WORKING GROUP ON ACCOUNTABILITY FOR RESULTS

Final Paper

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Notes:

1. This document is a technical submission of the Working Group on Accountability for Results for the consideration of the Commission.

2. This document was open for consultation prior to the final meeting of the Commission. Incorporation of input as a result of the consultation was at the discretion of the Working Group Chair.

3. The final version of this document will be presented to the Commission during the second and final meeting of the Commission. Further to that meeting, the final document will be made available on the Commission website.
The world is collectively off-track to meet the Millennium Development Goals for maternal and child health. The UN Secretary-General’s Global Strategy for Women’s and Children’s Health offers the best opportunity in a generation to intensify efforts to reverse this trend. Our Working Group report makes three sets of recommendations – for countries, on monitoring, and for the global community. Accountability is not only monitoring; it also includes elements of review and action. For countries, we ask the Commission to recommend prioritization and harmonization of investments for building robust health information systems for women’s and children’s health. We also ask the Commission to recommend that countries expand routine data collection and health surveys to provide timely information to document progress. We are optimistic about the part that can be played by ICT in this work, and we recommend continued evidence gathering about the contribution of e and m health to health information systems. We recommend that countries put in place ways - a formal national review mechanism, for example - to ensure accountability on commitments made to women’s and children's health. On monitoring, we recommend ten health status and coverage indicators, disaggregated to ensure that equity considerations will improve programmatic delivery. Quality of care should be an additional priority result in national accountability systems. We emphasise that accountability extends to non-state actors, as well as to states. Finally, we recommend the creation of a global Independent Review Group, reporting to the Secretary-General, to provide a regular, independent, and transparent mechanism for ensuring commitments made by all partners are being delivered. These arrangements are summarized in the figure.
Introduction

1. The health of a country’s women and children is a moral, political, economic, and social imperative. With four years remaining until the Millennium Development Goal target date of 2015, the world is collectively off track from meeting its commitments on maternal and child health. Although substantial progress on child survival has been made, some 8 million newborns and children under-5 still die annually from largely preventable causes. And much remains to be done to stop the unnecessary deaths of more than 350 000 women each year during pregnancy and childbirth. The UN Secretary-General’s Global Strategy for Women’s and Children’s Health, launched in September, 2010 (1), is the international community’s response to these challenges and offers the best prospect in a generation for advancing the wellbeing of millions of the world’s poorest and most disadvantaged women and children.

2. While much is known about where and why women and children die, as well as about how to prevent those deaths, too little is being done to address the causes, and implement the solutions, to reduce this huge burden of unnecessary morbidity and mortality. In too many cases, this reflects insufficient political attention to women’s and children’s health. The Global Strategy provides a valuable opportunity to raise women’s and children’s health to the highest political level – beyond Ministries of Health to Heads of State, other government departments, civil society, and the private sector. Several countries have already responded to the UN Secretary-General’s call to action with specific declarations of commitment (2). Delivering on these commitments, and motivating other countries and organisations to make similar pledges, is an urgent priority.

3. Existing monitoring efforts illustrate why this is so. In the 2010 Countdown to 2015 report (3), 17 of 68 countries were identified as making no progress towards MDG-4 and a further 32 countries were judged to be making insufficient progress. And although there have been substantial falls in maternal mortality during the past 30 years in some countries, progress has been greatly hampered by the HIV epidemic (4) and poorly functioning health systems. There remain coverage gaps and inequities across the whole continuum of care, from treatment of childhood illnesses, such as pneumonia, to skilled care during childbirth.
Countries in conflict or post-conflict situations face especially difficult circumstances.

4. At a moment of global financial recession, there is a danger that the momentum behind recent progress in women’s and children’s health will diminish as countries and donors ask whether their investments are giving value for money. In the donor community, for example, one sees new policies much more explicitly tied to results (5). Women and children risk losing international political support unless it can be shown that investments on their behalf are making a difference to measures of survival and wellbeing that the global community is most concerned about.

5. This UN Commission aims “to propose ways to make countries and their partners more accountable for women’s and children’s health.” The Working Group on Accountability for Results is charged with proposing ambitious actions at country and global levels to strengthen reporting and oversight of results. Several guiding principles have governed our work. First, the accountability framework we are recommending to the Commission is based on a fundamental human right - namely, the right of every woman and child to the highest attainable standard of health. We see this right to health for women and children as a foundation for the Commission’s work. Implementation of the Global Strategy must be consistent with the standards and obligations of human rights law. Second, we sought ways to empower countries to devise, own, and deliver their national plans for women’s and children’s health. We have tried not to be prescriptive. Third, we selected a minimum number of reliable and politically important indicators to monitor real-time progress. Fourth, we looked for robust evidence of the value of new technologies to support our accountability framework and accelerate that progress. And finally, we searched for ways to leverage the success of existing global health initiatives – e.g. HIV/AIDS.

6. The accountability framework we have used is based upon three separate but related activities. First, monitoring. Monitoring means acquiring data to find out what is happening, where, and to whom. Monitoring alone, however, is not accountability. A second crucial activity is analysis and review: have pledges, promises, and commitments, general and specific, been kept by countries, donors, and non-state actors? In other words, did we
deliver? The third element of accountability is remedy (or action): what needs to be done to put things right or maintain and accelerate progress? This cyclical process of monitoring, review, and action publicly recognizes success, draws attention to good practice, identifies shortcomings, and recommends what needs to be done. Our framework applies at both country and global levels, and includes important human rights principles, including equality and non-discrimination, transparency, and participation.

**Actions at Country Level**

7. Accountability begins with national sovereignty and the responsibility of a government to its people and to the global community. Two national functions are critical if proper reporting and oversight of commitments and pledges on women’s and children’s health are to take place. First, a sound health information system to collect and report health data. Second, a national deliberative mechanism to review these data, measure progress for country decision-makers, hold those decision-makers accountable to their people and to the global community, hold the global community accountable to countries, and devise remedies for remaining predicaments and barriers.

**National health information systems**

8. Monitoring will only be as good as the quality and timeliness of the data that monitoring can generate. The lack of health information systems in countries to count births and deaths, and to identify causes of death, has been called a “scandal of invisibility” (6). Vital statistics that come from various sources provide information that benefits individuals, societies, and decision-makers. Readily implementable solutions to these data gaps already exist. But building civil registration systems to deliver accurate and reliable data demands long-term political commitment and investment. That kind of political will has been largely lacking, with the result that the information base for improving women’s and children’s health has mostly stagnated.

9. Countries most off-track for women’s and children’s health generally have the weakest health information systems - underfinanced, fragmented, and with few skilled health
information professionals (7). There is no single blueprint for establishing and maintaining a health information system or for ensuring the provision of reliable vital statistics. Each country’s challenges are unique. Solutions need to be tailored to specific country circumstances and needs. The answer to a country’s health information needs will come from the integration of several sources of data – e.g. from expanded and more frequent surveys and censuses, and from routine health-facility data (8). We note there has been a reported decline in quality of some of these sources of information in recent years.

10. An additional gap is country analytic capacity - the skilled professionals to take health information and understand, synthesize, and use data for planning and action. There remains a neglected human resource dimension to health information system strengthening. While tools and technologies can accelerate progress to effective data systems, they can only do so with a cadre of appropriately trained technical experts.

11. Therefore, we recommend that the Commission requests national governments, with the support of partners, to prioritize and harmonise investments for building robust health information systems to monitor women’s and children’s health and health services – an initiative we call Vital Registration by 2020 or VR2020. These investments must be channeled into data gathering, together with the human and institutional capacities to support these systems of data gathering.

12. We also recommend that the Commission requests countries to support the development and implementation of an expanded, integrated system of routine health information and health surveys to provide timely national and subnational data to document progress in core health indicators, including measures of women’s and children’s health outcomes, coverage, and equity.

13. Broadband technologies offer opportunities to accelerate progress towards comprehensive health information for improving women and children’s health (9,10). Smart phones provide new possibilities for constructing patient records, collecting data remotely, and transmitting those data for central storage and analysis. The fields of e-health and m-health are
expanding rapidly. The diversity of projects – public, private, and mixed – is dramatically altering the possibilities for constructing an entirely new m-health system as an information spine for women and children’s health. Programmes across sub-Saharan Africa and Asia – such as that run by the Ifakara Health Institute in Tanzania and the BRAC-Click m-health Project in Bangladesh – are demonstrating the feasibility of tracking and supporting maternal and newborn care, assessing risk, identifying emergencies, providing clinical support and referral services, and synthesizing large amounts of data for review and action.

14. Together with WHO and other partners, the Health Metrics Network is now embarking on a new strategy to revitalize the monitoring of vital events by drawing on innovative IT solutions (MOVE-IT for the MDGs), combined with a monitoring tool - a periodic report describing the state of the world’s information systems for health (11). Together with unprecedented alignment between Global Health Initiatives to reposition health data as the central component of accountability (12) and calls to construct national information platforms for large-scale effectiveness evaluations (13), there is a renewed opportunity to incentivise countries to invest in this essential public good. We envisage considerable opportunities for strengthening accountability. ICT offers faster and better quality data collection, processing, and dissemination. With mobile devices, in particular, new data at community level can be generated. Improved storage and access from public databases will enhance transparency. New methods and information will be more easily shared. New ways to expand participation in the review process will be created. And social networking offers fresh opportunities for strengthening accountability mechanisms.

15. We recommend that the Commission endorses the findings of the ITU-UNESCO Broadband Commission, which called for “broadband inclusion for all” (14). The Broadband Commission saw ICT as a fundamental social asset, “where citizens have the skills and confidence to create, share, and preserve information and knowledge to improve their lives.” This information includes the data that underpins progress in women’s and children’s health. Although this Working Group is persuaded of the tremendous potential offered by e/m-health, we are also conscious of a lack of systematic and rigorous evidence for the contribution e/m-health could make to accountability systems for women’s and
children’s survival and wellbeing. The Working Group is not yet in a position to recommend a specific technology or approach to advance progress towards accountability for women’s and children’s health. Given this lack of systematic evidence, it is essential WHO and other health-related agencies continue to gather experience from the diversity of e/m-health initiatives worldwide and to formulate technical guidance on how lessons from these initiatives can be translated into practical recommendations for national, fully integrated e/m-health programmes in countries.

**Country level accountability arrangements**

16. As we have noted, monitoring alone is not accountability. There has to be an institutional mechanism to review emerging information about women’s and children’s health, to identify successes and continuing obstacles to progress, and to recommend what needs to be done. The challenge for countries is to make women’s and children’s health a high-level national political priority, not only an objective of the Ministry of Health. The commitment of Heads of State must be translated into accountability frameworks that reflect this national leadership. Evidence submitted by WHO to this Commission shows that country arrangements for accountability are at least modest, at worst weak. In addition to high-level political engagement, country-based accountability arrangements need an independent, autonomous element to review whether or not national and global stakeholders are keeping their commitments. In some countries, this task may be given to an existing institution - e.g. an ombudsperson or a national human rights body (15).

17. While all countries will need national arrangements on monitoring, review, and action for women’s and children’s health, these arrangements will, as noted earlier, depend on national and local contexts. Whatever arrangements are devised, they must be transparent, inclusive, accessible, and effective. They must complement, not duplicate, existing systems that are generating valuable information. And they must address the discrimination, exclusion, and barriers women and children face in accessing health services. There are several models countries might adopt (16, 17). As one example, some countries may wish to establish National Health Commissions for women’s and children’s health. These
Commissions would be chaired by an independent, prominent, and respected thought leader representing the interests of women’s and children’s health, be accountable (and report) to national Parliaments, be inclusive of all relevant government departments (including Ministries of Finance to ensure accountability for resources), and engage non-governmental actors.

18. The essential idea behind a National Health Commission would be to elevate the health system (for women and children) to the level of a “core social institution”, akin, for example, to the justice system (18). We envisage that National Health Commissions would convene annual or biannual meetings of all stakeholders to address national progress against country health plans and international goals, as well as subnational inequities and predicaments. The Commissions – and these annual or biannual meetings – should be informed by the views of a national level independent person or body – eg, an ombudsman with expertise in women’s and children’s health. They would recommend remedies and actions that might extend to restriction, compensation, and guarantees of non-repetition. Most importantly, they would provide a means for accountability to citizens and health care users.

19. Why create a National Health Commission? The most common existing review mechanism for women’s and children’s health is the annual health sector review. Annual Ministry of Health reports describe progress across a range of health performance measures. Results are discussed and the findings incorporated into succeeding national health plans. However, these health sector reviews often suffer from several weaknesses – too many indicators and targets, major data gaps, limited analytic capacity, weak political traction, and lack of engagement of key actors (eg, civil society). The Countdown to 2015 process has tried to promote country action through national Countdown conferences (e.g. in Senegal and Zambia). But this mechanism has not been reproduced in a systematic or effective way across all high-burden countries.

20. The benefits of a broader national accountability mechanism for women’s and children’s health would be multiple: country ownership, fully aligned with national health plans; a means to reduce fragmented and duplicated monitoring arrangements imposed on
countries by donors and agencies; incentives to create demand for better information and to build stronger institutions for data collection, analysis, reporting, and dissemination; intersectorality; and the opportunity to engage civil society organisations in a national dialogue. National Health Commissions would be empowering institutions, enabling citizens to participate in a process to track and trace progress in women’s and children’s health alongside other dimensions of the health sector. The functions of a National Health Commission would include:

- coordinating a national accountability system
- reporting national and subnational progress on outcomes and coverage
- curating knowledge and best practice from health programmes
- policy development, implementation, and review
- creating grievance redress bodies, nationally and subnationally
- resource mobilization, allocation, and tracking
- building partnerships among stakeholders
- strengthening political leadership
- advocacy and mobilization
- identifying research priorities

21. The review process led by a National Health Commission would also link to the third element in our accountability framework – namely, remedy or action. The results of the Commission’s work would be included in subsequent national plans, together with commitments over budgets, timelines, and further accountability measures, all led by the highest levels of political authority, including national parliaments.

22. Our concept of a National Health Commission comes partly from studying the way countries have responded to the UN General Assembly Special Session (UNGASS) on AIDS, held in 2001. Without question, UNGASS mobilized countries in an unprecedented way to address AIDS. We see an exceptional opportunity to build on the success of UNGASS on behalf of women and children. Part of the UNGASS response was the creation of National AIDS Commissions as multisectoral coordinating entities to lead and monitor the national response to AIDS (19, 20). They have facilitated country mobilization around one national
strategy, one national authority, and one national monitoring system. They are inclusive of civil society. And they have embedded high-level political commitment into the AIDS response.

23. National AIDS Commissions are not perfect (21). The advice taken by the Working Group has been that unless a National Health Commission was given greater and more formal legal authority, it could not fully achieve the objectives we are proposing for it. In particular, the formal relationship between a National Health Commission and the Ministry of Health would have to be carefully managed to avoid “distracting power-struggle issues.” That said, National AIDS Commissions “have been able to catalyse and spearhead strong leadership and advocacy in support of the national AIDS policy and action frameworks, and to provide effective multisectoral coordination, especially among non-governmental actors and development partners” (21). One might even envisage National AIDS Commissions being legally strengthened and their remits extended to broader health issues, including women’s and children’s health. The UNGASS+10 review in 2011 might provide such an opportunity for integration.

24. We recommend that, building on existing efforts, countries, together with the financial and technical assistance of partners, urgently put in place independent, transparent, inclusive, and effective national arrangements of monitoring, review, and action for women’s and children’s health. The data generated by such a process would provide the basis for the country’s submission to the Secretary-General’s Independent Review Group (see paragraph 39). This Review Group should give its own constructive feedback, taking account of local contexts.

**Monitoring of Progress**

25. Our objective has been to reduce the reporting burden on countries by keeping the number of indicators to track progress in women’s and children’s health as small as possible. We have sought a monitoring framework that meets this objective, but which also reflects the ambition of the Secretary-General’s Global Strategy, which is broad and far-reaching. The
Secretary-General, for example, identifies malaria, tuberculosis, other neglected diseases, education, water, sanitation, gender equality, and poverty as critical determinants of women’s and children’s health. It is tempting to include all of these dimensions into a single comprehensive indicator framework. The Countdown to 2015 process has progressively extended its monitoring to include, in addition to mortality rates, causes of death, nutrition, immunization, malaria prevention and treatment, diarrhoeal disease and pneumonia prevention and treatment, continuum of care coverage, equity, health policies, and health systems, among others (22).

26. While we believe that a comprehensive approach to indicators has technical merit and reflects a fuller understanding of the predicaments faced by women and children, we are also conscious that complexity has political and policy drawbacks. A simpler indicator framework could have the advantage of delivering stronger political commitment and broader societal mobilization around women's and children's health. Simplicity would also contribute to more accurate, reliable, and timely information, especially where health information systems are weak and the technical capacity to collect and analyse complex information is limited. How should the Commission decide between these competing approaches?

27. Whatever choice of indicators is made, the Commission must bear in mind the purpose of the monitoring mechanism it adopts. We see at least three potential purposes. First, to hold countries mutually accountable for the progress they have made on women’s and children’s health. This objective will likely require a medium-sized set of coverage indicators (perhaps 20-30 in total). Second, to hold the international community accountable for progress at the global level. This objective will likely require a much smaller set of measures. And third, to enable countries to measure detailed progress for country decision-making. This objective will probably involve an extensive set of measures defined by the local country context. This last purpose will not be covered by our Working Group.

28. We have therefore selected two sets of indicators - one based on their political importance for revealing the status of women's and children’s health, and one based on their broader
technical validity for informing action in countries (strengthening the concept of a continuum of care) and for holding countries accountable to the international community. Any indicator we recommend should have high public-health importance and be readily interpretable by non-specialists (23). We have also focused on the immediate policy objective - accelerating progress towards the MDGs for women and children, notably MDGs 1c, 4, and 5. This selective approach does not mean that we are indifferent to the laws, policies, and programmes that might create legal and regulatory barriers to improving women’s and children’s health. Far from it. We recognize that a dual approach to monitoring will be a critical element of success for the Global Strategy.

29. Using an MDG-focused approach, we began with the 11 indicators used for MDG reporting, which include indicators for coverage, risk factors, and health status: antenatal care, skilled birth attendance, measles vaccine coverage, contraceptive prevalence, children with fever requiring antimalarials, ITN use among children, children under 5 who are underweight, under-5 child mortality, infant mortality rate, maternal mortality ratio, and adolescent birth rate. We have reviewed these indicators and others, together with additional priorities and opportunities in women’s and children’s health as set out in the Global Strategy, to determine a minimum, policy-relevant indicator set.

30. We strongly believe that equity must be an essential component of any national and global accountability mechanism (24). Disaggregation of data is essential to understand where and how to direct future programmatic efforts. Equity can be measured in several ways - for example, by disaggregating data for wealth, gender, age, urban/rural residence, country region, and ethnicity (or a suitable proxy measure of ethnicity, such as region or language). Future surveys should collect disaggregated data to enable an equity-focused approach to accountability.

31. A further neglected aspect of monitoring is the quality of care that women and children receive. Quality measures are essential complements to tracking uptake or coverage. By quality, we mean whether care is effective, safe, and the experience positive for the user. Sub-standard care undermines progress towards achieving mortality reduction goals,
especially among the poorest women and children (25). It is a waste of scarce health resources and violates the right to the highest attainable standard of health. But data on quality of care are mostly lacking - a political as well as a technical failure. Several possible measures are currently being evaluated, such as timely access to emergency Caesarean section and the availability of essential drugs. We urge the Commission to emphasise the importance of measuring quality in delivering the Secretary General's Global Strategy and to task accountability mechanisms at country and global levels to include quality in their appraisals of progress towards women's and children's health.

32. Accountability does not rest only with the 74 countries we have highlighted in this report. There must also be high-quality monitoring, independent review, and action for all actors working to improve women's and children's health - including donors and non-state actors. As the Global Strategy makes clear, "In line with the principles of the Paris Declaration, the Accra Agenda for Action, and the Monterrey Consensus, all partners must work together" on country-led health plans; a comprehensive, integrated package of essential interventions and services; integrated care; health-systems strengthening; and health workforce capacity building.

33. After reviewing considerable evidence and experience about indicators and their monitoring, we recommend that for the purpose of holding national and international communities accountable for progress, the Commission adopts two groups of indicators on women's and children's health. The first group on health status represents the ultimate goal. This is a key indicator group aimed mainly at political accountability. However, some of these health status measures, such as the maternal mortality ratio, are relatively insensitive to change and therefore do not show progress over short time intervals. The estimates we have today, for example, represent the cumulative effect of policies going back over many years. A second group of coverage indicators, reflecting the continuum of care, is a more sensitive and timely set of measures, pointing to almost real-time changes in the conditions for women's and children's health (26).
Health status

- Maternal mortality ratio
- Under-5 child mortality (with the proportion of newborn deaths)
- Children under 5 who are stunted

Coverage

- Met need for contraception
- ARV prophylaxis for HIV+ pregnant women (PMTCT) and ART for women who are treatment-eligible
- Skilled birth attendants
- Postnatal care (within 48 h) for mother and child
- Breastfeeding exclusively for 6 months
- DPT3 vaccine coverage
- Children with suspected pneumonia receiving antibiotics

These data should be disaggregated to enable an equity-focused approach to maternal, newborn, and child health programmes. That is, the above indicators should be reported for the lowest wealth quintile, gender, age, urban/rural residence, geographic location, and ethnicity; and, where feasible and appropriate, for education, marital status, number of children, and HIV status.

34. These ten indicators should be tracked for the 74 countries where 98% of maternal and child deaths take place - the combined group of nations covered in the Countdown to 2015 report and those identified in the Global Strategy as the lowest-income countries (27). However, we note that the Secretary-General’s strategy has global reach. Our immediate focus on 74 countries does not exclude responsibilities by all nations to women’s and children’s health.

35. This core set of indicators should be adopted by all global partners; and these partners should pool their resources to support the coordination of data collection and reporting, and country analysis. Subnational data are especially important for a complete assessment
of a country's progress.

36. Quality of care should be a priority result in national accountability systems for women's and children's health. In the short term, routine audit of maternal, perinatal, and child deaths should be considered in all countries, associated with a confidential inquiry mechanism. In addition, existing data from facility-based surveys and routine performance monitoring should be used more effectively - and strategically expanded to inform improvements in service delivery. Indicators to reflect the perspectives of women and children regarding quality of care quality need to be validated and incorporated, wherever possible, onto data-capture platforms.

37. Donors and non-state actors (civil society, foundations, the private sector) who play a part in the Global Strategy must take deliberate, targeted, and progressive actions to deliver their commitments on women's and children's health. They must devise effective, transparent, and accessible ways for measuring the degree to which they are keeping their commitments. For donors, OECD-DAC should give greater visibility to women's and children's health in its monitoring arrangements. Not only should the commitments of donors and non-state actors be monitored, they must also be subject to national and global dialogue and independent review.

**Global Reporting, Oversight, and Accountability**

38. Accountability begins in countries. But there also needs to be some mechanism to ensure reliable arrangements for global reporting, oversight, and accountability. Accountability extends to state and non-state actors for the health policies and programmes they design and implement, and the extent to which their laws, policies, and programmes meet human rights standards. The commitments and responsibilities of all parties must be identified and each held accountable for their performance. Currently, accountability mechanisms for the MDGs are weak. There is a disturbing “accountability gap” in the global architecture around women’s and children’s health (28).
39. We recommend that a Secretary-General’s Independent Review Group on Women’s and Children’s Health be established to provide a regular, independent, and transparent process for ensuring commitments made by all partners - to results and resources - are being delivered, and to identify practical measures that need to be taken to achieve those commitments.

40. An Independent Review Group, agreed by all partners, but separate from any single partner organization, would meet the urgent need for a legitimate, objective, and credible mechanism for global oversight of the Secretary-General’s Global Strategy. We do not believe that existing mechanisms or networks fill this widely accepted accountability gap for women’s and children’s health. There are many examples of independent UN and non-UN associated expert review groups for the Commission to consider (28). We believe that establishing such a Group would add substantial global momentum to improving women’s and children’s health. A fuller discussion of what an Independent Review Group would do is provided in an Appendix to this report.

41. We envisage that the Independent Review Group would periodically examine performance data on results and resources from all partners (including recipient and donor countries, the private sector, civil society, philanthropic organizations, and professional groups), identify examples of good practice, pinpoint obstacles to progress, raise concerns, recommend actions, and provide an overall assessment of progress. The core task of the Group would be to ask whether partners had kept their promises and to identify practical measures that need to be taken. The Group would undertake its work in public through submission of results from national review mechanisms, reports from partners and interested parties (including academic and research communities), discussions with those parties and partners, field visits, and publication of a concluding report. The Independent Review Group and country review arrangements would work closely together. The Group's findings would feed directly into a country process to translate recommendations into actions, which may include a request that financial and/or technical assistance be provided. The goal would be to create a process that is open, transparent, responsive, and efficient. It would not add another layer of bureaucracy to policy making. On the contrary, it would provide an effective
means to deliver the Secretary-General’s Global Strategy.

42. Who would sit on the Independent Review Group? From looking at examples of other expert review mechanisms across the UN, we believe that a small team of 15-20 widely respected practitioner, academic, civil society, and policy experts would provide the necessary capacity. They would be nominated by partners to serve independently, and they would be led by an individual of international stature. Their final selection would be made by the Secretary-General after wide consultation. Once approved, they would exercise their professional judgments without taking instructions from any organization or partner. The advantages of such a Group, by contrast with several other independent review procedures in the UN, would be its specific focus on women’s and children’s health and the high level of independent expertise it could bring to bear on the issues under its review.

43. Who would the Independent Review Group report to? Given that the Global Strategy is an initiative of the UN Secretary-General, we suggest the Independent Review Group reports to the Secretary-General.

44. We also note that the Independent Review Group we propose would need to be adequately resourced for its work to be effective, trusted, and transparent. The operations of the Group would require administrative and technical support, perhaps based within the Secretary-General’s office, or perhaps linked to the Partnership for Maternal, Newborn, and Child Health.

45. Earlier, we recommended that part of the monitoring framework at national and global levels should focus on a small number of indicators for maximum political and policy impact. In the near absence of country health information systems, some of these data are mainly derived from estimates. Currently, there are multiple sources of these estimates - from the UN, academic institutions, and civil society, among others. The debates that follow from these complementary estimation initiatives can be valuable. They sharpen understanding about what is known and uncertain, and they give welcome public attention to women’s and children’s health (promoting greater demand for better health information systems). Strong,
open scientific debate must be part of any robust accountability process. Efforts to harmonise estimates into a single number or to choose only one source of data on which to base these indicators would stifle debate and reduce the quality of the accountability process.

46. **We recommend that the Commission emphasizes the paramount importance of bringing the best available science to bear on global monitoring processes.** Assessments of country progress should be based on a scientific, not a political, process - that is, on peer-reviewed scientific evidence rather than on data whose publication depends on endorsement by any one concerned party. The Independent Review Group should be free to use the best available evidence to reach its recommendations. The Group should explicitly report the source of the data it has used and explain how and why those data have been selected.

47. That said, debate and disagreement can sometimes impede clarity for decision-makers about what action they should take. We have also proposed that part of the necessary accountability framework should include a broader list of indicators. We have recommended that one of the most reliable sources of indicators is the Countdown to 2015 initiative. The Countdown was created as an independent technical process focused on monitoring all stakeholders in women’s and children’s health – donors, the UN, and other non-state actors, as well as countries.

48. **We recommend that the Commission endorses the work of the Countdown to 2015 process as a critical input to national reviews and the Independent Review Group, and finds ways to strengthen, sustain, and broaden its independent work as a critical, although not exclusive, part of global oversight and monitoring for women’s and children’s health.**

**Conclusions**

49. Our working group sees a once-in-a-generation opportunity to act on behalf of the world’s women and children. Accountability to ensure that commitments are delivered for women and children is now recognized to be an urgent priority across the health and donor
community (29, 30). In the evidence this Working Group has received from civil society actors (31), we have been reminded that, "Accountability in the context of women's health is intrinsically linked to an understanding of what it means to observe human rights in the delivery of maternal healthcare." The accountability framework we have adopted is explicitly based on the right to the highest attainable standard of health for women and children.

50. We have also been urged to emphasise the importance of birth and death registration; the creation of independent grievance and redress procedures; putting in place effective monitoring mechanisms to track progress; and ensuring that monitoring includes measures of equity for the most disadvantaged groups in a society. We believe that our recommendations meet these important requirements.

51. We recognize that the challenges for women and children are complex. There is much more that we must do beyond our immediate recommendations - e.g. around malaria, tuberculosis, and other neglected diseases; water and sanitation services; health system failures that contribute to women's and children's ill-health; adolescents' health needs; access to safe abortion services; gender equality, girls' education, and women's empowerment; and beyond the MDGs to non-communicable diseases and the social determinants of health. Our recommendations do not exclude these important dimensions of women's and children's health. But we have taken a phased approach to accountability: beginning with a small number of politically high-profile indicators whose assertive monitoring and review at national and global levels would catalyze new commitment and action. The history of HIV/AIDS suggests that such a focused approach will deliver broader benefits (32).

52. Our framework at country and global levels embeds the monitoring-review-remedy/action process in national and international arrangements that mirror and mutually support and reinforce one another. We see this country-global alignment around accountability - with a common language of politically strategic indicators - as a potentially powerful way to deliver the Secretary-General's Global Strategy.
53. There are costs. Financial, to create the mechanisms and systems to ensure that good data drive robust review procedures and thereby promote accelerated action. Human, in the skills needed to deliver these objectives. And time, to move rapidly and without delay to address the unnecessary burden of women's and children's mortality. These costs come at a difficult and financially constrained moment in the recent history of global health. But investments today in the accountability frameworks we propose will deliver a high return-on-investment in future years - value for money for women and children worldwide.

54. Finally, we reiterate our view that the recommendations we make here, while directed at the health of women and children, are also relevant to other health sectors. Implementation of our recommendations would not only benefit women and children, but also offer new opportunities to integrate wider health priorities within a single accountability framework.

References

1. UN Secretary-General Ban Ki-moon. Global Strategy for Women's and Children's Health, 2010.
2. A complete list of country and other commitments to the Global Strategy can be found at www.un.org/sg/hf/global_strategy_commitments.pdf.
5. In the UK’s Choices for Women: Planned Pregnancies, Safe Births, and Healthy Newborns, published in December, 2010, there is an explicit commitment to “enhance accountability for results at all levels with increased transparency.”
26. Inevitably, the subject of indicators is controversial. Our Working Group has been asked, for example, why we have not included indicators for malaria, stillbirths, vital registration, adolescent health, human resources, or health policies. The answer is that we have selected a small set of tracer indicators that measure important dimensions of the continuum of care. For health status, measures of maternal and newborn/child mortality, despite their insensitivity to short-term policy shifts, are essential for MDG monitoring. A nutrition indicator is also important for understanding not only outcomes, but also determinants of maternal and child health. Nutrition is also a useful proxy indicator for development. The real difficulties come with coverage indicators. A measure of contraception is needed as a tracer for reproductive health. HIV-related indicators are included to emphasise our view that we need to move towards a new era for integrating vertical health initiatives. Skilled birth attendance, postnatal care, and breastfeeding are clearly critical elements of the continuum. DPT3 is delivered routinely and so helpfully measures a child’s first interaction with the health system. Finally, case management of childhood pneumonia is an indicator of access to treatment. Although a vaccine will have long-term impact on pneumonia, in the short-term, case management will remain an important measure of success.
27. These countries are: Afghanistan, Angola, Azerbaijan, Bangladesh, Benin, Bolivia, Botswana, Brazil, Burkina Faso, Burma, Burundi, Cambodia, Cameroon, Central African Republic, Chad, China,


31. Letters to the Commission from Action Canada for Population and Development, Amnesty International, the Center for Reproductive Rights, the Canadian Society for International Health, Human Rights Watch, and IPPF, among many others.

APPENDIX

1. Our report recommends that a Secretary-General’s Independent Review Group (IRG) on Women’s and Children’s Health be established (paragraphs 38-48). This Appendix does not repeat these earlier paragraphs but develops options for Commissioners to consider under that recommendation. It does not offer a blueprint. If our recommendation is accepted, consultations will be needed to further develop and refine these proposals (eg, see para 30 below).

2. Our Working Group has considered several possible structures for an IRG. For example, one might envisage a high-level, more political group that meets for a short period once a year – reviewing reports prepared by other bodies, consulting, and issuing a statement that assesses the overall progress of the Secretary-General’s Global Strategy. Several members of our Working Group favoured such a mechanism. The advantage, they argued, of a high-level group would be that it attracts visibility and attention.

3. We have also considered a more substantive version of an IRG. This option is based on the idea of a robust, genuine, unstaged review of commitments arising from the Global Strategy – holding accountable countries, donors, and non-state actors. It is this option that is now developed further.

4. In summary, one could envisage a small and agile IRG that meets for about four weeks each year, supported by a small secretariat. We anticipate that such an IRG would divide into Working Groups that meet, and conduct reviews, in the regions. The IRG would draw extensively from the data and information already provided by existing initiatives on women’s and children’s health, such as the Countdown. Indeed, the IRG would complement and reinforce these existing initiatives by providing an independent review of the commitments made by all stakeholders in relation to the Secretary-General’s Global Strategy. The core task of the IRG would be to ask whether stakeholders have kept their promises and to identify practical measures that need to be taken in order to do so. The IRG would help all stakeholders to implement the Global Strategy.

5. An independent review body is composed of experts in their field. They exercise their professional, autonomous judgment. Although nominated or appointed by relevant stakeholders, once appointed they serve in their independent capacity. Independent review deepens the actual and perceived impartiality, credibility, legitimacy, integrity and authority of the accountability process.

6. While there are many critically important global initiatives on women’s and children’s health, none provides an independent review of all stakeholders’ commitments and responsibilities. This is the "accountability gap" that is widely recognised among observers of women’s and children’s health, and which has, at least in part, resulted in slower than hoped for progress in improving maternal, newborn, and child survival. It is this gap that our recommendation aims to fill.

Existing UN Independent Review Bodies

7. Independent review is commonplace within the UN "family". These UN review bodies are not the same - each reflects its distinctive context and objectives. The IRG has to reflect the
unique challenges raised by the Secretary-General’s Global Strategy. By way of illustration, however, here are examples of existing UN independent review bodies:¹

8. **World Bank Inspection Panel.** Established in 1993, the Panel comprises three members who are appointed by the Bank’s Executive Board for non-renewable periods of five years. Panel Members are selected on the basis of a range of criteria, including their integrity and independence from Bank management. The Panel investigates Bank-financed projects to determine whether or not the Bank has complied with its numerous operational policies and directives, such as those on the financial terms and conditions of loans, disbursement policies, gender and development, and social and environmental safeguards.

9. **Independent Evaluation Office (IEO) of the International Monetary Fund.** The IEO was established in 2001 to conduct independent and objective evaluations of Fund policies and activities. The Office is independent from management and operates at arm’s length from the Fund’s Board of Executive Directors. It consists of a Director and eleven other staff. As the Director’s terms of reference put it: “Actions taken by the Director will be taken on the basis of his or her independent judgment.”

10. **International Labour Organisation Committee of Experts on the Application of Conventions and Recommendations.** This Committee comprises 20 eminent independent experts appointed by the ILO Governing Body for three-year terms. Once appointed, the experts serve in their personal capacity. The Committee considers information from States, and elsewhere, on the implementation of ILO Conventions, and reports annually to the (non-independent) International Labour Conference Committee on the Application of Standards, comprising government, employer, and worker delegates.

11. **The Joint ILO-UNESCO Committee of Experts on the Application of the Recommendations concerning Teaching Personnel (CEART).** CEART comprises 12 appointed members, who act in their independent capacity. The ILO and UNESCO appoint six members each for renewable terms of six years. CEART reviews reports on the application of the ILO-UNESCO Recommendation Concerning the Status of Teachers (1966), makes findings, and issues recommendations.

12. **International Health Regulations (IHR) Review Committee.** The IHR Review Committee consists of around 30 members selected from the roster of experts for the IHR or other WHO expert committees. The Committee’s duties include carrying out an independent review of the global response to the H1N1 pandemic. The Committee considers the global response of States, WHO, and pharmaceutical companies.

13. **Independent Monitoring Board (IMB) for the Global Polio Eradication Initiative.** Meeting for the first time in December, 2010, the IMB was established at the request of the WHO Executive Board and the World Health Assembly to check on the implementation and impact of the new Global Polio Eradication Initiative Strategic Plan (2010-2012) against

major milestones and indicators, and to advise countries and partner agencies on corrective actions. It reports to the heads of the partner agencies, WHO, Rotary International, the US Centers for Disease Control and Prevention, UNICEF, and the Gates Foundation. Despite its name, IMB appears to have both monitoring and review functions. With nine members, the IMB has agreed to meet on a quarterly basis.

14. United Nations Human Rights Treaty-Bodies. These groups of independent experts are appointed to review States’ implementation of international treaties covering a wide range of civil, political, economic, social and cultural human rights. Today, there are eight independent treaty-bodies (eg, Committee on the Rights of the Child) reviewing eight human rights treaties (eg, Convention on the Rights of the Child, ratified by 193 countries.) Treaty-bodies range in membership from 18-23 independent experts. The first human rights treaty-body was established forty years ago.

Outline of an IRG Process

15. Our report recommends a particular focus on the 74 countries where 98% of maternal and child deaths take place – the combined group of nations covered in the Countdown to 2015 report and those identified in the Global Strategy as the lowest-income countries (para 34). However, the Global Strategy emphasises the role of all stakeholders. Consequently, the IRG will review the role of all major stakeholders – donors, implementing country governments, multilateral agencies, civil society, and the private sector – in relation to the 74 countries. In a particular country, the Group would ask if all major stakeholders are keeping their general and specific commitments under the Global Strategy and it would also recommend practical measures for further action. In short, while the starting point would be the commitments of the national government, the IRG would also review the commitments of other major stakeholders in the country, including donors.

16. The IRG’s secretariat would collect existing data and information from, for example, official sources of national governments; Countdown reports, including country profiles; national MDG reports; annual flagship reports of UN agencies; UNICEF’s child mortality website; the WHO Making Pregnancy Safer website; the Institute for Health Metrics and Evaluation; IHP+; World Health Statistics; OECD reports; among others.

17. Where the country has one, the IRG secretariat would liaise and collaborate closely with the national monitoring or accountability mechanism for women’s and children’s health, with a view to drawing from its data and information. In this way, highly engaged and strong local accountability bodies or mechanisms will secure much of the work that needs to be completed before the IRG meets. Accountability will be a permanent, not an episodic, concern.

18. The IRG would have access to a synthesis report prepared by the secretariat, as well as the original data sources. In some cases, the IRG might commission a particular report to assist with its work.

19. The IRG would invite key stakeholders to report briefly on their implementation of the general commitments arising from the Global Strategy and, if any were made, their specific Global Strategy commitments. We envisage stakeholders will often be able to draw extensively from existing reports - eg, Countdown or OECD.

20. The IRG would prepare a short, public report on each country review. This report would summarise:
• the achievements and good practices of key stakeholders;
• the main obstacles confronting implementation of the Global Strategy;
• the IRG’s main concerns;
• constructive, practical, remedial recommendations for further action by key stakeholders;
• an assessment of the degree to which key stakeholders are meeting their general and specific commitments arising from the Global Strategy.

21. As emphasised in our final report (paragraphs 45-47), the IRG should use the best available evidence to inform all its work and explicitly explain the source of the data it has used and how and why those data have been selected.

22. The IRG is not an implementing agency. Its recommendations would be considered, and action taken, by national and international stakeholders and partners working in close collaboration. Where the country has one, the IRG will present its report to the national level monitoring or accountability body for women’s and children’s health.

23. This process would be repeated every two years. Thus, two years later the IRG would check, and discuss with key parties, what steps have been taken to implement the IRG’s earlier recommendations. If stakeholders, without adequate explanation, have not taken appropriate steps, this will be recorded in the IRG’s public reports.

24. In special cases, one or two IRG members might visit a country to obtain first hand experience of challenges and progress, as well as to promote and discuss implementation of the IRG’s recommendations.

**IRG Working Groups in the Regions**

25. We envisage the IRG would have approximately 15-20 members and we propose it divides into Working Groups. The IRG would determine the number and composition of its Working Groups. For illustrative purposes, we assume it may establish three-to-four Working Groups of five members each. Each year the IRG would also meet in plenary for at least one week to review its working methods, ensure consistency between Working Groups, adopt its annual report, and so on.

26. Our final report gives particular attention to stakeholders in 74 countries. For the most part, the IRG would review key stakeholders in those countries. However, the IRG might also wish to separately review some international stakeholders. For example, it might wish to review a donor’s overall contribution to the Global Strategy. Thus, we are assuming that, in a two-year cycle, the IRG would wish to conduct approximately 100 reviews – ie, 74 country and 26 other reviews - about fifty reviews a year.

27. Reviews must use modern information technology as much as possible. However, we strongly recommend that a review does not become a technocratic exercise. As outlined above, we recommend the process includes discussion between the IRG, key stakeholders and others. While reviews will vary in length, we envisage that a country review will take about one day.

28. We would recommend that most country reviews take place in the regions.
Conclusions

29. Our final report signals how the IRG members might be selected and appointed (para 42) and recommends that the IRG reports to the Secretary-General (para 43). We would only add that, in addition to presenting its report to the Secretary-General/General Assembly, the IRG might also be required to report to suitable multi-stakeholder bodies, - eg, the Partnership on Maternal, Newborn, and Child Health. In this way, the IRG provides a critically important independent review element in multi-stakeholder mutual accountability processes.

30. Our final report also raises the question of where the IRG’s administrative and technical support might be based (para 44). As our final report notes, one possibility is the Secretary-General’s Office. We recognise that there may other options.
## Working Group Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Institution</th>
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