas here—for example, that we should pay more attention to the economic and environmental determinants of women's and children's health (assuming that the health community is already paying sufficient attention to the social determinants of women's and children's health, which may not always be true). Take two examples. First, the relation between early child development and economic output. Paul Gertler and colleagues have convincingly shown how investments in psychosocial stimulation for growth-impaired Jamaican children yield substantially increased earnings (63 a). Second, the impact of a mass society response to catastrophe. Agnes Binagwaho, Rwanda's Minister of Health, provides a compelling account of how an entire nation overcame genocide to reconstruct its society. Both examples illustrate why the idea of sustainable development is so important. But this definition still does not take us to the core of the meaning of sustainability. Sustainability is about all people, not just some people. It is about paying as much attention to the future as we do to the present. It means going beyond the control and eradication of disease, to assert the importance of a healthy life and wellbeing. Sustainability is about the value, not the price, we put on our lives and on the lives of our children. It is about the freedom to flourish, the opportunity to choose our futures without harming others, and to live in a state of dignity. If these can be the measures against which the health and wellbeing of women and children are measured, we are confident and optimistic that the post-2015 era will present the greatest possibilities women and children have ever enjoyed.

6. CONCLUSIONS AND RECOMMENDATIONS

95. To end our 2014 report, we make 4 observations about the present landscape for women's and children's health. The first is that the pace of progress, despite many challenges and missed opportunities, is accelerating. This report has highlighted reasons why we should be optimistic about this progress:

- Increasing numbers of countries are accelerating their reductions in maternal, newborn, and child mortality through continuous commitment and innovation
- Heads of State are showing exemplary global political leadership—eg, Tanzania and Canada—which not only delivers more resources for women and children but also keeps their cause high on the international political agenda
- More countries are documenting success, and the causes of success, through independent evaluation: we are learning the actionable determinants for improving women's and children's health (64,65)
- Greater momentum for action is being brought about by new initiatives, such as FP2020, the Every Newborn Action Plan, and the UN Commission on Life-Saving Commodities
- Institutional mandates are evolving rapidly to meet the needs of countries (eg, at the Global Fund)
- Important, but neglected, dimensions of women's and children's health are finally getting the attention they need and deserve (eg, CRVS)
- Expanding opportunities to bring human rights instruments to bear on advancing the status, health, and wellbeing of women and children are being created
- Research is giving new insights into future possibilities to enhance the health of women and children worldwide
- The power of partnerships to achieve more than any single institution could achieve alone is repeatedly being demonstrated (eg, *Every Woman, Every Child*; PMNCH; and Countdown to 2015).

96. Second, the landscape for global health, and inevitably for women and children, is about to undergo a seismic shift—from the MDGs to the SDGs. This shift is already ushering in a period of opportunity mixed with uncertainty:

- New visionary ideas, such as "grand convergence" and universal health coverage, are being advanced to motivate ambitious aspirations post-2015
- New frames of reference for health—environmental change, climate disruption—are recalibrating our understanding of the threats that face women and children
- New notions of sustainability are revealing neglected predicaments for women and children in high-income settings as well as in developing countries (66)
- New coalitions and alliances are producing important and innovative realignments in global health—eg, broadening of the AIDS agenda, inclusion of chronic diseases and mental health into the mainstream of global health, and a focus on the life course through early child development
- New opportunities are being created for institutional reform to address new priorities, which can lead to sometimes painful reconstruction (67)
- New conceptions of health are being discussed, moving away from ideas of survival and being disease-free and towards notions of resilience, wellbeing, and capability

97. Third, these opportunities and uncertainties must not be allowed to induce a state of complacency or paralysis during the transition from one set of goals to another. The positive trends we draw attention to are certainly promising. But they are not as widespread or as deeply ingrained as they need to be to address the huge challenges still facing women and children. There are powerful forces already acting to increase future threats—for example, rapid demographic transitions in already vulnerable and fragile settings; ongoing conflicts with the displacement of millions of women and children; persistent and deep inequities facing women and girls, often associated with extreme violence; and the rise of extremist trends in many parts of the world, led by groups deeply committed to fighting against gender equality and human rights for women and girls.

98. Finally, amid this landscape, accountability has emerged as a potentially powerful means to ensure that complacency is avoided, promises are kept, commitments are delivered, and lessons are learned. The success of the post-2015 era will be judged by the way the current rhetoric of accountability is translated into mechanisms for independent and robust monitoring, transparent and participatory review, and effective and responsive action. With this caution in mind, the iERG offers 6 recommendations for strengthening progress and accountability for women's and children's health.

99. Develop, secure wide political support for, and begin to implement a global plan during 2014-15 to end all preventable reproductive, maternal, newborn, child, and adolescent mortality for the 2016-2030 period—a new, broader, and more inclusive Global Strategy for Women's and Children's Health. Women and children cannot wait for the SDGs to be formally agreed between governments. Meanwhile, the danger of focusing on ever shorter-term targets—the MDGs—while waiting for the SDGs

to be finalised is leading to dangerous distortions in the global response for women and children. What we need to put in place today are long-term strategies that address the most critical needs for women and children. Many of these needs are set out in our report:

- Accelerate the delivery of life-saving interventions, including vaccines, to women and children
- Deliver on past commitments (eg, to tackle pneumonia and diarrhoea) as well as new commitments (eg, the *Every Newborn Action Plan*)
- Place greater attention on the sexual and reproductive health, rights, and wellbeing of the adolescent girl
- Invest now in education for girls as a critical means to protect health
- Fully integrate the AIDS response, together with nutrition, infectious disease, and non-communicable disease, including mental health programmes, into RMNCH
- Work now to deliver Universal Health Coverage: don't wait for an SDG goal
- Invest in health professional education as a means to create transformative leaders of health systems, leaders who understand that human rights lie at the core of health care
- Mobilise all sectors in a concerted strategy to eliminate violence against women, child marriage, and FGM
- Address the unmet need for safe abortion services
- Increase investment in research and development to create the new interventions needed for the next generation of challenges facing women and children

What has become much clearer during the course of *Every Woman, Every Child* is that there is no simple blueprint for reducing maternal and child mortality (68). What is needed in a new post-2015 Global Strategy is a much fuller recognition of the multisectoral nature of what it will take to advance women's and children's health. For example, around half the reductions in child mortality since 1990 have come from non-health sector investments.

100. In 2015, create a results-based financing facility to support and sustain this new Global Strategy. The iERG wants to see faster progress on executing the investment framework for women's and children's health. Women and children urgently need predictable performance-based financing systems, globally and domestically. The investment framework for this predictable financing is in place, but has not yet been fully acted upon (38). It is important that the investment framework now triggers serious activity by funders. Development assistance for maternal, newborn, and child health *fell* by 1% in the 75 Countdown countries in 2011 compared with 2010. This fall was due to a substantial drop in funding for child health. As the 2014 Countdown report notes, "the reduction in ODA to maternal, newborn, and child health in Countdown countries in 2011 continues a slowdown detected between 2009 and 2010 relative to previous years." The largest source of funding for RMNCH comes from the US Government. But the second largest source is the Global Fund. In evidence submitted to the iERG by the Global Fund, we were impressed by the way the Fund is evolving to make women and children part of its central financing concerns. Presently, this attention is mainly through the 3 diseases of AIDS, TB, and malaria. But the Global Fund is making very clear that it is inviting countries to bid for investments that have a strong RMNCH component. Is it impossible to imagine that the Global Fund is slowly moving from being a Global Fund to fight only AIDS, TB, and Malaria to becoming a Global Fund for Health? Based on the evidence we have seen, we believe the Global Fund is preparing for this eventuality. We would welcome such a strategic evolution. Indeed, we believe the Global Fund provides one possibility for creating a results-based financing facility for women's and children's health. We recommend that this goal becomes an explicit objective of the Global Fund and the RMNCH community jointly. Together with contributions from other partners—notably (in addition to the US), the UK, the World Bank's International Development Association, UNFPA, EU,GAVI Alliance, and Canada—there is an opportunity now to create the means to put in place long-term investments to support women and and children.

101. Between now and 2016, convene a Special Session of the UN General Assembly, led by the Secretary-General, to accelerate international collective action for women's and children's health—to align and harmonize the actions of partners, to promote leadership and stewardship, to ensure provision of global public goods, to manage externalities, and to provide direct country assistance. Donors must change their roles and responsibilities faster and more radically. Partners often talk of alignment and harmonisation. But the iERG has observed difficulties for countries in ensuring that those principles are adhered to. Alignment means that partners support a country's self-determined national development strategy, not impose their own. Harmonisation means that partners streamline their efforts to reduce the burden of parallel initiatives on country systems. Neither is fully happening in many of the countries we report on. The iERG is extremely concerned that donors are not being fully held accountable in a public and transparent way for their promises and commitments. This concern also extends to the roles and responsibilities of multilateral

organisations. Fragmentation of activity and failure to deliver measurable progress too often characterise the actions of well-intentioned partners. But the changes we envisage for partners go far beyond delivering their past commitments on aid effectiveness. We wish to see the SDGs trigger a new era of international collective action for women's and children's health. International collective action has recently been defined as 4 essential functions (11):

- *Leadership and stewardship:* convening, consensus-building, and advocacy
- *Ensuring provision of global public goods:* discovery, development, and delivery of new health tools; implementation research; knowledge generation and sharing; and market shaping
- *Management of externalities:* responding to global threats that transcend the responsibilities of any single nation-state; surveillance and information sharing
- *Direct country assistance:* technical cooperation, development assistance for health, and emergency humanitarian assistance

What do these functions mean in practical terms. First, that the impressive returns on investment in women's and children's health should encourage donors to continue to give generous assistance to countries and international financing facilities. Second, that work to get key life-saving interventions to women and children should be scaled up and accelerated. Third, that the international community should pay greater attention to providing global public goods (eg, new product development) and controlling negative externalities (eg, strengthening surveillance and response capacity. Fourth, that partners should invest more resources in ensuring strong multilateral health institutions for women and children. These institutions include WHO, UNICEF, UNFPA, the Global Fund, and the GAVI Alliance. And finally, that the international community should support the achievement of universal health coverage through investments in policy and implementation research, and through direct technical cooperation.

102. In 2015, establish a Global Commission on the Health and Human Rights of Women and Children to propose ways to protect, augment, and sustain their health and wellbeing. Women and children need a deeper and broader vision for their future beyond 2015. Let us not only revise the goals for child and maternal mortality or for sexual and reproductive health and rights. Or simply add new goals for newborn mortality, stillbirths, and adolescents, as important as these goals are. Let us write a bigger and more ambitious future for *all* women and *all* children. That future should be grounded in the idea that all women and children have the equal right to opportunities, not only to survive but also to flourish, to grow and develop with dignity and freedom, within the context of a safe and empowering political, social, economic, and environmental setting so that each may reach their full potential. We want to see sustainable development goals for health and wellbeing that articulate a positive and inspiring vision for women and children, not merely set out objectives for the narrow reduction of disease, disability, and risk. The iERG has seen the tremendous mobilising power of two Commissions—CoIA and the Commodities Commission. Commissions create policy space and political momentum to deliver step changes in our global response to seemingly intractable predicaments. We believe that a joint WHO-Human Rights Council Commission on the Health and Human Rights of Women and Children would deliver practical recommendations about how to create synergies between these two vitally important, but too often mutually exclusive, domains.

103. From 2015 onwards, hold a civil-society-led World Health Forum adjacent to the World Health Assembly to strengthen political accountability for women's and children's health. The purpose of the Forum would be to bring all parties with an interest in global health together at the time of the World Health Assembly—to hold the intergovernmental process accountable to the citizens of countries, and to facilitate and coordinate action by non-government actors. This World Health Forum would be an important contribution to the democratisation of global health.

104. In 2015, establish and fully resource a new Independent Expert Review Group to monitor, review, and propose actions to accelerate global and country progress towards improved women's and children's health during the period of the Sustainable Development Goals. Setting new goals and targets in the post-2015 period for women's and children's health is not enough. We are not in a position to judge the success (or not) of the iERG. The iERG comes to the end of its term of office in 2015. We are certainly not calling for a renewed term of office for the present iERG. But we can say that we believe independent accountability has an important part to play in the post-2015 period (Annex 6). We believe that a multidisciplinary team, committed to the overall goals of *Every Woman, Every Child*, but independent of the programmes that deliver the Global Strategy, has a potentially valuable role in encouraging continuous improvements in programmes and accountability to advance women's and children's health. In the proposals made for accountability mechanisms post-2015 so far, independent accountability, in line with the terms of reference of the iERG, has not been supported. We hope that our work, annual reports,

and now country reports can strengthen the case for independent accountability as a core function for the post-2015 period. We invite partners to join together to affirm their commitment to independent accountability, to write a new mandate and terms of reference for a post-2015 IERG, and to construct this mechanism in the light of the new priorities implicit in the idea of sustainable development.

105. The need for a longer-term and larger vision, a more predictable financing mechanism, greater international cooperation, and stronger accountability mechanisms post-2015 is well illustrated by the recent repositioning of *A Promise Renewed*, an ambitious effort launched in 2012 by USAID, in collaboration with UNICEF, the Bill & Melinda Gates Foundation, and other partners. At an update of progress on *A Promise Renewed*, held in June, 2014, in Washington, DC, the US announced the realignment of US$2.9 billion to save the lives of 500 000 children over a 2-year period. This investment was constructed by deprioritising funds from some countries and reinvesting that money in countries with higher burdens of child mortality. The announcement seemed wholly positive—a US Government programme that enjoyed bipartisan support, was directed at countries most in need, and which was the outcome of deliberations from a "blue-ribbon" panel of experts, supported by the Gates Foundation. But if one examines this announcement more closely, important questions might reasonably be asked. First, USAID claimed that the 24 countries that were the focus of *A Promise Renewed* were "on-track" to reach MDG-4. But as we have seen in Chapter 2, that cannot be true if one believes independent estimates of progress towards the MDGs. This difference of interpretation of "success" raises a question—just who should be the judge of a donor programme's success? Having the donor "marking their own homework", so to speak, is not accountability. Second, a 2-year commitment, while welcome, is still short term. Canada's decision to invest over a 5-year period gives countries more predictability in their budgetary planning. Third, the new announcement was still firmly rooted in the important, but too narrow, area of child survival. It is surely time for donors to offer a more comprehensive vision for the impact of their investments on the lives and futures of women and children. Fourth, US$2.9 billion is a large sum of money and, given that it is money from the American taxpayer, it is not unreasonable that the US would want to be the primary steward of that investment. But since there is now a global investment framework for women's and children's health it might also be possible for the US to consider some kind of "funders forum", where investments can be allocated in a more transparent and less fragmented way to those countries and peoples most in need. Finally, the US has an important leadership role in encouraging international collective action to strengthen global public goods, secure multilateral institutions, and achieve universal health coverage. Unfortunately, not these issues were not emphasised in the June announcement by USAID.

106. At an Accountability Stakeholders Meeting, held in Geneva in January, 2014, Dr Margaret Chan, Director-General of WHO, noted that accountability had become "the norm in any global health discourse, debate, or discussion." But she also pointed out that women's and children's health was the "hardest test case" for accountability. "Why is every initiative," she asked, "having a separate accountability mechanism? Countries ask why. Don't have parallel systems. They undermine already limited capacity. I don't mind telling you how unhappy many countries are." Her challenge is important because she also argued that a "vigorous and independent mechanism for accountability" was essential for the post-2015 era. This 2014 report from the iERG, in addition to describing progress on *Every Woman, Every Child*, the CoIA recommendations, and the Commodities Commission, has tried to set out its vision for women and children, and for accountability to those women and children, in an era of sustainable development. In our final report next year, we will seek to sum up the impact of this work and the lessons we should take with us into a very different political era.

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ANNEXES

ANNEX 1. TERMS OF REFERENCE OF THE IERG AND ITS COUNTRIES OF CONCERN

The UN Commission on Information and Accountability for Women's and Children's Health was established by WHO at the request of the United Nations Secretary-General to accelerate progress on the Global Strategy for Women's and Children's Health. The Commission was chaired by H.E. Jakaya Kikwete, President of the United Republic of Tanzania and Rt. Hon. Stephen Harper, Prime Minister of Canada, with the Director-General of WHO and the Secretary-General of ITU as vice-chairs. The Final Report of the Commission proposed an accountability framework and ten recommendations. The full Report is available online at www.everywomaneverychild.org/accountability_commission. On the issue of global reporting, the Commission proposed a time-limited independent Expert Review Group be established and operate until 2015:

"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."

In response to Recommendation 10 (Global oversight), starting in 2012 and ending in 2015, the independent Expert Review Group (iERG) will serve as the principal global review group and report to the UN Secretary-General, through WHO Director General.

The independent ERG will:

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

Countries

The global oversight covers 75 low- and middle-income countries with 98% of the world's maternal and child mortality. 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.

African Region (AFRO)

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

Pan American Health Organization (PAHO)

Bolivia*, Brazil*, Guatemala*, Haiti, Mexico*, Peru*

Eastern Mediterranean Region (EMRO)

Afghanistan, Djibouti*, Egypt*, Iraq*, Morocco*, Pakistan, Somalia, 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, China*, Lao PDR, Papua New Guinea, Philippines*, Solomon Islands, Viet Nam

ANNEX 2. LIST OF ALL COMMITMENTS MADE TO *EVERY WOMAN, EVERY CHILD*

Total Commitments as of June 3, 2014

74 Governments
30 Foundations
39 UN, Multilateral Organizations & Partnerships
85 CSOs/NGOs
48 Businesses
23 Research & Academia organizations
4 Healthcare Professionals & Workers
303 Total Commitments

Legend:

(YEAR) – year when the commitment was made
LIC – low income country
MIC – middle income country
HIC – high income country
FP2020 – commitment made under the Family Planning 2020 initiative
Born too Soon – commitment made under the Born too Soon initiative
FIGO - International Federation of Gynaecology and Obstetrics
ICM - International Confederation of Midwives
ICN – International Council of Nurses
IPA - Independent Physician Association
RANZCOG - Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCOG - Royal College of Obstetricians and Gynaecologists
SCOG - Catalan Society of Obstetrics and Gynaecology Perinatal Medicine Section
WFSA - World Federation of Societies of Anaesthesiologists

Government (*Indicates enhanced commitment)

1. Afghanistan (2010; LIC)
2. *Australia (2010; 2012 HIC) (FP2020) (Born Too Soon)
3. *Bangladesh (2010; 2012 LIC) (FP2020)
4. Benin (2010; LIC) (FP2020)
5. *Burkina Faso (2010; 2012 LIC) (FP2020)
6. Burundi (2011; LIC)
7. Cambodia (2010; LIC)
8. Cameroon (2011; LIC)
9. Canada (2010; HIC)
10. Central African Republic (2011; LIC)
11. Chad (2011; LIC)
12. China (2010; MIC)
13. Comoros (2011; LIC)
14. Congo (2010; LIC)
15. *Cote d'Ivoire (2011, 2012; LIC) (FP2020)
16. Denmark (2012) (FP2020)
17. DRC (2010; LIC) (FP2020)
18. Djibouti (2011; LIC)
19. *Ethiopia (2010, 2012; LIC) (FP2020)
20. *France (2010 & 2011, 2012; HIC) (FP2020)
21. Gambia (2011; LIC)
22. *Germany (2010, 2012; HIC) (FP2020)
23. *Ghana (2010, 2012; LIC) (FP2020)
24. Guinea (2011; LIC) (FP2020)
25. Guinea-Bissau (2011; LIC)
26. Guyana (2011; LIC)
27. Haiti (2010; LIC)
28. India (2010; MIC) (FP2020)
29. *Indonesia (2010, 2012; MIC) (FP2020)
30. Israel (2011; HIC)
31. *Japan (2010, 2012; HIC) (FP2020)
32. *Kenya (2010, 2012; LIC) (FP2020)
33. Korea (2012) (FP2020)
34. Kyrgyzstan (2011; LIC)
35. Lao PDR (2011; LIC)
36. Lesotho (2011; LIC)
37. Liberia (2010; LIC) (FP2020)
38. Madagascar (2011; LIC)
39. *Malawi (2010, 2012; LIC) (FP2020)
40. Mali (2010; LIC)
41. Mauritania (2011; LIC) (FP2020)
42. Mongolia (2011; MIC)
43. *Mozambique (2010, 2012; LIC) (FP2020)
44. Myanmar (2011; LIC) (FP2020)
45. Nepal (2010; LIC)
46. *Netherlands (2011, 2012; HIC) (FP2020)
47. *Niger (2010, 2012; LIC)(FP2020)
48. Nigeria (2010; LIC) (FP2020)
49. *Norway (2010, 2012; HIC) (FP2020)
50. Pakistan (2012 LIC) (FP2020)
51. Papua New Guinea (2011; LIC)
52. Philippines (2012) (FP2020)
53. *Rwanda (2010, 2012 LIC) (FP2020)
54. Sao Tome and Principe (2011; LIC)
55. *Senegal (2011, 2012; LIC) (FP2020)
56. *Sierra Leone (2010, 2012; LIC) (FP2020)
57. *Solomon Islands (2012) (FP2020)
58. South Africa (2012 MIC) (FP2020)
59. South Sudan (2011; LIC)
60. Sri Lanka (2011; LIC)
61. Sudan (2011; LIC)
62. *Sweden (2010,2011, 2012; HIC) (FP2020) (Born Too Soon)
63. Tajikistan (2011; LIC)
64. Tanzania (2010; LIC) (FP2020)
65. Thailand (2012)
66. Togo (2011; LIC)
67. *Uganda (2011, 2012; LIC) (FP2020)
68. *United Kingdom (2010, 2012; HIC) (FP2020) (Born Too Soon)
69. *United States (2010, 2012; HIC)
70. Uzbekistan (2011; LIC)
71. Viet Nam (2011; LIC)
72. Yemen (2010; LIC)
73. *Zambia (2010, 2012; LIC) (FP2020)
74. *Zimbabwe (2010, 2012; LIC) (FP2020)

TOTALS: **74 Governments**

Philanthropy & Funders

1. AIDS Life/ Life Ball (2013)
2. A.K. Khan Healthcare Trust (2011)
3. Aman Foundation (2012) (FP2020)
4. Bloomberg Philanthropies (2012) (FP2020)
5. *Gates Foundation (2010, 2012) (FP2020) (Born Too Soon)
6. Goal4.org (2013)
7. Centre for Infectious Disease Research in Zambia (CIDRZ) (2010)
8. Clinton Health Access Initiative (CHAI)
9. *Children's Investment Fund Foundation (2010, 2012) (FP2020)
10. *David & Lucille Packard Foundation (2010, 2012) (FP2020)
11. Elizabeth Glaser Pediatric AIDS Foundation (2011)
12. EMpower (2010)
13. European Foundation for the Care of Newborn Infants (2012) (Born Too Soon)
14. IKEA Foundation (2012)
15. Ford Foundation (2010)
16. Geddes Group (2011)
17. Global Fund for Women (2010)
18. Grand Challenges Canada (2010)
19. John D. & Catherine T. MacArthur Foundation (2010)
20. King Hussein Cancer Foundation (2012)
21. Lundin Foundation (2013)
22. *Medtronic Foundation (2010 & 2011)
23. Planet Wheeler Foundation (2010)
24. Rockefeller Foundation (2012)
25. TY Danjuma Foundation (2010)
26. The Bansidhar & Ila Panda Foundation (2013)
27. *UN Foundation (2010, 2012) (FP2020)
28. Wellbeing Foundation Africa (2013)
29. William and Flora Hewlett Foundation (2012) (FP2020)
30. Women's Funding Network/International Network of Women's Funds (2010)

TOTALS: **30 Foundations**

UN, Multilateral Orgs & Parnterships

1. Association of Women's Health, Obstetric and Neonatal Nurses (2012) (Born too Soon)
2. The Alliance- United States, United Kingdom, Australia and Gates Foundation
3. Committing to Child Survival: A Promise Renewed (2012)
4. Countdown to Zero (2011)
5. Decade of Vaccines Collaboration (2012)
6. Declaration on Scaling Up Treatment of Childhood Diarrhea and Pneumonia (2012)
7. The Elders (2011)
8. European Commission (2012) (FP2020)
9. European Parliamentary Forum on Population and Development (2011)
10. Flour Fortification Initiative (2012) (Born Too Soon)
11. *GAVI Alliance (2010, 2011, 2012) (Born Too Soon)
12. Global Alliance for Clean Cookstoves (2012) (Born Too Soon)
13. *Global Fund (2010,2011,2012)
14. Global Health Workforce Alliance (2011)
15. Global Polio Eradication Initiative (2011)
16. Helping Babies Breathe (2012)
17. HRP (January 2012)
18. H4+ (2010)
19. Inter-Parliamentary Union (2011)
20. mPowering Frontline Health Workers (2012)
21. NCD Alliance (2014)
22. Organization of the Islamic Conference (2011)
23. Partnerships for Enhanced Engagement in Research (PEER) Health (2012)
24. Partners in Population and Development (2014)
25. *PMNCH (2011, 2012) (born too soon)
26. Saving Children through behavior change: religions in action (2012)
27. Saving Lives at Birth (2012)
28. Saving Mothers, Giving Life (2012)
29. Stop TB Partnership (2011)
30. Special Unit for South-South Cooperation (2012)
31. Survive and Thrive: Professional Associations, Private Sector and Global Scholars Saving Mothers, Newborns and Children (2012)
32. UN Global Compact/UN Foundation (2011)
33. *World Bank (2010, 2012) (FP2020)
34. *World Health Organization (2012) (FP2020) (Born Too Soon)
35. UNICEF (2012) (Born too Soon)
36. UNFPA (2012) (FP2020)
37. United Nations Global Compact and UN Foundation Hew
38. Muskoka Initiative (2010)
39. U.S., UK, Australia & Gates (2010)

TOTALS: **39 UN, Multilateral Organizations & Partnerships**

*Discrepancies with PMNCH: divided UN and "Global Partnerships" into two categories; counted European Commission (as part of Muskoka – wasn't aware of EC's inclusion); individually counted H4+ members; didn't count 2 enhanced commitments

CSOs & NGOs

1. 34 Million Friends of the UNFPA (2011)
2. Accessories Council (2012)
3. Action for Global Health (2011)
4. ActionAid (2012) (FP2020)
5. Advance Family Planning (2012) (FP2020)
6. Africa MNCH Coalition (2011)
7. African Medial and Research Foundation (2011)
8. Arogya World (2014)
9. Akaa Project (2011)

10. American Academy of Pediatrics (2011)
11. Amnesty International (2010)
12. BRAC (2010)
13. BBC World Trust (2010)
14. *CARE (2010, 2012) (FP2020)
15. Caring & Living as Neighbors (2011)
16. Center for Interfaith Action on Global Poverty (CIFA) (2012)
17. CORE Group (2012) (Born Too Soon)
18. D-Tree International (2011)
19. DKT International (2010)
20. DSW (2012) (FP2020)
21. EngenderHealth (2011)
22. Every Mother Counts (2011)
23. Family Care International (2010)
24. *FHI 360 (2010, 2011, 2012)
25. Friends of UNFPA (2013)
26. *GAIN (Sept. 2011, Nov. 2011, 2012)
27. *Global Alliance to Prevent Prematurity and Stillbirth (2010, 2012) (Born Too Soon)
28. Global Health Council (2010)
29. Global Leaders Council for Reproductive Health (2010)
30. Health Alliance International (2011)
31. Home for Premature Babies (2012) (Born too Soon)
32. International Association of Infant Massage, Australia (2011)
33. Interact Worldwide (2012)
34. International Association of Infant Massage, Australia (2012)
35. International Baby Food Action Network (2011)
36. International Budget Partnership (2010)
37. International Council for Control of Iodine Deficiency Disorders (2011)
38. International Diabetes Federation (2011)
39. IFPMA (2011)
40. International Museum of Women (2012)
41. International Pediatric Association (2012) (Born Too Soon)
42. *International Planned Parenthood Federation (2010, 2012) (FP2020)
43. International Union Against Tuberculosis and Lung Disease (2013)
44. International Zinc Association (2013)
45. *IntraHealth International (2010,2012) (FP2020)
46. Ipas (2012) (FP2020)
47. Jhpiego (2012) (FP2020)
48. Junior Chamber International (2011)
49. Management Sciences for Health (2011)
50. *March of Dimes (2011, 2012) (Born Too Soon)
51. *Marie Stopes International (2011, 2012) (FP2020)
52. Micronutrient Initiative (2012)
53. mothers2mothers (2011)
54. National Association of Patent and Proprietary Medicines
55. Nigerian Inter-Faith Action Association (NIFAA) (2013)
56. ONE (2011)
57. PATH (2011)
58. *Pathfinder International (2011, 2012) (FP2020)
59. *Planned Parenthood Federation of America (2011, 2012) (FP2020)
60. Population Action International (2010, 2012) (FP2020)
61. *Population Council (2011) (FP2020)
62. *Population Services International (2010 & 2011)
63. Population Reference Bureau (2012) (FP2020)
64. *Reproductive Health Supplies Coalition (2010,2011, 2012) (FP2020)
65. Rotarian Action Group for Population and Sustainable Development (2011, 2012) (FP2020)
66. Save the Children (2010, 2012) (FP2020) (Born Too Soon)
67. Sesame Workshop (2011)
68. Society for Family Health (SFH (2013)
69. Susan G. Komen for the Cure Global Health Alliance (2010)
70. The Bangladesh Women Chamber of Commerce and Industry (2011)
71. Together for Girls (2011)
72. US Coalition for Child Survival (2010)
73. Water.org (2011)
74. WaterAid (2011)
75. Wellbeing Foundation Africa (2012)
76. White Ribbon Alliance for Safe Motherhood (2010)
77. Women and Children First (UK) (2011)
78. WomenCare Global (2012) (FP2020)
79. Women Deliver (2010) (Born Too Soon)
80. World Association of Girl Guides and Girl Scouts (2012)
81. Women's Health and Education Center (2011)
82. World Vision International (2010)
83. Worldwide Universities Network (2013)
84. World YWCA (2011)
85. Youth Coalition on Sexual and Reproductive Rights (2011)

TOTALS: **85 CSOs/NGOs**

Business Community

1. (RED) (2011)
2. Abdul Monem Limited (2011)
3. Beckton Dickinson (2010)
4. Body Shop (2010)
5. Business Leadership Council for a Generation Born HIV Free (2012)
6. Bristol-Myers Squibb Foundation (2011)
7. BSR HerProject (2013)
8. Caterpillar (2013)
9. CHI Pharmaceuticals Ltd. (2013)
10. Dow Corning (2011)
11. ESPN (2013)

12. Fashion 4 Development & Fendi (2012)
13. Female Health Company (2012)
14. Fidson Healthcare PLC (2013)
15. *GE/GE Healthcare (2010 & 2011)
16. GlaxoSmithKline (2010)
17. *Hewlett Packard (2011, 2012) (fp2020)
18. Hyde Park-Image Nation (2012)
19. Infosys (2012)
20. Intel (2011)
21. *Johnson & Johnson (2010 & 2011)
22. *John Snow (2010 & 2011) (moved from NGO)
23. LG Electronics (2010)
24. LifeSpring Hospitals of India (2011)
25. McCann Health (2013)
26. mediaReach OMD (2013)
27. Mercado Global (2012)
28. *Merck (2010,2011, 2012)
29. MMG Mining (2013)
30. *Nestle (2010 & 2011)
31. Nigeria Private Sector (2011)
32. Novartis (2011)
33. *Novo Nordisk (2010 & 2011)
34. Olpharm Nigeria Ltd (2013)
35. Pfizer (2010)
36. Safaricom (2011)
37. SingleHop (2010)
38. Strengthening Health Outcomes through the Private Sector (SHOPS)/Abt Associates (2013)
39. Teck Resources Limited (2012)
40. TeleConsult Group (2011)
41. TMA (2010)
42. TOMS (2013)
43. Unilever (2012)
44. Vestergaard Frandsen (2011)
45. ViiV Healthcare (2010)
46. Viyellatex Group (2011)
47. Walgreens (2013)
48. WaterHealth International (2011)

TOTALS: **48 Businesses**

Research & Academia

1. Centre for Health and Population Studies, Pakistan (2011)
2. Global Student Forum (2011)
3. Guttmacher Institute (2012)
4. icddr, b (2011)
5. International Center for Research of Women (2012)
6. Institute for Global Health of Barcelona (2010)
7. Institute for Tropical Medicine, Antwerp (2011)
8. International Federation of Medical Students' Associations (2011)
9. International Partnership for Microbicides (2010)
10. The International Union Against Tuberculosis and Lung Disease (The Union)
11. Johns Hopkins Bloomberg School of Public Health (2012)
12. Kinshasa School of Public Health (2012)
13. Medsin Aberdeen (2011)
14. Peking University Center of Medical Genetics (2012) (Born Too Soon)
15. Preterm Birth International Collaborative (PREBIC) (2012), (Born too Soon)
16. Other Academic and Research Institutes (2010)
17. Royal College of Obstetricians and Gynaecologists (2011)
18. Royal Medical Society/University of Edinburgh (2011)
19. RTI International (2011)
20. University of Aberdeen (2011)
21. University of Malawi College of Medicine (2012) (Born Too Soon)
22. The University of Texas Medical Branch (2012) (Born Too Soon)
23. University of Philippines Manila (2012) (Born Too Soon)

TOTALS: **23 organizations**

Healthcare professionals & Workers

1. Council of International Neonatal Nurses (2011)
2. Edna Adan University Hospital (2011)
3. Health Care Professionals Associations (HCPA): including FIGO, ICM, ICN, IPA, RANZCOG, RCOG, SCOG, WFSA (2010)
4. WomanCare Global (2012) (fp2020)

Total: **4 organizations**

ANNEX 3. EVIDENCE SUBMITTED TO, AND COMMISSIONED BY, THE IERG

Evidence submitted to the iERG

1. *Submission on national accountability to the 2014 iERG Report – from World Vision Tanzania*
   Submitted by Agnes Victor

2. *Submission on national accountability to the 2014 iERG Report - from World Vision Sierra Leone*
   Submitted by Jeremiah Sawyerr

3. *Submission on national accountability to the 2014 iERG Report - from World Vision Niger*
   Submitted by Soumana Sambo

4. *Submission on national accountability to the 2014 iERG Report - from World Vision Mali*
   Submitted by Kené Mark Guindo

5. Submission on national accountability to the 2014 iERG Report - from World Vision Ghana
   Submitted by Micah Ayo Olad

6. *Demanding Accountability for Maternal Health in South Asia: Experiences from Women's Health and Rights Advocacy Partnership (WHRAP)-South Asia*
   Submitted by Women's Health and Rights Advocacy Partnership (WHRAP)-South Asia

7. *Early Age Marriage Act, Sindh Pakistan, 2014_ A journey towards improving adolescent reproductive health through Evidence Generation and Advocacy*
   Submitted by Dr Tabinda Sarosh, Director, Shirkat Gah

8. *Using mobile phones to report informal fees for maternal health care. Case Study of a pilot intervention by Averting Maternal Disability and Death (AMDD) and SAHAYOG*
   Submitted by Jashodhara Dasgupta (*SAHAYOG)*

9. *Speech of the Chief Guest Hon. Dr. Ruhakana Rugunda, Minister of Health, at the Launch of "Act Now to Save Mothers Campaign" at Sheraton Hotel, Kampala. 25th APRIL, 2014*
   Submitted by Katy Woods (White Ribbon Alliance)

10. Documents on accountability campaigns in Tanzania
    Submitted by White Ribbon Alliance

11. Documents on accountability campaigns in Uganda
    Submitted by White Ribbon Alliance

12. *Do efforts to standardize, assess and improve the quality of health service provision to adolescents by government-run health services in low and middle income countries, lead to improvements in service-quality and service-utilization by adolescents ?'*
    Submitted by Dr Venkatraman Chandra-Mouli (WHO) and Dr Krishna Bose (WHO)

13. *Table 1: Analysis of how adequately the WHO dimensions of quality are addressed in the national standards for quality health service provision for adolescents of selected countries*
    Submitted by Dr Venkatraman Chandra-Mouli (WHO) and Dr Krishna Bose (WHO)

14. *Table 2: Analysis of the context in which the quality of health service provision to adolescents was assessed, who assessed it, how the assessment was done, and what the findings of the assessment were.*
    Submitted by Dr Venkatraman Chandra-Mouli (WHO) and Dr Krishna Bose (WHO)

15. *Table 3: Analysis of the context in which the health service utilization by adolescents was measured, who measured it, how the measurement was done, and what the findings of the measurement were.*
    Submitted by Dr Venkatraman Chandra-Mouli (WHO) and Dr Krishna Bose (WHO)

16. *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries*
    Journal of Adolescent Health 52 (2013) 517e522
    Submitted by Dr Venkatraman Chandra-Mouli (WHO)

17. *Contraception for adolescents in low and middle income countries: needs, barriers, and access*
    Reproductive Health 2014, 11:1
    Submitted by Dr Venkatraman Chandra-Mouli (WHO)

18. *Progress review: contraception use among adolescent girls*
    Guardian Professional, Monday 17 February 2014
    Submitted by Dr Venkatraman Chandra-Mouli (WHO)

19. *What has enabled some low and middle income countries to take adolescent health seriously when so many others are not doing so ?*

Submitted by Dr Venkatraman Chandra-Mouli (WHO)

20. *Making health services adolescent friendly: developing national quality standards for adolescent-friendly health services*
Submitted by Jane Fergusson (WHO)

21. *HIV and adolescents: HIV testing and counselling, treatment and care for adolescents living with HIV. Summary of key features and recommendations. November 2013*
Submitted by Jane Fergusson (WHO)

22. *Materials on Data2X: Mapping Gender Data Gap*
Submitted by Mayra Buvinic, Rebecca Furst-Nichols and Gayatri Koolwal

23. *The contribution of laws to change the practice of child marriage in Africa*
Submitted by Dr Joar Svanemyr (WHO)

24. *Scaling up of Life Skills Based Education in Pakistan: A case study*
Submitted by Dr Joar Svanemyr (WHO)

25. *Best practices and photography from the Safe Motherhood initiative in Latin America and the Carribean*
Submitted by Gina Tambini (PAHO) and Clair Schaub (PAHO)

Evidence commissioned by the iERG

1. *A Promise Renewed*
2013/2014 progress report on the implementation of A Promise Renewed commitments in the 75 priority countries, including both under-five mortality and maternal mortality targets, highlighting both positive developments and challenges.
Note: no response to the original request

2. *Action Aid*
A report with information on how the Action Aid work supports the CoIA recommendations and on the engagement in the national accountability mechanisms in the 75 priority countries.
Note: no response to the original request

3. *Countdown to 2015*
A progress report on the Accountability Commission's health indicators, with the inclusion of an indicator on adolescent pregnancy: the proportion of women aged 20-24 years who report having had a baby by the age of 18 years.
Note: submission received

4. *Family Care International*
A report with information on how the FCI work supports the CoIA recommendations and on the engagement in the national accountability mechanisms in the 75 priority countries.
Note: submission received

5. *Family Planning 2020*
A report on the progress made in monitoring the implementation of FP commitments by the 75 priority countries.
Note: submission received

6. *GAVI*
A progress report on the new vaccination agenda in the 75 priority countries, including the plans to scale up and strengthen routine immunization systems in these countries.
Note: submission received

7. *Global Fund*
Evidence or case studies about the progress in implementation of health programmes supported by the Global Fund that cover a range of interventions for women and children across the continuum of pre-pregnancy, pregnancy, birth and infant and child care, including adolescent health metrics, worldwide and in particular in the 75 priority countries.
Note: submission received

8. *Guttmacher Institute*
A report with data reflecting progress in addressing unsafe abortion worldwide and in particular in the 75 priority countries.
Note: response received informing that data are not available; a number of references were provided instead

9. *H4+*
A report on the progress made in monitoring the implementation of commitments made to the Global Strategy by the countries that are among the 75 priority countries, highlighting both positive developments and challenges.
Note: no response to the original request

10. *IPPF*
A report with information on how the IPPF work supports the CoIA recommendations and on

the engagement in the national accountability mechanisms in the 75 priority countries.
Note: submission received

11. *IPU*
A report on the progress achieved in parliamentary engagement and oversight for reproductive, maternal, newborn and child health in the 75 priority countries.
Note: submission received

12. *OHCHR*
(1) A progress on the implementation of the 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;
(2) progress on the implementation of the 2013 HRC Resolution on the Child's Right to Health and all the actions that followed from this resolution.
Note: submission received

13. *Oxfam*
A report with information on how the Oxfam work supports the CoIA recommendations and on the engagement in the national accountability mechanisms in the 75 priority countries.
Note: request not applicable

14. *PEPFAR*
A report on how PEPFAR's programmes are advancing women's and children's health worldwide and in particular in the 75 priority countries, highlighting both positive developments and challenges.
Note: no response to the original request

15. *PMNCH*
A progress report on the implementation of the Global Strategy commitments by stakeholders, with a particular focus on the 75 priority countries.
Note: submission received

16. *RMNCH Steering Committee*
A report on 2013/2014 progress related to the work of the RMNCH Steering Committee in our 75 priority countries, as well as an overview of your strategy and plans up to and including 2015
Note: submission received

17. *SAGE*
The progress report for the World Health Assembly (WHA) as well as any relevant update or information on immunization and the contribution it makes to children's and women's health worldwide and in particular in the 75 priority countries.
Note: submission received

18. *Save the Children*
A report with information on how the Save the Children work supports the CoIA recommendations and on the engagement in the national accountability mechanisms in the 75 priority countries.
Note: submission received

19. *UN Commission on Life Saving Commodities*
A formal report on progress towards implementation of the Commission's recommendations with a particular focus on:
(1) recommendations that were supposed to have been met in 2013 (1. Shaping global markets; 3. Innovative financing; 9. Performance and accountability)
(2) recommendations that are to be met in 2014 (2. Shaping local delivery markets; 7. Demand and utilization; 8. Reaching women and Children; 10. Product innovation)
Note: submission received

20. *UN Statistics – UNECA*
A report with information on the progress in strengthening health information systems in the countries of your region that are on the 75 priority countries list.
Note: submission received

21. *UNAIDS*
(1) information on the progress made in the Global Plan for Elimination of Mother to Child Transmission especially in the 75 priority countries
(2) an appraisal of progress on AIDS treatment and prevention for women, children, and adolescents
Note: submission received

22. *WHO, including HQ and Regional Offices (AFRO, EMRO, EURO, PAHO, SEARO, WPRO)*
(1) information on the progress made in implementing the first nine CoIA recommendations in the 75 priority countries
(2) information on specific actions that were taken by WHO and the partners to address the iERG 2012 and 2013 recommendations, and their outcomes.
(3) provide feedback to 2013 report and submit any evidence around reproductive, maternal, newborn and child health in the context of relevant areas of work.
Note: submission received, including a separate submission from WHO WPRO

23. *World Bank*
We hope that your commendable initiative ['the cornerstone of a successful Post-2015 Development Agenda is a strong, reliable, timely

and comparable measurement framework'] can provide us with annual updates on this important contribution to both Global Health and development.
Note: reporting through H4+

24. *World Vision International*
(1) Information on the progress achieved under the World Vision's commitment for Strategic Alignment, in particular in the implementation of the Health and Nutrition Strategy in the 75 priority countries (2) Information on the progress achieved under the World Vision's commitment for Social Accountability, in particular in tracking commitments and parliamentary engagement of the IPU in the 75 priority countries.
Note: submission received

ANNEX 4. MALAWI COUNTRY REPORT

iERG Mission to Malawi, 23-28 March, 2014

1. Introduction

From 23-28 March, 2014, three members of the independent Expert Review Group (iERG), Miriam Were, Tarek Meguid and Sejal Hathi, supported by Paul Hunt and Genevieve Sander, visited Malawi, following the Government's approval of a request for the visit from the Office of the UN Secretary-General. The main objective of the visit was to review progress in relation to recommendations 7 and 8 of *Keeping Promises, Measuring Results*, the final report of the UN Commission on Information and Accountability for Women's and Children's Health (2011) (CoIA). Recommendations 7 and 8 concern national oversight and transparency of all stakeholders for their commitments to women's and children's health.

During the mission, the team had the honour to meet and discuss with the President, Her Excellency Dr Joyce Banda; the Minister of Health, Hon. Catherine Gotani, and senior officials from the Ministry; the Minister of Gender, Children and Social Welfare, Hon. Mary Clara Makungwa, and senior officials from the Ministry; Law Commissioner, Mrs Gertrude Lynn Hiwa; and Commissioner Mr Dalitso Kingsley Kubalasa and senior staff of the Malawi Human Rights Commission. Rich discussions were held with the United Nations Country Team; development partners, including the United States Agency for International Development (USAID), the UK's Department for International Development, and the Norwegian Agency for Development Cooperation; the President of the Malawi Law Society; and the National Youth Council of Malawi.

During the visit, the team also had the privilege of meeting representatives from the Presidential Initiative on Maternal Health and Safe Motherhood; regulatory bodies, including the Medical Council and the Nurses and Midwives Council; the National Statistics Office and the National Registration Bureau; civil society organisations, including the Malawi Health and Equity Network and the Health and Rights Education Programme; research institutions, including the University of North Carolina and the Wellcome Trust; as well as the private and business sectors, including representatives from the Christian Health Association of Malawi, Johnson and Johnson, and SADM Pharmaceuticals. They were very grateful to also have the opportunity to visit the Kamuzu Central and Bwaila hospitals in Lilongwe, as well as the Queen Elizabeth Hospital and the College of Medicine in Blantyre, where they met with medical doctors, including Paediatricians and Obstetricians/Gynaecologists.

The iERG extends its sincere gratitude to the Government of Malawi for consenting to the visit, appreciates the open and constructive dialogue the team enjoyed with a wide range of stakeholders and warmly thanks everyone for their time, hospitality and valuable contributions. For expertly coordinating the entire visit, which was divided between Lilongwe and Blantyre, the team is most grateful to the UNFPA country office.

2. Positive Aspects

There have been impressive initiatives, developments and achievements within Malawi for which the Government, and many other stakeholders, deserve credit. For example:

A. In the last 20 years, Malawi has undergone a dynamic political transition from a one-party regime to a multi-party democracy. A short time after the iERG's visit Malawi held presidential, parliamentary and local elections (May 2014). The local elections mark the first time the country has elected local representatives in 15 years, as well as a real opportunity to strengthen the connection between citizens and their government.

B. Malawi has ratified core regional and international human rights treaties, including the African Charter on Human and Peoples' Rights, Protocol to the African Charter on Women's Rights,[1] African Charter on the Rights and Welfare of the Child, International Covenant on Economic, Social and Cultural Rights, Convention on the Elimination of Discrimination Against Women and the Convention on the Rights of the Child. Its Constitution also enshrines human rights, many of which protect women's and children's health. However, some rights, including the right to health, are not enforceable in courts.

C. Recent macroeconomic policy reforms have led to progress in achieving economic growth. In 2013, the country's economy expanded by 6.1 percent, representing a three-fold growth rate from the year before. The challenge is to ensure sustainability as well as an equitable distribution of benefits, especially to the most vulnerable.

1 Its full title is Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

D. One of the few low-income countries to make significant strides in reducing under-five mortality rates by two-thirds, Malawi has reached Millennium Development Goal (MDG) 4 ahead of the 2015 deadline. However, despite commendable activity, MDG5 on maternal health is still far from being achieved.

E. There is evidence of high-level political will to improve women's and children's health in Malawi. President Banda's first official act in Office, for example, was the establishment of the Presidential Initiative on Maternal Health and Safe Motherhood.

F. Government representatives and some other stakeholders have given serious attention to the Secretary-General's *Global Strategy for Women's and Children's Health*, as well as the CoIA report and its recommendations. For example, officials from the Ministry of Health attended the 3-day multi-country workshop in Tanzania (February, 2012) organized by WHO to facilitate the development of country accountability frameworks in accordance with the CoIA Workplan (2011). This was followed by a 3-day CoIA workshop in Lilongwe (May, 2012), attended by participants from the Ministry of Health, development partners (e.g. the Norwegian Embassy, USAID and Cida), UN agencies, civil society organizations, and others. This workshop agreed on a country accountability framework 'roadmap' for Malawi and prioritised a number of activities for which 'catalytic funding' from WHO was obtained. These funds of US$240 000 had been disbursed by the time of the team's visit to Malawi.

G. The UN Country Team in Malawi is committed to working as a unit and 'delivering as one', which could enable more effective and coordinated development operations.

3. Structural obstacles

Some of these achievements are all the more commendable because Malawi continues to face significant structural obstacles to achieving progress in women's and children's health. For example:

A. Widespread poverty and underdevelopment, exemplified by Malawi's lack of a manufacturing base, bear upon all women's and children's health initiatives in the country. In 2011, Malawi ranked 171 out of 187 countries on the Human Development Index, with life expectancy at birth recorded as 54.8 years and 73.9 percent of the population living below the income poverty line.[2]

2 Using the purchasing power parity (PPP) of $1.25 per day.

B. Corruption and its consequences continue to pose serious challenges to development in Malawi. Most recently, the siphoning of millions of dollars from public finances, dubbed 'Cashgate' by the media, prompted some development partners to reallocate funds while others withdrew an estimated $150 million.[3] While the iERG team understands that the Ministry of Health is not implicated in 'Cashgate', development partners' response to the scandal has had a major negative impact on the Ministry and health sector.

C. Heavy reliance on aid continues to be a critical issue. For example, only 20 percent of the health budget derives from the national budget; the remaining 80 percent comes from development partners.[4] This dependence has clear implications, which have come into sharp focus in the wake of 'Cashgate', on the country's ability to meet the heath needs of its citizens.

4. Principal concerns

A. *Profile of the Global Strategy and CoIA final report*
Mention has already been made of the commendable attention devoted to CoIA follow-up by some stakeholders which led to 'catalytic funding' of US$240 000 from WHO. Yet, paradoxically, the team found very limited awareness of the *Global Strategy*, the CoIA report and its recommendations, and relevant commitments entered into by different stakeholders. For example, on the whole, development partners were only vaguely aware of CoIA, while neither of the two business representatives that the team met had heard of either the *Global Strategy* or CoIA. One development partner observed that attempts to reach out to the private sector, to secure more support for women's and children's health, were very limited. In short, the team gained the impression that familiarity with the *Global Strategy* and CoIA is confined to a small group and that these initiatives do not enjoy the profile and

3 For the official "Cashgate" report, see National Audit Office of Malawi, *Report on Fraud and Mismanagement of Malawi Government Finances – Covering transactions and controls in the six month period 1 April 2013-30 September 2013*, 21 February 2014, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/285877/20140221_National_Audit_Office_Malawi_-_Forensic_Audit_Report_-_FINAL_ISSUED.pdf. See also the Norwegian Government's official statement on the suspension of its budget support to Malawi, 11/10/2013: http://www.regjeringen.no/en/archive/Stoltenbergs-2nd-Government/Ministry-of-Foreign-Affairs/Nyheter-og-pressemeldinger/nyheter/2013/budget-support-malawi.html?id=738930. For media coverage on the response of development partners to "Cashgate" see for example: Kim Yi Dionne, "Behind the Headlines: The Deeper Roots of Malawi's Cashgate Scandal", *AidData Beta, Open Data for International Development*, 12 February 2014, available at: http://aiddata.org/blog/behind-the-headlines-the-deeper-roots-of-malawis-cashgate-scandal; and Rachel Wood, ""Cashgate" shakes Malawi and donor confidence" *Georgetown Public Policy Review*, 6 January 2014, available at: http://gppreview.com/2014/01/06/cashgate-shakes-malawi-and-donor-confidence/.

4 While these figures were related to us in several interviews, we have been unable to find documentary verification. The latest data available indicates that in 2008/2009 development partner contributions accounted for 61.2 percent of the total health expenditure (Ministry of Health, *Malawi National Health Accounts with Subaccounts for HIV/AIS, Malawi, Reproductive Health, and Child Health 2006/07-2008/09*, May 2011, p. 29.)

currency envisaged by the Secretary-General when they were launched in 2010 and 2011.

B. *Respect and dignity*
Although many health workers in Malawi are highly professional, committed and hardworking, several stakeholders reported that women and children, often very vulnerable patients, are regularly treated without respect and dignity. Many health professionals work under enormous pressure. Nevertheless it is crucial that they always treat patients with respect and dignity. The duty to treat everyone in this way is a basic human rights principle and, as already highlighted, human rights enjoy national, regional and international protection in Malawi. Also, CoIA's final report emphasizes the importance of human rights. The imperative of treating women and children with dignity is one of the golden threads that runs throughout iERG's work, as signalled by the title of its second annual report *Strengthening Equity and Dignity through Health*.

As observed, when health systems are weak, both patients and staff suffer. For example, the team was informed that those working in the health sector do not enjoy fair terms and conditions of employment.

C. *National accountability mechanism (recommendation 7)*
At the beginning of the mission, the Ministry of Health provided the team with a helpful memorandum which includes 'National Accountability Mechanisms and Processes' with sub-sections on 'National Level' (e.g. Cabinet Committee on Health) and 'District and Community Levels' (e.g. Village Health Committees).[5] As the memorandum explains, civil society organizations are engaged at both levels. These various mechanisms are important and commendable. However, we suggest that, in two respects, they do not fully reflect, in practice, the meaning of 'review' as set out in the CoIA final report.

Pledges, promises and commitments. According to the CoIA final report, the accountability framework consists of monitoring, review and remedial action.[6] Review is described as having two functions: analyzing data to determine "whether reproductive, maternal, newborn and child health has improved" (first function) and "whether pledges, promises and commitments have been kept by countries, donors and non-state actors" (second function). When considering the second function of review, a good place to start is the UN publication, *Commitments to the Global Strategy for Women's and Children's* Health which includes stakeholders' commitments directly relevant to the women and children of Malawi.[7]

In the material that the team looked at for its visit to Malawi, and during its numerous meetings in-country, the team found considerable attention was devoted to the first function of review. However, it found little or no attention devoted to the second function of reviewing "pledges, promises and commitments". Regrettably, during the visit nobody referred to any specific commitments made by any stakeholder arising from the *Global Strategy* or CoIA.

The independent element of review. The CoIA report, and the iERG in its first and second annual reports, has highlighted the value of an independent element being included in the review process. However, when we consider the national accountability mechanisms outlined in the Ministry of Health's memorandum, we primarily find *internal* accountability arrangements that do not have a robust independent element. There are exceptions, such as the Parliamentary Committee on Health and the engagement of CSOs, although the country accountability framework 'scorecard', agreed at the CoIA workshop in Lilongwe during 2012, reports that "(l)egislative support for MNCH issues is weak… (and)… (c)ivil society (is) not active in RMNCH", and we do not see a dramatic improvement over the last two years. Accordingly, we suggest there is a serious need to strengthen the independent element of the national accountability mechanisms, and we speculate that the absence of a strong, adequately resourced independent element might explain why the second function of review has been neglected.

D. *Transparency (recommendation 8)*
As the CoIA final report puts it, transparency fosters learning, continuous improvement, more informed decision-making, and accountability.[8] The transparency requirement extends to all stakeholders, including the Government, development partners and civil society organisations, and we view it in three ways. First, are all relevant data and information publicly available? Second, are they accessible to interested laypeople in the different regions of Malawi? Third, are they accessible at the

5 *Ministry of Health Responses on the iERG Visit to Malawi 2014*, pages 4-7.
6 Commission on Information and Accountability for Women's and Children's Health, *Keeping Promises, Measuring Results*, 2011, page 9.
7 *Every Woman, Every Child, Commitments to the Global Strategy for Women's and Children's Health*, 23 February 2012, available at: http://www.everywomaneverychild.org/images/Every_Woman_Every_Child_Commitments_Cumulative_3.22.2012.pdf. Updated commitments are also available at: http://www.everywomaneverychild.org/commitments/all-commitments.
8 Ibid, page 17.

international level? Although the third aspect of transparency is highlighted in recommendation 8, we do not examine it here because it has to be considered with recommendation 9 (reporting aid for women's and children's health to OECD-DAC) which is beyond this report.

Is data and information publicly available?
The Ministry of Health informed us that "many channels are used to openly and publicly share information on commitments, resources provided and results achieved annually".[9] For example, it reported that the Health Sector Strategic Plan Joint Annual Reviews, which are an integral part of reporting under the Joint Financing Arrangement (see below), have "created a platform for openly and publicly sharing information". It added that "Ministry of Health documents such as resource mapping and budget documents from Treasury are widely shared". Voluminous national health accounts, and sub-accounts, are in the public domain. The Ministry of Health explained that government and civil society websites also help "government and donors to openly and publicly share information".

When asked by the iERG team, representatives of the Malawi Health Equity Network, a leading non-governmental organisation, remarked that accessing official documents had been a problem in the past but there had been an improvement in the last three years and currently they found "things were pretty transparent". Broadly speaking, this appears to reflect the view of other stakeholders, too. All those responsible deserve credit for improving transparency in recent years.

However, there is a deep shadow over this encouraging picture: corruption persists in Malawi. While inquiries continue and criminal proceedings have begun, 'Cashgate' demonstrates a grave absence of transparent accounting and this requires the serious attention of all stakeholders.[10]

Is data and information accessible to interested laypeople of Malawi? Despite the valuable endeavours of some organisations, such as the Presidential Initiative on Maternal Health and Safe Motherhood and some civil society organisations, like the Malawi Health Equity Network, it appears that concise, clear and accessible data and information on women's and children's health are not readily accessible to the public at large.

E. *Country compacts (recommendation 5)*
Although this report focuses on recommendations 7 and 8, they require brief consideration of recommendation 5 on country compacts between governments and all major development partners.

The CoIA final report confirms that country compacts can be integrated into existing mechanisms, such as joint financing arrangements.[11] In Malawi, there is no compact between the Government and all major development partners. However, there is a Health Sector Strategic Plan (2011-16) (HSSP) Joint Financing Arrangement (JFA) between the Ministry of Health and the Health Sector Pool Fund Development Partners (May, 2012). Development partners' response to 'Cashgate', the large-scale withdrawal or reallocation of health funds,[12] underlines the critical importance of the JFA's terms.

We confine ourselves to three observations on the Arrangement. First, the JFA has a number of positive features, for example, it provides agreement on fundamental principles (e.g. the importance of tackling corruption), procedures for consultation, decision-making, monitoring and reporting, and it contributes to predictability, transparency and a reduced administrative burden on the Government. Second, although the UK, Germany, Norway, UNFPA and UNICEF have signed the JFA, some important development partners fall outside the Arrangement, such as USAID and the Global Fund to fight AIDS, Tuberculosis and Malaria. Third, if "any dispute or conflict arises" between the parties "they will consult each other in order to reach an amicable solution"; however, if there is a "failure to resolve the dispute", development partners "may suspend further disbursements to the HSSP".[13]

In its memorandum to the iERG, the Ministry of Health makes a number of remarks about the JFA, for example, "disbursement is not always done as scheduled" and "there is no explicit accountability for technical support". The memorandum adds that "commitments are not fully honoured by donors".[14]

During one interview, a senior official of the Ministry of Health gratefully acknowledged the very significant financial contribution made by the Global Fund to fight HIV/AIDS, tuberculosis and malaria in Malawi, but he regretted that 94% of the contribution was for the three diseases (HIV 71%,

9 *Ministry of Health Responses on the iERG Visit to Malawi* 2014, page 8.
10 National Audit Office of Malawi, *Report on Fraud and Mismanagement of Malawi Government Finances – Covering transactions and controls in the six month period 1 April 2013-30 September 2013*, 21 February 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/285877/20140221_National_Audit_Office_Malawi_-_Forensic_Audit_Report_-_FINAL_ISSUED.pdf
11 *Ministry of Health Responses on the iERG Visit to Malawi* 2014, page 14.
12 See footnote 3.
13 Malawi Health Sector Strategic Plan (2011-16) (HSSP) Joint Financing Arrangement (JFA), May 2012, para 57.
14 *Ministry of Health Responses on the iERG Visit to Malawi* 2014, pages 4 and 7.

malaria 22%, tuberculosis 1%), while only 6% was for health system strengthening.[15] The preliminary findings of the HSSP mid-term review observe: "The growing divide between successful disease control programmes and general health care affects equity. Do women have fewer rights than HIV patients? Do children with diarrhoea have fewer rights than children with malaria?"[16] During its visit, the iERG team repeatedly heard that the overriding health challenge was to strengthen the country's health system but this does not yet appear to be reflected in the approach agreed by the Global Fund and Ministry of Health in Malawi.

F. *Managerial capacity*
The debilitating impact of structural obstacles on the Ministry of Health and health sector (see 3 above) extends to managerial capacity for women's and children's health. Ensuring quality service delivery and achieving desired health outcomes requires good management. Some stakeholders reported weak managerial capacity in some parts of the Ministry of Health and health sector, including a reluctance to invite and accept constructive criticism. Some suggested, for example, that if staff 'rocked the boat', or offered unwelcome advice, jobs or advancement might be in jeopardy.

G. *Lack of accountability for health at the grassroots*
During the mission the team was informed by members of civil society that many patients and their families are unaware that public officials, health practitioners and other duty-bearers are accountable to them. Accountability requires mechanisms through which people can hold duty-bearers accountable with a view to identifying what is going well, what is not and why. There is currently a lack of accessible, effective and transparent accountability procedures in communities, health centres and hospitals. This is compounded by the fact that, despite the efforts of regulatory bodies, civil society, and the Malawi Human Rights Commission, most patients, in particular women and children, have limited awareness of, and capacity to demand, their rights.

H. *Public Health Act (1948) and enhancing health governance*
Public health law should provide the framework for a country's public health activities, including the values upon which they are based, and the structure and governance of the health system. Malawi's Public Health Act dates from colonial times and is in urgent need of reform. For example, the country's major health facilities are not subject to effective participatory governance, such as an elected Board to support a Hospital Director. The Act is currently being reviewed by the Malawi Law Commission, a development the team welcomes.

5. Principal recommendations

A. *Profile of the Global Strategy and CoIA final report*
In recent years, the international community has generated a plethora of global health initiatives and it is not easy to give all of them the attention they deserve. However, the Secretary-General established the iERG precisely to ensure that the CoIA recommendations are implemented and commitments are honored. Moreover, since the Secretary-General created the iERG, it has been given responsibilities in relation to other global health initiatives, such as the Commission on Life-saving Commodities. Accordingly, all stakeholders in Malawi are urged to re-double their commitment to the *Global Strategy*, CoIA, the Commission on Life-saving Commodities, and related initiatives. It is strongly recommended that CoIA and its related initiatives are routinely on the agendas of development partners, as well as the Ministry of Health. Since WHO has primary responsibility for ensuring implementation of CoIA, it is encouraged to devote more time and resources to CoIA follow-up. Given the relevance of CoIA to the mandates of UNICEF, UN Women and UNFPA, these agencies are urged to vigorously support WHO, in keeping with the UN Country Team's commitment to 'delivering as one'. The Ministry of Health and development partners are recommended to reach out to the private sector which is strongly encouraged to play a more active role in advancing the *Global Strategy* and CoIA, as explicitly anticipated by both initiatives.

B. *Respect and dignity*
Respect, dignity, compassion and empathy should be in the DNA of everyone working in the health sector, including health practitioners and government officials. This requires inspired leadership and appropriate training. Those holding high political office, as well as those responsible for hospitals, clinics and community health, should lead by example and also insist on the highest professional standards. We suggest that current arrangements for accreditation, and Continuing Professional Development, are revisited with a view to strengthening training on professional conduct, ethics and human rights. In addition to the formal training of professionals and officials,

15 The Global Fund, *Malawi Grant Portfolio*, 2013, available at: http://portfolio.theglobalfund.org/en/Country/Index/MWI
16 *Malawi Health Sector Strategic Plan (2011-16), Mid-Term Review, Preliminary Findings*, presentation of 7 March 2014 by J. Koot, T. Hammett and R. Seip.

more community campaigns to raise awareness of human rights and responsibilities should be encouraged, a task that the Malawi Human Rights Commission is well-placed to contribute to, in collaboration with civil society organizations and others.

Attention should be devoted to ensuring the respect and dignity of all those working in the health sector, for example, improving their terms and conditions of employment.

C. *National accountability mechanism (recommendation 7)*
We recommend the existing national accountability mechanisms in Malawi are strengthened by reinforcing the independent element through the inclusion of the Malawi Human Rights Commission.

A Constitutional body. The Malawi Human Rights Commission is an independent institution established under the Constitution to promote and protect human rights. The Human Rights Commission Act (1998) elaborates its functions, responsibilities and powers. For example, the Commission may submit reports and recommendations to the President, Parliament or other competent authority, on an advisory basis, either at the request of the President, Parliament or other authority, or on the Commission's own initiative. The hallmark of the Commission is its independence: "Every member of the Commission, of a committee of the Commission, or of the staff of the Commission shall serve independently and impartially and exercise his powers or perform his duties and functions in good faith and without fear or favour".[17] The legislation carefully constructs appointment processes, and other measures, to protect the Commission's independence.

Experience on relevant health issues. In recent years, the Commission has run an advocacy programme on maternal health funded by UNFPA. One of the Commission's statutory powers is to hold public inquiries and the Commission held a "community-based public inquiry" as part of its maternal health advocacy programme. The inquiry led to a report called *Access to Maternal Health Services: A Human Rights Perspective* (2010), the conclusion of which is entitled 'Towards Accountability for Maternal Health Rights'.

Summary. On condition that it is provided with adequate resources, including the necessary expertise, we recommend that the Human Rights Commission plays an active role in the existing national accountability arrangements for women's and children's health. We suggest that a new Commissioner, with health expertise, is appointed and suitably supported by Commission staff, with particular responsibility for oversight of the *Global Strategy*, CoIA and women's and children's health. We recommend that, in a constructive spirit, the Commission considers whether "pledges, promises and commitments have been kept by countries, donors and non-state actors… recognizing success, drawing attention to good practice, identifying shortcomings and, as required, recommending remedial action".[18] The Commission should do all in its power to be perceived as independent and not party political.

D. *Transparency (recommendation 8)*
In relation to the public availability of data and information, it is important that recent improvements in transparency are consolidated and extended. In a later paragraph, we recommend more participatory governance of health facilities which depends upon all facility-specific data and information being available. When 'Cashgate' inquiries and legal proceedings are complete, additional safeguards against corruption must be put in place; improved transparency is most likely to form a major part of these measures. We recommend the Access to Information Bill is enacted as soon as possible provided its provisions serve as a powerful tool for transparency.

Also, we recommend steps are taken to ensure clear data and concise information on women's and children's health are accessible in all communities. For example, local government, Village Health Committees, faith networks, health professionals, non-governmental organisations and the mass media should be utilised. Material should be available in English, Chichewa and other major local languages. An informed public is the bedrock of responsive health services and a dynamic democracy.

E. *Country compacts (recommendation 5)*
The JFA represents progress towards a country compact and we recommend that the Government and development partners revisit the Arrangement and align it more closely with the final report of the CoIA. The Arrangement should be even-handed. One revealing provision says: "It is agreed that as a principle, [development partners] should not impose additional conditions to the Government, but it is understood by the signatories of this JFA that derogations to this principle may be necessary" – which means development partners may impose

17 Human Rights Commission Act, 1998, Section 34(1). Available at: http://www.rwi.lu.se/NHRIDB/Africa/Malawi/Malawi_NHRI_Act_1998.pdf

18 Commission on Information and Accountability for Women's and Children's Health, *Keeping Promises, Measuring Results*, 2011, page 7.

additional conditions if they wish![19] Apart from demonstrating a lack of mutuality, such a provision may lead to the arbitrary exercise of authority. We strongly recommend that an independent third party is established to review the interpretation and implementation of the JFA, at least insofar as it relates to women and children. This might be a role for the suitably resourced Malawi Human Rights Commission. As development partners' response to 'Cashgate' demonstrates, the fair and balanced application of the JFA is literally a matter of life and death for many Malawians.

F. *Managerial capacity*
We recommend measures are taken to strengthen managerial capacity for women's and children's health. These measures will encompass, for example, ensuring managers have appropriate competences; ensuring adequate numbers and deployment of managers throughout the health system; strengthening support services to manage money, staff, supplies and information; developing a strong organizational context and rules; offering reasonable incentives; and strengthening transparency and accountability mechanisms. We recognize that improving managerial capacity has to be part of a wider policy of strengthening the health workforce and this has major financial implications and we encourage development partners to work closely with the Ministry of Health on these issues and to give them sympathetic consideration. WHO has a wealth of advice to offer on strengthening leadership and management in low-income countries.[20]

G. *Enhancement of accountability for health at the grassroots*
Empowerment and accountability are interrelated. Patients need to be able to actively participate in decisions that affect their health and hold duty-bearers accountable, while duty-bearers need to be able and willing to respond and take action. Accordingly, we recommend participatory governance of health facilities, as well as the establishment of accessible, effective and transparent accountability procedures in communities, health centres and hospitals.

H. *Public Health Act (1948) and enhancing health governance*
In 2012, the Law Commission published a substantive review of the Public Health Act and the legislation remains in the Commission's programme of work. We recommend the legislation is reformed as soon as possible. While reform will encompass many issues, it is suggested that attention is given to establishing participatory governance of health facilities, in accordance with democratic principles and local customs, as a way of invigorating Malawi's health system, including services for women's and children's health.

19 Malawi Health Sector Strategic Plan (2011-16) (HSSP) Joint Financing Arrangement (JFA), May 2012, para 29.

20 See, for example, *Towards better leadership and management in health – Report on an international consultation on strengthening leadership and management in low-income countries*, WHO, 2007, available at: http://www.who.int/management/working_paper_10_en_opt.pdf?ua=1

6. Conclusion

In this final section, we will not summarise our earlier analysis and discussion, but confine ourselves to a very brief assessment of progress in relation to the CoIA recommendations that are the main focus of this report (recommendations 7 and 8). Since the report gives some attention to recommendation 5, we will also provide a brief assessment on this recommendation.

National accountability mechanism (recommendation 7)
While Malawi has a number of important and commendable *internal* national accountability mechanisms, none of them fully reflects the meaning of 'review' as set out in the CoIA final report. All stakeholders have a responsibility to address this shortcoming.

Transparency (recommendation 8)
Is data and information available? While there is evidence that transparency of data and information has improved in recent years, 'Cashgate' demonstrates a grave absence of transparent accounting and this requires the serious attention of all stakeholders.

Is data and information accessible to interested laypeople in Malawi? No, and all stakeholders have a responsibility to address this shortcoming.

Country compact (recommendation 5)
Malawi does not have a compact between the "country [government] and all major development partners", as anticipated by recommendation 5. JFA is a significant step in the right direction but is seriously problematic in some respects. The Government of Malawi and all major development partners have a responsibility to address this shortcoming.

For-profit private sector
In Malawi, the for-profit private sector is absent from *Global Strategy* and CoIA implementation. Accordingly, it is not in conformity with its responsibilities arising from either initiative and it has a duty to address this shortcoming.

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ANNEX 5. PERU COUNTRY REPORT

iERG Mission to Peru, 14-20 May, 2014

1. Introduction

From 14-20 May, 2014, two members of the independent Expert Review Group (iERG), Carmen Barroso and Kathleen Ferrier, supported by Natasha Shapovalova, Paul Hunt and Genevieve Sander, visited Peru to review progress in relation to recommendations 7 and 8 of the UN Commission on Information and Accountability for Women's and Children's Health (CoIA), which pertain to the national oversight and transparency of all stakeholders for their commitments to women's and children's health.

During the visit, the team had the privilege to meet with the Vice Minister of Health, José del Carmen Sara and officials from the Ministry of Health; the Minister of Development and Social Inclusion, Paola Bustamante, Vice Minister of Development and Social Inclusion, Ariela Luna, and officials from the Ministry; as well as the Vice Minister of Women, Marcela Huaita, and officials from the Ministry of Women and Vulnerable Populations. We also met with Congressmen Jaime Delgado and Juan Carlos Egúren, as well as Patricia Crosby, a representative of Congresswoman Karla Schaeffer. In Cajamarca, the team met with regional government representatives, including the Vice President, Cesar Aliaga, the Regional Director of Social Development, Marco Gamonal, and the General Director of Health, Reinaldo Nuñez. Meetings and productive discussions were also held with the United Nations Country Team, including PAHO, UNICEF, UNFPA and UN Women; and development partners, including the United States Agency for International Development (USAID), the Spanish Agency for International Development Cooperation (AECID) and the Belgian Development Agency (BTC).

During the mission, the team also met with the Interim *Defensor del Pueblo* (Ombudsman), Eduardo Vega Luna, and senior staff from the Defensoría del Pueblo (Defensoría); several members of the *Mesa de Concertacíon para la Lucha Contra la Pobreza* (Mesa), including the Chairman, Federico Arnillas; members from the Driving Group for Maternal and Child Health, as well as the Driving Group Investing in Children; and SUSALUD. The team had the honour to meet and discuss with representatives from the Licliconga community, Cajamarca Region; representatives from several health professional organizations, for example, the Colegio Medico; civil society organisations, including ForoSalud, PROMSEX, INPPARES, CARITAS, CARE Peru, ADRA, Plan International, MATHOC, and representatives from Rondas Campesinas; regulatory bodies, including the union workers of Cajamarca; prominent journalists; and the private sector, including members from national and regional pharmaceutical associations and industries, and from the Chamber of Commerce in Cajamarca. We were grateful to also have the opportunity to visit several primary, secondary and tertiary health care facilities in and around Lima and Cajamarca, including the National Hospital Hipólito Unanue, the Cajamarca Regional Hospital and the Baños del Inca Health Centre, where we held rich and inspiring discussions with a wide range of health professionals, including nurses, physicians and hospital Directors, such as Dr. Luis Fuentes Tafur, Director General of the DISA IV Lima Este.

We are extremely thankful for the time dedicated to us, the collaboration and valuable contributions we received, as well as the warm hospitality we experienced, from all stakeholders at every stage of their mission. We are especially grateful to PAHO, and Dr. Adrían Díaz in particular, for skillfully coordinating our visit.

2. Positives Aspects

Several important steps have been taken, innovative strategies and policies put in place, and significant achievements attained, for which the government of Peru and other stakeholders deserve great credit. For example:

A. Considerable progress has been made in improving maternal and child health in the past two decades. Millennium Development Goal (MDG) 4 has been met ahead of the 2015 deadline, with Peru recognized as the country making the greatest advances in reducing its under-five mortality rate, and the achievement of MDG 5a is on track.[21]

B. Universal health coverage (UHC) has been prioritized, demonstrated by the establishment of Comprehensive Health Insurance (SIS) in 2002 and the approval of the Universal Health Insurance (AUS) law in 2009, which can be understood as steps towards UHC. The government has also reduced the cost of essential medicines by promoting the importation, production and use of generic drugs.

C. Peru has ratified core regional and international human rights treaties, including the American

21 Partnership for Maternal and Child Health, *Success Factors in Women's and Children's Health: Mapping Pathways to Progress – Peru* (DRAFT), WHO, November 2013.

Convention on Human Rights, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, the Convention on the Elimination of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child, and the International Covenant on Economic, Social and Cultural Rights. Importantly, the right to health enjoys constitutional protection.

D. Birth registration, which is key to ensuring the fulfillment of numerous human rights, has experienced very rapid progress in Peru, with coverage presently around 98 percent.[22]

E. With an average economic growth rate of 6.5 percent in the last decade, Peru is one of the highest performing economies in Latin America.[23] The challenge is to ensure sustainability as well as an equitable distribution of benefits.

F. Following two decades of internal armed conflict, Peru adopted a transitional justice agenda and concrete steps have been taken to account for the past and redress human rights violations. For example, the *Comisión de la Verdad y Reconciliación* produced a strong report and individuals, including some who held the highest political and military positions, have been prosecuted and imprisoned.[24] Some transitional justice issues, however, have not yet been satisfactorily addressed, for example the forced sterilization of women between 1995 and 2000 by the Fujimori government. Although the number of women who were forcibly sterilized is not clear, we were informed they numbered more than 2 000.[25]

3. Structural Obstacles

These advances are all the more impressive when placed within the context of the considerable and complex structural obstacles to achieving progress in women's and children's health that confront Peru. For example:

A. Peru's diverse geography, spanning the *Sierra* (mountains) and the Selva (jungle), impedes access to health facilities, goods and services of certain populations living in very remote, hard-to-reach areas (see Section 4(B) '*Serious equity gaps*').

B. Peru is a society in transition from two decades of internal armed conflict. The legacy of this conflict continues to have an impact on many aspects of society. For example, this may account for the reported hesitancy, in some quarters, to publicly express concerns about authorities and public services.

4. Principal Concerns

During the mission, the team identified several areas of concerns. While the following section only focuses on six of these due to space constraints, we recognize the critical importance of others bearing upon women's and children's health. For example, Peru's spending on health, which is currently at around 5 percent of its GDP, is far below what is expected for an upper-middle income country.[26] Also, there is a serious scarcity of human resources in health, especially in rural areas; this is partially due to inadequate incentives and retention policies, contributing to a skills-drain.[27]

A. Responsibilities and accountabilities: the importance of national mechanisms

According to CoIA, the accountability framework consists of monitoring, review and remedial action.[28] *Monitoring* demands the disaggregation of data "by sex, socioeconomic status and other demographic or geographic variables to reveal inequities".[29] *Review* means "analysing data to determine whether reproductive, maternal, newborn and child health has improved, and whether pledges, promises and commitments have been kept by countries, donors and non-state actors... [this] involves recognising success, drawing attention to good practice, identifying shortcomings and, as required, recommending remedial actions."[30] CoIA and the iERG highlight the value of an independent element being included in the review process.[31] *Remedial* action, if needed, is likely to be the responsibility of a range of stakeholders.

As already mentioned, the mission focused on CoIA's recommendations 7 (national accountability mechanisms) and 8 (transparency). Accountability and transparency are potent weapons in the struggle against corruption. Within recommendation 7, the team gave particular attention to the second element of accountability i.e. review, especially independent review.

Horizontal and vertical accountability. Discussions in Peru distinguished two types of responsibilities.

22 The latest available data available on birth registration in Peru is from 2007, when coverage was at 93 percent. The updated figure in the text (98 percent) was given to us in an interview.
23 Partnership for Maternal and Child Health, *Success Factors in Women's and Children's Health: Mapping Pathways to Progress – Peru* (DRAFT), WHO, November 2013.
24 The report was made public on 28 August, 2003. It is available here: http://www.cverdad.org.pe/ingles/ifinal/index.php
25 Miranda and Yamin report that 250 000 women were sterilized, many without giving their full consent, see Jaime Miranda and Alicia Ely Yamin, "Reproductive health without rights in Peru", The Lancet, Volume 363, Issue 9402, January 2004, p. 68.
26 See, Pedro Francke, *Peru's Comprehensive Health Insurance and New Challenges for Universal Coverage*, The World Bank, January 2013.
27 See, for example, International Planned Parenthood Federation/Western Hemisphere Region, *The Case for Continued Population Funding in Latin American/Carribean: Why the United States Should Invest in Sexual and Reproductive Health*, 2011; and Luis Huicho, "Job Preferences of Nurses and Midwives for Taking up a Rural Job in Peru: A Discrete Choice Experiment", in PLOS ONE, vol. 7, No. 12, December 2012.
28 Commission on Information and Accountability for Women's and Children's Health, *Keeping Promises, Measuring Results*, 2011, p. 7 and 17.
29 Ibid, p. 17. See also, Recommendation 2 on health indicators, at p. 10.
30 Ibid, p. 7.
31 See, for example, UN Commission on Information and Accountability for Women's and Children's Health, *Keeping Promises, Measuring Results*, 2011, p.18.

The government has responsibilities to a wide-range of stakeholders, including its citizens ('horizontal' responsibility). Second, there are responsibilities between different levels of government ('vertical' responsibility), for example, health responsibilities in Peru are divided between the central government in Lima and 25 regional governments. While Lima is responsible for providing health funds to the regions by agreed dates, the regions are responsible for implementing nationally agreed health policies.

Responsibilities require accountabilities otherwise they run the risk of becoming meaningless. Several different national accountability mechanisms are needed to accompany complex, inter-related health responsibilities. For example, the government may be accountable to its citizens through democratic elections, national human rights institutions and the courts ('horizontal' accountability). Additionally, national accountability mechanisms are needed to check that the regions are fulfilling their responsibilities to the central government, and vice versa ('vertical' accountability).

This distinction between 'horizontal' and 'vertical' is helpful because it highlights that accountability assists all parties. Accountability mechanisms help the central government ensure that the regions carry out nationally agreed health policies and efficiently use the central government's funds for the agreed purposes. They help the regions ensure that the central government, for example, provides agreed funds on time. They help citizens ensure that all levels of government abide by law and take all reasonable measures to progressively realize women's and children's health-rights. They can also be a way of helping to ensure that non-state bodies fulfill their promises and responsibilities.

Internal accountability. While not independent, internal accountability mechanisms, such as accountability arrangements *within* government, are essential. We learned, for example, about regular meetings between the Ministry of Health and Regional Directorates of Health to consider progress, identify problems and address shortcomings. We were also informed about another form of internal accountability: the central government's health funding-for-results initiative. In our view, this is a promising initiative provided that, in the race to achieve the prescribed results, quality care for all and other human rights standards, are not compromised. Also, data must be reliable and not distorted.

A need to strengthen accountability. Peru has a number of constitutional and other mechanisms, such as Congress and the *Defensoria*, making vital contributions towards accountability for women's and children's health. Indeed, during our visit, Congress, in a heated debate, considered progress towards health gains for women. Our task is to consider whether or not the existing arrangements carry out monitoring and review, and recommend remedial action, as anticipated by CoIA recommendation 7. In particular, do existing accountability mechanisms provide adequate review, especially independent review? As we consider this question, we keep in mind CoIA's understanding of review as set out at the beginning of this sub-section, and also the distinction between 'horizontal' and 'vertical' accountability.

After careful consideration of extensive documentation, as well as numerous discussions with a wide range of stakeholders, we have formed the view that Peru's existing national accountability mechanisms do not yet provide all the important functions and features anticipated by recommendation 7, although we appreciate that they make a vital contribution towards the achievement of this goal. In short, there is a need to find ways to strengthen the existing national accountability mechanisms for women's and children's health and, in Section 5, we suggest how this might be done.

B. Serious equity gaps

One of the recurring themes in our interviews was that recent improvements in the national health data mask deep and persistent health inequalities between different communities and populations. These serious equity gaps prevail in relation to Amazonian indigenous peoples, Afro-Peruvian communities, women and adolescents, socioeconomic status, geographic location and other factors.[32] In 2011, for example, 96 percent of births in urban areas, and only 64.4 percent of births in rural areas, were attended by a health professional.[33]

Often intersecting, equity gaps are to some extent a legacy of Spanish colonial rule, which was highly centralized and discriminatory, especially to indigenous peoples and Afro-Peruvian communities. Current expenditure on health reveals that these gaps are not presently being adequately addressed. Of Peru's 5 percent GDP expenditure on health, only 54 percent is channeled to the public system.[34] What is even more striking is that 35 percent is private, out-of-pocket spending, which is especially burdensome on the poor.[35] Unequal funding and health insurance coverage have a negative impact on the quality of services and

32 See, for example, Pedro Francke, *Peru's Comprehensive Health Insurance and New Challenges for Universal Coverage*, The World Bank, 2013, p. 1; Partnership for Maternal and Child Health, *Success Factors in Women's and Children's Health: Mapping Pathways to Progress – Peru* (DRAFT), WHO, November 2013, p. 17; and UNFPA, *Final Country Programme document for Peru*, UN Document, DP/FPA/CPD/PER/8, 26 September 2011, p. 2.
33 UNFPA, Perú en CIFRAS, Salud Sexual y Reproductiva.
34 Pedro Francke, *Peru's Comprehensive Health Insurance and New Challenges for Universal Coverage*, The World Bank, January 2013.
35 Ibid.

leave an estimated 50 percent of Peruvians without health insurance.[36]

This deep inequality and inequity reflects a profound imbalance in the distribution of power and tends to engender a fragile democracy, especially when combined with acute poverty. We speculate that this may be one of the reasons why Peru is vulnerable to the transit and production of illicit drugs, which is a growing problem in parts of the country.[37]

C. The implementation of decentralization

Following a long history of highly centralized government, a major reform of public management across sectors was initiated in 2002. Today, the Ministry of Health has direct oversight and administrative power over health care in Lima, while autonomous regional governments manage health care in the regions through Regional Directorates for Health. While decentralization within the health sector was long overdue and is extremely important, it remains work-in-progress. As indicated in a recent World Bank report, "when the decentralization process transferred funds and authority to the regions, it did so in a context of weak management capabilities, and it failed to clearly define the relationship between the national and regional governments."[38]

Many of the pieces necessary for a decentralized health sector are being assembled, but they are not yet functioning in an integrated, coherent manner. Some important features remain underdeveloped, for example, national accountability mechanisms, with oversight of health responsibilities that are shared between central and regional governments, urgently need strengthening. Also, we were informed that sometimes funds and commodities are not transferred promptly, suggesting a weakness in current arrangements. For example, two primary health care facilities were out of condoms at the time of our visit. Accountability can assist all parties as they make the challenging journey towards a well-functioning, decentralized health sector.

D. Health sector reforms

During our visit to Peru, we heard a lot about the health sector reforms, which have been initiated to address existing fragmentation and are presently before Congress. Like decentralization, the current health reforms bear closely upon women's and children's health, but a detailed consideration of them extends beyond the scope of our report. Accordingly, we confine ourselves to two brief remarks.

First, the success of the reforms depend upon a marriage between high quality technical advice and the adoption of explicit fundamental values, such as those enshrined in Peru's Constitution,[39] the Declaration of Alma-Ata[40] and the binding international human rights obligations to which Peru has subscribed.[41] These values include dignity of the individual, equity, transparency, participation, empowerment, respect for the culture of different groups ('interculturality'), and accountability. Crucially, they require institutional expression, such as outreach programmes for indigenous communities and independent accountability mechanisms to ensure all stakeholders are fulfilling their responsibilities. The combination of excellent technical advice and explicit fundamental values provides firm foundations for a quality, effective, integrated, responsive health system accessible to all. The absence of either excellent advice or fundamental values will jeopardize the success of the entire enterprise. *Second*, both the reform process and outcomes are vital. We heard concerns that the reform process is not sufficiently inclusive, allowing only a marginal role for Congress, civil society and the UN country team.

E. Transparency (recommendation 8)

While on mission, we rarely heard complaints about the *availability* of data, information and laws relating to women's and children's health, with one exception. We were informed that while Peru has made progress towards the disaggregation of data by sex, age, region, wealth quintile and educational level, it does not routinely report data by ethnicity. To its credit, the National Institute of Statistics has organized a task force, which includes UNFPA and UNICEF, on ethnicity and statistics. Although we recognize the technical challenges associated with reliable estimates for small groups, we urge the use of innovative methods because there is compelling evidence that indigenous peoples, and some other ethnic groups, suffer from deep disadvantage in Peru, requiring strategic interventions to reduce and eliminate inequitable disparities.[42] Thus, we recommend that measures are urgently taken to report data by ethnicity, in keeping with CoIA which emphasizes that a commitment to equity demands data disaggregation by variables that "reveal inequities in the ... use of services among population groups."[43]

36 See International Planned Parenthood Federation/Western Hemisphere Region, T*he Case for Continued Population Funding in Latin American/Carribean: Why the United States Should Invest in Sexual and Reproductive Health*, 2011.
37 See UN Office on Drugs and Crime, 2012 World Drug Report.
38 Pedro Francke, *Peru's Comprehensive Health Insurance and New Challenges for Universal Coverage*, The World Bank, 2013, p. v.
39 Constitution of Peru, 1993.
40 Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978
41 Such as those included in the Convention on the Elimination of all Forms of Discrimination against Women (1979) and the Convention on the Rights of the Child (1989).
42 See paragraph 4B.
43 Commission on Information and Accountability for Women's and Children's Health, *Keeping Promises, Measuring Results*, 2011, page 17.

We were frequently told that data, information and laws are not adequately accessible to all stakeholders, including the *poblador común*. For example, the Government promulgated *National Policy Guidelines for the Promotion of Citizen Health Monitoring* in 2011 (see Section 5A) and yet we found that neither well-organized civil society groups nor a prominent journalist working on health issues were familiar with this important initiative. In Section 5, we recommend that the *Defensoria, Mesa, ForoSalud* and *SUSALUD* have an important role to play in strengthening accountability and transparency, one element of which is to improve access to data, information and laws on women's and children's health.

F. Sexual and reproductive health

During the mission, the team was informed that sexual and reproductive health issues are highly politicized in Peru, often generating intense public debate, and that relevant policies, and their implementation, have tended to correspond more closely with the views of powerful members of the Catholic Church rather than the needs and rights of women and adolescents. Although some welcome steps have recently been taken, including the decriminalization of consensual sexual relations between teenagers over 14 in 2012, alarming trends and policies remain, a few of which are highlighted below.[44]

Contraception. While several methods of contraception are widely available in Peru, the team learned that the use of modern methods of contraception among women in union is one of the lowest in the region, with a prevalence rate that has hovered around 50 percent since 2000.[45] This raises serious concerns about accessibility. We are also concerned by the Constitutional Court decision which led to the suspension, yet again, of the free distribution of emergency contraception in public health facilities, including to victims of rape.

Adolescent pregnancies. The team was struck by the high, and rising percentage of adolescent pregnancies, especially for a middle-income country.[46] This is exacerbated by article 4 of Peru's General Health Care Law,[47] which currently requires parental consent for adolescents to access contraception. The team was encouraged to hear that the Vice-Minister of Health, members of Congress, *Defensoría del Pueblo* and civil society organizations are pushing to have this article amended. The team is encouraged by the recent approval of a Multisectoral Plan for Adolescent Pregnancy Prevention and calls for its swift resourcing and implementation.

Unsafe abortion. In Peru, abortion is lawful when the life or health of the woman is threatened.[48] Until recently, however, there were no clear national protocols to help doctors determine when they may lawfully perform an abortion (see next paragraph). Consequently, many doctors who might otherwise have been willing to perform a therapeutic abortion, declined to do so because they feared they may expose themselves to criminal sanctions. This is one of the reasons why there are more than 350 000 illegal abortions every year in Peru,[49] many of which result in the death of the woman or adolescent.[50]

Two groundbreaking international human rights cases have addressed this profoundly important issue. In *K.L. v Peru*, involving an adolescent carrying an anencephalic fetus who was denied an abortion, the UN Human Rights Committee found Peru to be in violation of the ICCPR and recommended, among other things, the adoption of a national protocol for therapeutic abortion.[51] The case of *L.C. v Peru,* which came before the Committee on the Elimination of Discrimination Against Women, concerned a 13 year old girl who tried to commit suicide upon learning she had been impregnated by her rapist.[52] The doctors denied her an abortion and postponed giving her life-saving surgery, which left her paralyzed. The Committee found Peru to be in breach of CEDAW and recommended, among other things, that Peru "review its legislation with a view to decriminalizing abortion when the pregnancy results from rape and sexual abuse."[53] These cases were decided in 2005 and 2011, respectively. In 2012, the UN Human Rights Council specifically highlighted the importance of both cases.[54] On 29 June 2014, 90 years after the decriminalization of therapeutic abortions, the Government released a national protocol for therapeutic abortions for public health centers and clinics. While this is an important step, we remain dismayed that Peru has not further decriminalized abortion.

44 The law criminalizing consensual sexual relations between teenagers was ruled unconstitutional by the Constitutional Court in 2012. The Court's decision can be found here: http://www.unfpa.org.pe/WebEspeciales/2013/Ene2013/Documentos/STC.pdf

45 See International Planned Parenthood Federation/Western Hemisphere Region, *The Case for Continued Population Funding in Latin American/Carribean: Why the United States Should Invest in Sexual and Reproductive Health*, 2011, p. 54; and INEI. National Institute of Statistics. DHS Reports, 2000, 2004-2008, 2009, 2010, 2011, 2012, 2013.

46 Ibid.

47 Law 26842, 1997.

48 Peruvian Penal Code, Legislative Decree no. 635, published April 3, 1991, ratified April 8, 1991 (Código Penal de Perú, Decreto Legislativo No. 635, Promulgado 03.04.91, Publicado 08.04.91), Article 119.

49 Martín Hevia, "The Legal Status of Emergency Contraception in Latin America", *International Journal of Gynecology and Obstetrics*, 116, 2012, p. 89.

50 Abortion is the 3rd leading cause of maternal death in Peru. The leading cause is hemorrhaging, however the team was informed that half of these are probably due to abortion. See Amnesty International, *Fatal Flaws: Barriers to Maternal Health in Peru*, 2009, p. 14.

51 UN Human Rights Committee, *K.L. v Peru,* 22 November 2005, CCPR/C/85/D/1153/2003.

52 UN Committee on the Elimination of Discrimination Against Women, L.C. v Peru, 2 November 2011, CEDAW/C/50/D/22/2009.

53 Ibid. para 12(b)(iii).

54 Human Rights Council, Report of the Working Group on the Universal Periodic Review – Peru, 27 December 2012, A/HRC/22/15, para. 119.8 (p. 23).

5. Recommendations

During the course of our mission, we were informed that the peoples of Peru have grown skeptical of electoral promises that are not honored and laws that are not implemented. That so many people went out of their way to meet us, including Dr. Reynaldo Alvarado, the head of the *Mesa* in Cajamarca, who drove 8 hours through the night to meet us on a Sunday morning, highlights the importance that people place on accountability. Like in so many countries, it is time to close the gap between policy and practice, and to move from commitments to action. This underscores the profound importance of strengthening accountability and transparency and we hope the following recommendations assist in relation to women's and children's health.

A. Strengthen accountability and transparency

Strengthening accountability and transparency for women's and children's health requires a package of complementary initiatives involving several institutions. This package can help to ensure Peru conforms to CoIA recommendations 7 and 8, and it can also play a formative role in improving equity, decentralization and health sector reform, as well as addressing other concerns identified in the preceding section. The package depends upon respectful, close collaboration among several institutions and we recommend that the *Defensoría del Pueblo* plays the key coordinating role in a participatory and inclusive manner.

I) *Defensoría del Pueblo*. The *Defensoría del Pueblo* is an autonomous institution established under the Constitution (1993).[55] Its mission is to protect the constitutional and fundamental rights of individuals and communities, and to oversee public administrative duties and the provision of public services. The *Defensoría* takes-up individuals' complaints and also, under a supervisory mechanism, conducts research and prepares wide-ranging reports. Although authoritative, the *Defensor's* recommendations are not legally binding. The *Defensoría* frequently investigates individuals' complaints on health services and it has also published reports on health issues, for example, it recently published a major report on healthcare after visiting 173 health facilities.[56]

The *Defensoría* has over 800 staff throughout the country although, during discussions, it acknowledged that it has very limited health expertise. A great strength of the *Defensoría* is that it has 38 offices across Peru's regions. Most of the *Defensoría's* funding is provided by the Government. However, it has other funding sources, including Peru's development partners. The Government has recently reduced the *Defensoría's* budget and this has led to cuts in some of its services.

On condition that the *Defensoría* is provided with additional funding, and appoints suitably trained staff, we recommend that it is the 'backbone' of collaborative initiatives to strengthen accountability and transparency for women's and children's health. In this way, it can:

(a) contribute to CoIA recommendation 7, especially by strengthening the element of *independent* review, and recommendation 8, by increasing the *accessibility* of data, information and laws;

(b) raise awareness of the UN Secretary-General's *Global Strategy on Women's and Children's Health*[57] (and commitments made as a result of the Strategy),[58] CoIA's final report, and the UN Commission on Life-Saving Commodities for Women and Children;[59]

(c) help to ensure that women's and children's health are high on the national agenda.

We strongly encourage the *Defensoría* to reach out to all stakeholders, including the executive and legislative branches of Government, to explain and demonstrate how its work can help them discharge their constitutional and other responsibilities. It is vital that the *Defensoría* forges strong partnerships with civil society and key institutions, especially the *Mesa*, *ForoSalud*, and *SUSALUD* -- all these organizations have a crucial role to play in the strengthening of accountability and transparency for women's and children's health (see below).

One of the most distinctive functions of the *Defensoría* would be to determine "whether pledges, promises and commitments have been kept by [government], donors and non-state actors."[60] We recommend that the findings and other activities of the *Defensoría* are as accessible as possible, including to the *poblador común*. Accordingly, it needs a dynamic, imaginative communications strategy.

55 Constitution of Peru, 1993, articles 161 and 162.
56 Defensoria Del Pueblo, Camino al Aseguramiento Universal en Salud (AUD) – Resultados de la supervision nacional a hospitals, Informe No 161, June 2013, available at: http://www.defensoria.gob.pe/modules/Downloads/informes/defensoriales/informe-161.pdf
57 United Nations Secretary General, *Global Strategy for Women's and Children's Health*, 2010.
58 Commitments to the Global Strategy can be accessed here: http://www.everywomaneverychild.org/commitments
59 UN Commission on Life Saving Commodities for Women's and Children's Health, *Commissioner's Report*, 2012.
60 Commission on Information and Accountability for Women's and Children's Health, *Keeping Promises, Measuring Results*, 2011, p. 9.

II) *The Mesa and ForoSalud*. Both the *Mesa*[61] and *ForoSalud*[62] has extensive networks, and rich experience in awareness-raising and community engagement, which would be immensely helpful as Peru endeavours to implement the *Global Strategy*, CoIA recommendations and related initiatives. Thus, we recommend that the *Mesa* and *ForoSalud*, in close collaboration with the *Defensoría* and *SUSALUD*, redouble their activities on women's and children's health, including campaigns to improve the accessibility of relevant data, information and laws to the *poblador común*, in keeping with CoIA recommendation 8.

III) *SUSALUD*. A public supervisory body, *SUNASA* was established in 2009 to monitor the quality of health insurers and private health providers. Renamed *SUSALUD*, its responsibilities were expanded to include public health facilities and services at the end of 2013.[63] These are very early days for *SUSALUD*: it is not well-known and foundation staff members are still being appointed. We recommend that it collaborates closely with the *Defensoría del Pueblo*, *Mesa* and *ForoSalud* in relation to women's and children's health. Unlike these other bodies, *SUSALUD* has statutory powers to impose sanctions and thus it could play a critically important role, especially in relation to CoIA recommendation 7. We also recommend that all parties find ways to enhance the independence of *SUSALUD*.

IV) Deepening Social Accountability: Citizen Health Monitoring. Worldwide, there is a growing interest in social accountability.[64] In Peru, the *Mesa, ForoSalud* and other organizations contribute to social accountability, but more could be done. In 2011, for example, the *Government promulgated National Policy Guidelines for the Promotion of Citizen Health Monitoring*.[65] In brief, citizen health monitoring is a form of participation by which organized, informed individuals monitor compliance of public health services in relation to their commitments and responsibilities; the monitors then discuss their findings with the duty-bearers. CARE Peru's citizen monitoring project at Puno is a fine example of this sort of health initiative.[66] As one way of deepening social accountability for women's and children's health, we recommend the Guidelines are widely implemented as soon as possible, explicitly taking into account a human rights-based approach (see Section 5(B), second paragraph, below).

Conclusion

We wish to emphasise that this package of complementary initiatives, especially if it is to be sustainable, depends upon adequate funding. The role we envisage for the *Defensoria* requires additional funding and the appointment of suitably trained staff; citizen monitoring is not an expensive initiative but it cannot flourish without some financial support; and so on. While financial responsibility certainly does not rest with development partners alone, they have a crucial role to play, as discussed in Section 4(A).

B. Sexual and Reproductive Health

The Government and other stakeholders deserve great credit for generating the political will that has led to demonstrable improvements in children's health. Now it is time to galvanize comparable political will for equivalent improvements in women's and adolescent's health. When striving to achieve this goal, we recommend that all measures are based on scientific evidence and Peru's national and international commitments, including human rights obligations and the Montevideo Consensus on Population and Development, agreed by the Government in 2013.

When the Government recently affirmed the Montevideo Consensus, it agreed to "[a]pply a human rights approach with a gender and intercultural perspective".[67] Today, there is practical guidance on how to implement a human rights approach to sexual and reproductive health, such as UN Human Rights Council guidance on the reduction of preventable maternal morbidity and mortality[68] and WHO recommendations on ensuring human rights in the provision of contraceptive information and services.[69] We recommend that all stakeholders use these and other human rights guidance to shape their interventions.

We support current efforts to amend Article 4 to enable adolescents to access contraception freely and independently and urge the government to swiftly make strides in implementing the Multisectoral Plan for Adolescent Pregnancy Prevention. In Montevideo, the Government agreed to put in place measures designed to lower adolescent pregnancies, including the "implementation from early childhood of comprehensive sexuality education programmes"[70]

61 For more information on the Mesa de la Concertacion para la Lucha Contra la Pobreza, please visit their website: http://www.mesadeconcertacion.org.pe
62 For more information on ForoSalud, please visit their website: http://www.forosalud.org.pe
63 We understand the legal formalities to change the name to 'SUSALUD' approach completion.
64 Dena Ringold et al, *Citizens and service delivery: assessing the use of social accountability approaches in the human development sectors*, World Bank, December 2011.
65 Resolucion Ministerial No. 040-2011/MINSA, 14 January 2011.
66 See Ariel Frisancho and Maria Luisa Vasquez, *Citizen Monitoring to Promote the Right to Health Care and Accountability*, CARE, Peru, ForoSalud and COPASAH, March 2014; Ariel Frisancho, "Citizen Monitoring to promote the right to healthcare and accountability", in Paul Hunt and Tony Gray (Eds), *Maternal Mortality, Human Rights and Accountability*, Routledge, 2013; independent Expert Review Group, *Every Woman, Every Child: from commitments to action*, 2012, p. 27; and Laura Malajovich, *Transparencia Presupuestaria y Salud Reproductiva: Experiencia en cinco países de America Latina*, International Planned Parenthood Federation
67 Montevideo Consensus on Population and Development, 15 August 2013, para. 2.
68 2012. Available at: http://www.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf
69 2014. Available at: http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf
70 Montevideo Consensus on Population and Development, 15 August 2013, para. 11.

and "comprehensive, user-friendly [sexual and reproductive health] services for adolescents and youth".[71] When next reporting to the relevant UN human rights treaty-bodies, we encourage the Government to explain what it has done to implement these important commitments.

Finally, we urge Peru to work towards abortion law reform to ensure that all women are able to freely decide on matters relating to reproduction, and recommend the full implementation of the *K.L. v Peru* and *L.C. v Peru* decisions, specifically the decriminalization of abortion.[72]

C. Evolving role of multilateral and bilateral development partners

The UN Secretary-General's *Global Strategy* and CoIA spread responsibility for the improvement of women's and children's health among all stakeholders, including multilateral and bilateral development partners. CoIA decided to give particular attention to the 75 countries that account for more than 98 percent of maternal and child deaths, one of which is Peru.[73] Thus, under the *Global Strategy* and CoIA, development partners have a particular responsibility to take measures for the improvement of women's and children's health in Peru. Yet, in recent years, some bilateral donors have done the opposite: they have withdrawn support from the country.

While we are aware of Peru's middle-income status and recent economic progress, in our view it is both premature to withdraw support from the country and also inconsistent with development partners' specific responsibilities under the *Global Strategy* and CoIA. As explained to us by AECID, there is no guarantee of the continuity of the gains made over the last decade and the large majority of the world's poor lives in middle-income countries.[74] Another reason to continue support for middle-income countries, especially in health, is that health is a global public good. During our visit it was clear that accountability efforts are seriously underfunded and we were informed that donor withdrawal has had a particularly negative impact on civil society initiatives.

We recognize that the role of multilateral and bilateral development partners is evolving, especially in relation to countries such as Peru. This evolution gives rise to new possibilities, but disengagement should not be among them.

In conclusion, we are strongly of the view that there remains a crucial role for development partners to play in Peru and we recommend that they revisit their positions on this issue and urgently prioritize support for one or more of the organizations and initiatives outlined in Section 4(A), consistent with their responsibilities under the UN Secretary-General's *Global Strategy* and CoIA.

D. Corporate social responsibility

In discussions, representatives of the for-profit private sector observed that they were unfamiliar with the *Global Strategy* and CoIA. Accordingly we recommend that all stakeholders endeavour to find ways of including the corporate sector in their planning and initiatives, and we urge the sector to respond positively. The private sector representatives also acknowledged that corporate social responsibility (CSR) is underdeveloped in Peru. In these circumstances, we recommend that the Chamber of Commerce takes the lead and develops a CSR strategy encompassing women's and children's health. This strategy should not only be developed in consultation with the Chamber's members, but also with the participation of the Government, UN Country Team, and the *pobladores comúnes*.

6. Conclusions

In this final section, we will not summarize our earlier analysis, discussion and recommendations, but confine ourselves to a brief assessment of progress in relation to the CoIA recommendations that are the focus of this report.

National accountability mechanisms (recommendation 7)

While Peru has a number of constitutional and other mechanisms making vital contributions towards accountability for women's and children's health, in practice they do not yet provide all the important functions and features anticipated by CoIA recommendation 7. All stakeholders have a responsibility to strengthen the existing arrangements so that their combined effect is to provide national accountability for women's and children's health in keeping with recommendation 7. Section 5(A) outlines how this might be done through the *Defensoría, Mesa, Forosalud*, and *SUSALUD*.

Transparency (recommendation 8)

Are data, information and laws available? Today, Peru has a good record of making available data, information and laws that relate to women's and children's health. However, there is one exception: Peru does not yet routinely report data disaggregated

71 Ibid. para. 35.
72 See World Health Organization, *Safe abortion: technical and policy guidance for health systems*, 2nd Edition, 2012. Available at: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1
73 Commission on Information and Accountability for Women's and Children's Health, *Keeping Promises, Measuring Results*, 2011, p. 7.
74 José Antonio Alonso, *Cooperacíon Con Países de Renta Media: Un Enfoque Basado en Incentivos*, Cooperacíon Española (AECID), December 2013.

by ethnicity. All stakeholders have a responsibility to address this shortcoming and we commend the National Institute of Statistics for taking the lead in this matter.

Are data, information and laws adequately accessible?
In our view, data, information and laws that relate to women's and children's health are not adequately accessible to all stakeholders, including the *poblador común*. All stakeholders have a responsibility to address this shortcoming.

Development partners

As discussed in Section 5C, several bilateral donors have withdrawn all their support from Peru. Such withdrawal is inconsistent with development partners' commitments arising from the UN Secretary-General's *Global Strategy on Women's and Children's Health* and CoIA, and the relevant stakeholders have a responsibility to redress this situation.

For-profit private sector

We learned that the non-profit private sector has very limited familiarity with the *Global Strategy* and CoIA; corporate social responsibility (CRS) is underdeveloped; and the sector does not have a CRS strategy. Accordingly, we conclude that the corporate sector is not in conformity with its responsibilities arising from the UN Secretary-General's *Global Strategy* and CoIA, and it has a responsibility to address this shortcoming.

This report was prepared by Paul Hunt (University of Essex, United Kingdom), Genevieve Sander (University of Essex, United Kingdom), Carmen Barroso, and Kathleen Ferrier.

ANNEX 6. THE iERG'S SUBMISSION TO THE UNSG'S REVIEW ON POST-2015 ACCOUNTABILITY

Independent accountability post-2015: a critical and necessary catalyst for sustainable development

Evidence submitted by the independent Expert Review Group on Information and Accountability for Women's and Children's Health

Introduction

1. Transition from the era of the Millennium Development Goals (MDGs) to the post-2015 epoch of sustainable development is an inspirational opportunity to create a new movement for social justice, human rights, peace, and equity. Success will depend upon unprecedented international cooperation. Accountability will be a critical mechanism to ensure that the promises and commitments made in this new and ambitious global intergovernmental agreement are fully delivered.

2. In the Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda (1), accountability was placed at the forefront of their vision for eradicating poverty and transforming economies through sustainable economic and social development. The Panel proposed that the UN should establish a single accountability mechanism for the post-2015 period. This mechanism "would be responsible for consolidating its multiple reports on development into one review of how well the post-2015 agenda is being implemented." Specifically, the Panel recommended the publication of a "Global Sustainable Development Outlook" every one-to-two years through a collaboration between UN agencies and international organisations. Its goal would be to monitor results, trends, and risks, as well as to "recommend ways of implementing programmes more effectively." The Panel included two supplementary ideas. First, that the UN should periodically convene a high-level political forum to review post-2015 progress and challenges. This forum would receive recommendations from an independent advisory committee that would include representatives of civil society and the private sector. Second, the Panel suggested regional reporting and peer review to complement global monitoring.

3. The Open Working Group, established after the Rio + 20 conference in 2013, is also considering the role of accountability post-2015. In its June 2, 2014, "zero draft", the Open Working Group includes a statement on accountability in its proposed goal 15: "Achieve peaceful and inclusive societies, rule of law, effective and capable institutions." In paragraph 17.43, the Open Working Group makes this proposed commitment: "undertake regular monitoring and reporting of progress on SDGs within a shared accountability framework, including means of implementation, the global partnership among Member States, and multi-stakeholder initiatives and partnerships."

4. The next 18 months will see intense deliberation about the nature of accountability for sustainable development. The independent Expert Review Group on Information and Accountability for Women's and Children's Health is a new entity in global health governance, established in 2011. Our task is to strengthen accountability in one important sphere of global health. This paper describes our perspective on the contribution independent accountability could and should make to the post-2015 development agenda.

5. The MDGs have been a remarkable political and moral commitment to reduce poverty and address some of the most urgent threats to human survival. Accountability—the notion that all actors are responsible and answerable for their actions—was built into the MDGs from the very beginning: time-bound goals and targets, together with an array of indicators, that held all nations accountable for their promises and commitments. Responsibility for reporting on progress towards achieving the MDGs rested largely with countries, but was also shared with UN institutions. WHO, UNICEF, and UNFPA were essential partners with countries in delivering effective monitoring to track progress towards health-related MDG outcomes. But half way through the MDG era, which began in 2000, there was a growing sense that some development goals were badly off-track. There was a special concern about lack of progress towards MDGs 4 and 5—on child survival and reproductive/maternal health. Unless political commitments were substantially scaled up, there was a real danger that progress towards MDGs 4 and 5 would fall well short of expectations. In parallel with greater political commitment, accountability also needed to be strengthened if new and existing initiatives were to fulfil the hopes of their authors, and of women and children worldwide.

6. In 2010, the UN Secretary-General, Ban Ki-moon, launched his Global Strategy for Women's and Children's Health, which became the basis for his signature health initiative, *Every Woman, Every Child* (2). No previous Secretary-General had made such a strikingly high-profile commitment to health. His intervention was carefully considered and based on a remarkably strong foundation of scientific evidence. As the Secretary-General himself wrote in

the introduction to his Global Strategy, "Together we must make a decisive move, now, to improve the health of women and children around the world. We know what works. We have achieved excellent progress in a short time in some countries. The answers lie in building our collective resolve to ensure universal access to essential health services and proven, life-saving interventions as we work to strengthen health systems." The Global Strategy was built on two pillars: leadership and accountability—"accountability at all levels for credible results." Immediately the Global Strategy was launched, Ban Ki-moon announced that, "The UN Secretary-General requests that the World Health Organisation chair a process to determine the most effective international institutional arrangements for global reporting, oversight, and accountability."

7. The Commission on Information and Accountability for Women's and Children's Health was established in 2010. It reported in May, 2011 (3). Chaired by the President of Tanzania, Jakaya Kikwete, and the Prime Minister of Canada, Stephen Harper, the Commission delivered a powerful vision for what accountability should mean (and could achieve) for women's and children's health. Drawing on human rights principles, the definition of accountability was divided into three parts—monitoring, review, and remedy (or action). The Commission made 10 recommendations that focused on "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." The recommendations focused on strengthening country health information systems (including the use of innovative technology); ensuring that countries were able to monitor, review, and report on resource flows; establishing national oversight mechanisms; sharing information transparently; and reporting aid expenditures fully and accurately. The final recommendation of the Commission was on 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." The Commission on Information and Accountability established the legitimacy, independence, terms of reference, framework, and scope of the iERG.

8. The iERG began its work in 2011 and has published two annual reports that, together, have made 12 recommendations to reinforce the conclusions of the Commission on Information and Accountability for Women's and Children's Health and to improve accountability for women's and children's health for the 75 countries where 98% of maternal and child deaths take place (4,5). The iERG's recommendations so far are shown in Table 1.

Table 1: Recommendations from the 2012 and 2013 iERG annual reports

2012 Annual Report	*2013 Annual Report*
• Strengthen the global governance framework for women's and children's health • Devise a global investment framework for women's and children's health • Set clearer country-specific strategic priorities for implementing the Global Strategy and test innovative mechanisms for delivering those priorities • Accelerate the uptake and evaluation of eHealth and mHealth technologies • Strengthen human rights tools and frameworks to achieve better health and accountability for women and children • Expand the commitment and capacity to evaluate initiatives for women's and children's healt	• Strengthen country accountability: Ministers of Health, together with partners, must demonstrably prioritise and evaluate country-led, inclusive, transparent, and participatory national oversight mechanisms to advance women's and children's health • Demand global accountability for women and children: Advocate for and win an independent accountability mechanism to monitor, review, and continuously improve actions towards delivering the post-2015 sustainable development agenda • Take adolescents seriously: Include an adolescent indicator in all monitoring mechanisms for women's and children's health, and meaningfully involve young people on all policymaking bodies affecting women and children • Prioritise quality to reinforce the value of a human-rights-based approach to women's and children's health: Make the quality of care the route to equity and dignity for women and children • Make health professionals count: Deliver an expanded and skilled health workforce, especially in sub-Saharan Africa, which serves women and children with measurable impact • Launch a new movement for better data: Make universal and effective Civil Registration and Vital Statistics systems a post-2015 development target

The iERG's contribution to accountability

9. The iERG has benefitted considerably from being part of a political process initiated by the UN Secretary-General and implemented by a Commission led by two heads of state. This process has given valuable legitimacy to the iERG's work. It has also given us a vital multilateral agency channel through which we can communicate to countries, regions, and globally. Being closely connected with, but independent from, WHO has been critically important to the iERG's work. The result of this evolving process is that partners—countries, UN agencies, donors, civil society, academia, health professionals, foundations, and the private sector—have been highly engaged with the iERG's work and recommendations. After each iERG report, partners convened a stakeholder meeting: to review progress, gaps, and lessons in the implementation of the accountability framework developed by the Commission; to discuss and prioritise the recommendations of the iERG; and to examine how this work on accountability is contributing to the goals of *Every Woman, Every Child*. The objective of each stakeholder meeting was to identify specific actions to improve mechanisms of accountability for women's and children's health.

10. An especially encouraging effect of the Commission's recommendations has been the activity it has triggered in countries. In January, 2014, WHO reported that 10 multicountry workshops had taken place to plan implementation of the Commission's findings; 74 country self-assessments have been completed; 68 national stakeholder consultations have taken place; 56 accountability road maps have been completed (12 are in progress); 55 funding submissions have been made; and 50 disbursements have delivered (with 5 in progress). 30 countries have completed comprehensive assessments of their needs for civil registration and vital statistics systems. There has also been substantial activity to prepare for actions on maternal death surveillance and response; monitoring results; eHealth and innovation; tracking resources; country compacts; national oversight mechanisms; and transparency. Several countries have presented progress reports on different dimensions of this accountability framework—Nigeria on independent national oversight and budget transparency; Cambodia on maternal death surveillance and response; Nepal on partnership and accountability; and Tanzania on national health accounts.

11. The iERG's specific recommendations have also been addressed by stakeholders. See Table 2.

Table 2: Actions by partners to address the iERG's recommendations

2012 Recommendations	
Global governance:	An RMNCH Steering Committee was created in 2013 to coordinate the work of partners
Global investment framework:	WHO led a process that resulted in the publication in 2013 of a new global investment framework for women's and children's health (6)
Country strategic priorities:	The development of country accountability frameworks in 68 of 75 priority countries is the beginning of that prioritisation process
eHealth and mHealth:	A global survey of progress towards eHealth and mHealth is being completed
Human rights tools:	Through meetings between WHO and the Human Rights Council (and other relevant human rights bodies and mechanisms) the links between health and human rights have been growing stronger—eg, General Comment 15 on child health was adopted in 2013
Evaluation:	The research community has made, and continues to make, a major contribution to better understanding progress in women's and children's health—research is an accountability tool in itself
2013 Recommendations	
Country accountability:	WHO will take responsibility for monitoring inter-ministerial coordination on accountability, involving a broad set of stakeholders
Global accountability post-2015:	UNSG's office will take responsibility to help improve coordination of global RMNCH mechanisms for accountability
Adolescent health:	H4+/UNFPA will take responsibility for developing/applying adolescent indicators and for hard-wiring adolescents into existing work on accountability; the iERG has itself recruited an outstanding young person to join its team

Quality:	WHO/H4+ will take responsibility for developing principles/frameworks/tools for quality of care for use in national health plans
Health professionals:	WHO and GHWA will jointly take responsibility for reporting on progress towards strengthening human resources for health and galvanising high-level political commitment
Better data:	UN Statistics Department will take responsibility: for member states to submit resolutions to the UNGA and WHA ahead of post-2015 final negotiations to make CRVS a post-2015 development target; to use the Open Working Group as an opportunity to highlight CRVS; to aim for universal civil registration by 2035; to ensure that effective data from civil registration systems are used for decision-making by 2035; to ensure that UNSD and WHO collaborate with partners to make the case for "making everyone count"

12. The iERG is also tracking progress towards fulfilling the recommendations of the Commission on Information and Accountability. In our 2013 report, we summarised progress in the form of a scorecard (see overleaf). As already described, the Commission has triggered serious engagement by over 30 countries with assessments of their civil registration and vital statistics systems. eHealth and mHealth innovation strategies are being monitored in countries. Country accountability frameworks are being delivered, although the exact nature of national oversight mechanisms is still uncertain in many cases. Transparency is often still poor. Reporting of aid flows for women's and children's health will begin through the creditor reporting system of OECD-DAC in 2014. In sum, the iERG has sought to be an effective independent accountability tool for assessing progress of the Commission's recommendations. It has greatly benefitted from and, we hope, contributed to the movement towards greater accountability that is growing across the world.

13. Nevertheless, there are gaps in the iERG's work. First, we have not been able to track resource flows as effectively as we had hoped. Resource tracking in countries—and obtaining evidence of how resources are reviewed and allocated in countries—has not been an easy task. The iERG is not staffed or resourced to conduct this kind of detailed analysis. Second, although the iERG is visible at the global level, our experience has been that we are largely invisible in countries. As a result, we have been less successful than we would have liked in engaging countries in our work (we have sought to redress this deficiency in 2014 with two country visits—Malawi and Peru—to study more intensively accountability arrangements for women's and children's health). Finally, we have not been able to devote time to discover evidence of the impact of our own work on behalf of women and children.

14. We have also been disappointed in some areas. Although we we were given a mandate to be the accountability mechanism for the Commission on Life-Saving Commodities, that expectation was and remains unfunded. We have been dismayed that the proliferation of new initiatives under the umbrella of *Every Woman, Every Child*, has led to parallel monitoring and review mechanisms for women's and children's health, reducing the efficiency and effectiveness of accountability overall because of fragmentation and lack of coordination. The iERG has also struggled to find a platform to present its findings to countries through the UN—eg, via WHO's governing bodies or at the UNGA itself—despite being explicitly required to report directly to the UN Secretary-General.

Summary of global progress on implementation of the recommendations from the Commission on Information and Accountability

Recommendation	Target year	Global progress
Vital events	2015	
Health indicators	2012	
Innovation	2015	
Resource tracking	2015	
Country compacts	2012	
Reaching women and children	2015	
National oversight	2012	
Transparency	2013	
Reporting aid	2012	
Global oversight	2012	

The target will be difficult or impossible to achieve
Progress is being made, but continued and concerted effort is needed to achieve the target
The target is on track or has already been achieved

Accountability in the post-2015 era

15. We do not wish to propose a simple or single blueprint for post-2015 accountability. The High-Level Panel has done so and there will likely be further iterations of the model they have offered, not least through the Open Working Group. Whatever mechanism is proposed will require considerable review and deliberation by countries, agencies, and civil society, among many other partners. However, our experience does lead us to suggest broad principles that might be considered by those formulating post-2015 accountability processes. These principles are important. Accountability is a fashionable word in global health today. But accountability must be precisely defined if it is to have any meaning or impact. It will quickly be seen that the principles we set out do have implications for the model of accountability proposed by the High-Level Panel.

- **Legitimacy:** Whatever global accountability mechanism is devised should have political legitimacy—that is, it should arise from a formal intergovernmental-generated political process that endorses and supports its creation and work. As a result, there should be strong commitment derived from all stakeholders towards this accountability mechanism.
- **Independence:** Although the accountability mechanism should be politically endorsed through formal intergovernmental channels, the work of accountability itself should be independent—ie, the members of the accountability body should not be members of any agency (UN or otherwise) or institution that is subject to monitoring and review. Independent accountability is different from mutual accountability or UN tracking of results, trends, and risks. Mutuality means that each entity holds each other entity accountable. But this mutual accountability is not the best way to achieve a frank and unvarnished appraisal of the strengths and weaknesses of a programme or initiative. And while the UN is an essential source of technical data and support, it is not well placed to offer independent and critical comment.
- **Framework:** The accountability mechanism must have a theory of accountability underpinning its work. The framework adopted by the iERG was that of monitoring, review, and remedy or action. This framework allows the process of accountability to measure progress against a pre-specified set of criteria, as set out by the Commission (its 10 recommendations and the 11 indicators selected on the basis of health status, sensitivity, and equity). The framework for accountability we have adopted is not the only framework available. But the point we wish to emphasise is that a framework of whatever kind is essential. We believe our framework has particular merits because of its close connection with universal periodic review, a method that has strong connections with the human rights community.
- **Terms of reference:** The goals and deliverables of the accountability mechanism must be clear and unambiguous. As far as possible, these terms of reference should ensure that monitoring and review

processes do not duplicate or conflict with existing accountability tools.

- **Reliable data:** To monitor any initiative, reliable data must be available to ensure that accountability is credible. Typically, indicators that require such data should be specific, meaningful, directly measurable, and sensitive to change. As far as possible, data should be disaggregated so that different dimensions of equity can also be monitored.
- **Parsimony:** Although identifying, gathering, and analysing data are essential for effective accountability, not all data are equally useful. Accountability mechanisms should confine their interests in data to those that are relevant for policymaking aimed at better serving the needs of women and children. All those concerned with improving accountability must take seriously the reporting burdens, costs, and inefficiencies that come with enhanced monitoring and review.
- **Country engagement:** For accountability to have the strongest possible impacts, country engagement is essential. Engagement means awareness, understanding, communication, exchange, responsiveness, respect, and full participation in decision-making at all levels.
- **Review mechanisms:** The accountability mechanism should have procedures in place to enable open and transparent engagement with key constituencies. This engagement could be through many channels, such as invited submissions, calls for evidence, open consultations, briefings, debates, and presentations.
- **Participation:** Global accountability cannot be effective unless there is parallel accountability nationally, sub-nationally, within individual communities, and at every health facility. Accountability demands active participation of the users of the health system—those women and children the health system is supposed to benefit.
- **Regular reporting:** Those charged with delivering accountability should be expected to publish a freely accessible report of their findings. This report should be addressed to the highest political level. In addition, there should be an "accountability space" created within the official governing bodies of the UN to enable the findings of the accountability process to be fully and formally presented and discussed. The same platform should be available at country level to ensure that countries are leading remedial action.
- **Resourcing:** Whatever accountability mechanism is chosen should be appropriately resourced. It is essential that the accountability process is properly resourced in terms of administrative and technical staff, the conduct of accountability work itself, and report preparation, publication, and dissemination.
- **Monitoring impact:** The accountability mechanism should itself be accountable. Ideally, the means of evaluating accountability should be pre-specified. Evaluation will involve judging the effectiveness and efficiency of the accountability process and its outcomes for the target population.

Conclusion

16. A remarkable moment presents itself. We have a once in a generation opportunity to achieve a grand convergence in health within our lifetimes. We have the technical knowledge and financial resources to dramatically improve reproductive, maternal, newborn, child, and adolescent health and wellbeing. The launch of *Every Woman, Every Child* in 2010 was a critical part of delivering this opportunity. The Commission on Information and Accountability has changed the global conversation about the importance of accountability in accelerating progress towards better health for women and children. The iERG is one material expression of the Commission's conclusions. It is for others to evaluate the impact of the iERG's work. But we believe the evidence is strong that independent accountability must continue to play an important part in tracking results and resources for health, in countries and globally post-2015. We also believe that our experience is relevant beyond health to other sectors within the concern of sustainable development and the SDGs.

17. This new movement for accountability is driven by a growing interest in the importance of better data for improving decision-making and outcomes in health and other areas of development. The High-Level Panel called for a "data revolution"—"a new international initiative to improve the quality of statistics and information available to citizens." Accountability is also driven by a concern for the individual rights of women and children—a right not only to the highest attainable standard of health, but also the right to an identity and access to the services and benefits provided by society: a "passport to protection" (7). Accountability is now a vital force to support new initiatives in global health, such as universal health coverage (8), action on non-communicable diseases (9), and even climate change (10). Ensuring the best arrangements are in place post-2015 to secure accountability will be crucial to deliver the promises and commitments made by partners.

18. In May, 2014, Ban Ki-moon, the UN's Secretary-General, noted that "Accountability will be an important part of the new development agenda." It is essential that the lessons of the Commission on Information and Accountability, and those of its daughter entity, the iERG, are fully learned. Margaret Chan, WHO's Director-General, has said that women's and children's

health is the "hardest test case" for accountability. And yet she celebrated the "good progress" made towards better outcomes for women and children through stronger accountability. And she concluded that a "vigorous and independent mechanism for accountability" was essential for the post-2015 era. We agree with Dr Chan. And we would add that the lessons we have learned in the iERG might be useful for the optimal design and implementation of that mechanism.

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Final draft, June 13, 2014

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Note added in proof

Since completing and submitting this report to the UNSG, the Open Working Group has finished its deliberations. Its work on accountability has evolved. Accountability is now cited in 3 specific parts of of the Open Working Group's post-2015 recommendations. First, in Goal 10 to Reduce inequality within and among countries—"ensure enhanced representation and voice of developing countries in decision making in global international economic and financial institutions in order to deliver more effective, credible, accountable, and legitimate institutions" (10.6). Second, in Goal 16 to Promote peaceful and inclusive societies—"develop effective, accountable, and transparent institutions at all levels" (16.6). And third, in Goal 17 to Strengthen the means of implementation—two sub-goals (17.18 and 17.19) on Data, monitoring, and accountability (although accountability is mentioned in neither). The conclusion we draw from the Open Working Group's final submission is that it failed to propose any credible working model or institutional framework for accountability post-2015, an immensely disappointing outcome.

independent Expert Review Group (iERG)

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Carmen Barroso is the Regional Director of International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR). Among her responsibilities is the leadership of a comprehensive accreditation system to ensure accountability among member associations.

Professor Zulfiqar Bhutta
iERG Member

Zulfiqar Bhutta is the Noordin Noormahomed Sheriif Endowed Professor and Founding Chair of the Division of Women and Child Health, Aga Khan University, Karachi, Pakistan. He also holds adjunct professorships at several leading Universities globally including the Schools of Public Health at Johns Hopkins (Baltimore), Harvard and Tufts Universities (Boston), University of Alberta and the London School of Hygiene & Tropical Medicine.

Mrs Kathleen Ferrier
iERG Member

Kathleen Ferrier is strongly committed to global social change. She has been a member of the Dutch parliament for over ten years and is the founder of the Dutch All Party Initiative on SRHR and HIV/AIDS. She has lived in different countries and worked as an expert in sustainable development, population policies and migration.

Ms Sejal Hathi
iERG Member

Sejal Hathi is an MD/MBA student at Stanford University, and the Cofounder & Global Ambassador for Girltank. She is a Stanford Hospital & Clinics Innovation Fellow, a Yale University Global Health Fellow, and a Paul & Daisy Soros Fellow. Sejal is pursuing a career at the nexus of technology, policy, and global health.

Professor Dean Jamison
iERG Member

Dean Jamison is Professor in the Department of Global Health at the University of Washington. In 2006-2008 Prof. Jamison served as the T. & G. Angelopoulos Visiting Professor of Public Health and International Development in the Harvard Kennedy School and the Harvard School of Public Health. He concurrently served as a Professor in Global Health Sciences at the University of California, San Francisco.

Professor Tarek Meguid
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Tarek Meguid is Associate Professor and Head of the Department of Obstetrics & Gynaecology at the University of Namibia School of Medicine. He is the former Head of the Department of Obstetrics & Gynaecology at Bwaila Hospital and Kamuzu Central Hospital in Lilongwe, Malawi.

Professor Miriam Were
iERG Member

Miriam Were's career path includes working for the University of Nairobi Faculty of Medicine, the Ministry of Health in Kenya, UNICEF as Chief of Health and Nutrition in Ethiopia, Representative of the World Health Organisation in Ethiopia and Director of the UNFPA for the Technical Advisory Team (Country Support Team) for East, Central and Anglophone West Africa from which she retired in 2000. Since retirement, she has continued to be professionally involved in the health sector.

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