Introduction

An unprecedented step towards global reporting, oversight and accountability for women’s and children’s health (Millennium Development Goals 4 and 5) was taken in 2011 when the United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health, the Commission on Information and Accountability for Women’s and Children’s Health (CoIA) was created. The Commission, convened by President Kikwete of the United Republic of Tanzania and Prime Minister Harper of Canada put forth 10 recommendations to strengthen accountability for women’s and children’s health.

Implementing the Commission’s 10 recommendations has demonstrated that the process for developing Country Accountability Frameworks is an innovative approach to strengthening accountability, transparency and improving data quality. Accountability and transparency are now key critical issues when dealing with women’s and children’s health, with improvements sought by donors and countries alike. The implementation process has been an excellent platform for bringing together donors and country stakeholders, and for strengthening International Health Partnership (IHP+) processes.

The Accountability Framework has clearly gained traction in countries and is guiding the implementation of the CoIA recommendations. To date, **68 countries have Country Accountability Frameworks completed** (or near completion). The favourable and higher than expected demand from countries has elevated the action on accountability and also created an immediate need for financial investment in countries.
Progress

Better information for better results

1. There is now more than ever, strong political commitment for Civil Registration and Vital Statistics (Recommendation 1) improvement, expressed in ministerial and/or senior official endorsements and commitments through regional bodies such as the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), the United Nations Economic Commission for Africa (UNECA), and the Eastern Mediterranean Regional Committee in 2012-13. The Accountability Framework has accelerated the momentum, especially evident in Asia-Pacific and Eastern Mediterranean, and in the African CRVS assessment.

2. More than 30 countries have assessed their CRVS systems in order to develop national plans of action; and some countries are showing progress in developing their systems. The health sector remains an integral component of a functioning CRVS system, as both a beneficiary and contributor to the improvement of these important systems. WHO and partners including the World Bank, USAID, UNICEF and Canada recently considered the role of health sector in further strengthening of CRVS systems; identifying principles and practices in reproductive, maternal, newborn and child and adolescent health (RMNCAH, cause of death and vital statistics as means to guide health investments to strengthen CRVS.

3. Through the accountability work, there has been a move from maternal death reviews to maternal death surveillance and response, an active approach which aims to identify ALL maternal deaths, make each one a notifiable event ("surveillance") and take action ("response") to learn and prevent deaths in the future. This approach also reviews the circumstances leading to maternal death and identifies potentially preventable factors in each death, paving the way for development and implementation of feasible, targeted recommendations to prevent maternal deaths and improve quality of care. More than 50 countries have adapted the new approach and are taking steps to implement it with support from a range of partners, including WHO, UNFPA, Centers for Disease Control, Evidence for Action, Liverpool School of Tropical Medicine, Saving Mothers Giving Life, FIGO, ICM and USAID. A core set of indicators of quality of RMNCT care in facilities has been developed recently and will be used for monitoring and reporting on effective coverage of health services.

4. Countries are taking concrete actions to strengthen their health information systems (Recommendation 2). Routine monitoring of core indicators has improved through use of web-based reporting in over 30 countries. Many have conducted facility assessments to measure and monitor the readiness of country health systems to provide high quality services for women and children and to scale up essential interventions including the 13 essential life-saving commodities identified by the United Nations Commission on Life-Saving Commodities. Many countries have introduced systematic data quality monitoring and improvement. Global partners such as the Global Fund, GAVI, PEPFAR and the European Union are increasingly investing in national capacities for monitoring of results and reviews, including health information systems, data quality and analytical capacity building for stronger health reviews and policy dialogue.

5. Countries are increasingly planning how to adapt and employ innovation, information and communication technologies (Recommendation 3) in health for the benefit of women and children, through tools and technical support from WHO and the ITU. In 2013, 38 additional countries developed eHealth strategies through a stakeholder process that reflected national priorities, playing a catalytic role in adoption of eHealth while building the foundations for systematic, coordinated use of ICT in health services and systems. Sixty five countries have completed the eHealth profiles which provided a base line for uptake of ICT for women’s and children’s health. Through implementing
eHealth projects, countries build the evidence on what works and what doesn’t work for women’s and children’s health, providing a learning platform and lessons learned which can be shared with other countries.

Better tracking of resources for women’s and children’s health results

6. The country resource tracking platform is a strong vehicle for harmonizing the work to track health expenditure flows (Recommendation 4) based on a standard framework, the Systems of Health Accounts 2011 as embedded in the health accounts production and analysis tools. Several partners are working with WHO in this effort, including partners such as The Global Fund to Fight AIDS, Tuberculosis and Malaria, Bill & Melinda Gates Foundation, and GAVI. The approach is being implemented in 25 countries with results available from 8 countries.

7. National budgets are a key policy lever to influence women’s and children’s health outcomes. As such partners are also joining efforts to strengthen the capacity of these civil society coalitions to better engage with budgets. PMNCH, WHO, Save the Children, the Inter-Parliamentary Union (IPU), UNICEF, Evidence for Action, the East African Community Open Health Initiative, Family Care International, White Ribbon Alliance, Countdown to 2015, and World Vision International, are supporting capacity building of parliamentarians, civil society and the media from Kenya, Liberia, Sierra Leone, Tanzania, and Uganda to engage with budgets and undertake budget advocacy for improved women’s and children’s health.

8. Forty countries have signed a country compact (Recommendation 5) or equivalent agreement with development partners. The accountability framework is an integral part of the Country Compact. With the renewed global momentum around IHP+, there is further opportunity and need to coordinate partner investments in, and work on, accountability processes at country level.

Better oversight of results and resources: nationally and globally

9. Fifty five countries have received catalytic funding in support of their Country Accountability Frameworks. The following illustrates how countries have prioritized their catalytic funding across the various work streams.

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13 additional countries are in the process of completing their Country Accountability Frameworks and are expected to request catalytic funds.
10. Fifty-three countries are conducting annual health sector reviews (Recommendation 6), to build a clearer picture of the gaps in their health-care provision and as the basis for national accountability mechanisms. (Recommendation 7). Broader participation of stakeholders in this process has increased transparency. Furthermore, a recent analysis of 17 countries’ annual review reports found that while most reviews (94%) covered RMNCAH issues, mechanisms for implementing recommendations are often lacking. Recognizing the importance of reviews, global partners such as the Global Fund, GAVI, PEPFAR and the European Union are increasingly investing in national capacity building.

11. Transparency (Recommendation 8) is enhanced by better monitoring of results and tracking of resources. The benefits include better data on the 11 health indicators and better data and analyses to inform reviews of progress and performance. Dissemination of information is improved by the launch of regional initiatives such as the African Health Observatory. Parliamentarians, civil society organizations (CSOs) and the media are all contributing to gradual improvements in review processes. Work with the Inter-Parliamentary Union (IPU) has led to greater involvement of parliamentarians in women’s and children’s health issues. However, many countries lack strong CSOs and media that can play a role in regular reviews and accountability processes, which should lead to greater transparency and effective action.

12. Partners are collaborating to strengthen the capacity of national civil society alliances to promote accountability for women’s and children’s health. PMNCH continues to support national reproductive, maternal, newborn and child health advocacy coalitions with a view to intensify joint action to enhance accountability relating to women’s and children’s health. These coalitions have conducted successful advocacy for improved accountability. In Uganda, for example, the national CSO coalition led by ACHEST and World Vision Uganda worked with legislators to hold the budget approval process until the allocation to health was increased. The Ugandan Coalition has also been instrumental in advocating for the leadership of the Ministry in undertaking a national Countdown process. In Kenya and Burkina Faso, the CSO coalitions are leading in the proposal of country Countdown to 2015 processes. In Burkina Faso this advocacy has resulted in the Minister of Health making Countdown to 2015 a national health advocacy priority and allocating resources for its implementation.

13. Work to develop and refine reporting instructions and guidance for the new RMNCH scoring system/marker has been completed and sent to members of the OECD-DAC Working Party on Development Finance Statistics for approval under the OECD’s written procedure. Accordingly, these will soon be formally incorporated into the reporting directives for entities reporting to the DAC statistical system. Reporting using the RMNCH scoring system/marker will begin in the latter half of 2014 for 2013 Overseas Development Assistance (ODA) flows (Recommendation 9).

**Implementing the iERG recommendations (Recommendation 10)**

14. In its report in 2012, the iERG made six recommendations of its own, three of which were prioritized by stakeholders and are reported here.

15. The first iERG recommendation from 2012 was to strengthen global governance. The Reproductive, Maternal, Newborn and Child Health (RMNCH) Steering Committee was formed as a result of this recommendation. In 2013, it put in place a country engagement process which brings together high-level decision-makers from different initiatives under the Every Woman Every Child banner to harmonize the international RMNCH response and align and coordinate funding streams in countries, in line with IHP+ principles. A catalytic RMNCH Trust Fund was established to support
this process. These developments aim to align the international RMNCH response under the Every Women Every Child banner, to more effectively respond to country needs, underpinned by one accountability framework.

16. As per the second iERG recommendation from 2012, a global investment framework for women’s and children’s health has been developed and was published in the Lancet in November 2013. The investment framework, which contributed to a larger December Lancet article looking at investments in health, looks at the evidence we have on the interventions that work across the reproductive, maternal, newborn and child health continuum – focusing on the impact that could be attained in the 75 countries most affected by maternal and child mortality. By accelerating current investments and thereby investing an additional USD 5 per capita per year until 2035, it would be possible to prevent the deaths of 147 million children, 32 million stillbirths, and 5 million women from 2013-2035, yielding up to nine times the value in economic and social returns. The framework can serve as a guide to countries to optimise investments in women’s and children’s health within national health and development dialogues over the next two decades.

17. In response to the sixth iERG recommendation from 2012, there has been increased attention to a human rights approach as evidenced by the 2013 United Nations Human Rights Council adopting a number of resolutions in relation to RMNCH. In March, the Council adopted a comprehensive resolution on children’s right to health, in which it invited WHO, OHCHR, UNICEF and key civil society partners, to prepare a study on under-five mortality as a human rights concern. The study was submitted to the Council and adopted as a report in September, followed by the adoption of a thematic resolution on under-five mortality. The resolution led to Technical Guidance (under preparation) on the application of a human rights-based approach to reducing preventable under-five mortality and morbidity. A second resolution on birth registration was also adopted by the Council. The UN Committee on the Rights of the Child adopted its General Comment on children’s right to the highest attainable standard of health, following lead support from WHO, UNICEF, Save the Children and World Vision. Currently, four countries in the African Region are conducting human rights assessments of laws, policies and programmes related to RMNCH with support from OHCHR, WHO, UNFPA and PMNCH. In addition, in May 2013, WHO published a study highlighting evidence of impact of a Human Rights Based Approach on women’s and children’s health.

18. Adolescents is an area highlighted by the iERG in its 2012 report (and 2013 report) and countries are embracing the need to address adolescent health recognizing the contribution of adolescent mothers to maternal and newborn morbidity and mortality. An online report entitled Health for the World’s Adolescents is being prepared which will provide trends in adolescent mortality and morbidity and a ‘one stop shop’ for WHO guidance in countries.

**Moving Forward**

Through the Accountability Framework, countries have adopted accountability, measurement and transparency as a means to achieving the Global Strategy goals. This has resulted in greater inclusion of civil society, media and parliamentarians in monitoring progress toward women’s and children’s health; taking on new methodologies and approaches for tracking resources and maternal death reviews and response, and creating platforms for e- and m-Health projects that benefit women’s and children’s health. This level of accountability has not been witnessed in other sectors.

Sixty-eight countries have come forward and engaged in the accountability work, exceeding original expectations. Of these, we expect that approximately forty countries will want to further the accountability work. A second phase of funding should envisage an updated Country Accountability
Framework, moving towards ONE accountability framework that underpins the various initiatives through a strengthened measurement framework.

Some fragile states that have embraced the concept of accountability have not been able to implement to scale due to lack of stability and weak health systems. Since these are the countries with greatest needs, they should not be forgotten, and other approaches should be explored for them.

**Financing**

As of December 2013 USD 35.4 million has been received from Canada, Norway, United Kingdom and Germany (Table 1).

**Table 1 Funding and Pledges**

<table>
<thead>
<tr>
<th>Donors</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Totals</th>
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<tr>
<td>CIDA</td>
<td>155,300</td>
<td>19,822,162</td>
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<td>19,977,462</td>
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<td>DFID</td>
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<td>796,133</td>
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<td>2,388,420</td>
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<td>4,776,820</td>
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<td>NORAD</td>
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<td>11,553,752</td>
<td>2,995,572</td>
<td>-</td>
<td>-</td>
<td>14,704,369</td>
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<tr>
<td>NORAD/iERG</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>GIZ</td>
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<td>-</td>
<td>884,297</td>
<td>-</td>
<td>-</td>
<td>884,297</td>
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<tr>
<td><strong>Totals:</strong></td>
<td><strong>310,345</strong></td>
<td><strong>32,172,047</strong></td>
<td><strong>5,772,136</strong></td>
<td><strong>2,388,420</strong></td>
<td>-</td>
<td><strong>40,642,948</strong></td>
</tr>
<tr>
<td><strong>Running Totals:</strong></td>
<td><strong>32,482,392</strong></td>
<td><strong>38,254,528</strong></td>
<td><strong>40,642,948</strong></td>
<td><strong>40,642,948</strong></td>
<td><strong>40,642,948</strong></td>
<td></td>
</tr>
<tr>
<td><strong>net psc 13%</strong></td>
<td><strong>270,000</strong></td>
<td><strong>27,989,681</strong></td>
<td><strong>5,021,758</strong></td>
<td><strong>2,077,925</strong></td>
<td>-</td>
<td><strong>35,359,365</strong></td>
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</table>

To date, USD 29.63 million has been distributed. The majority of the funds have gone to countries in support of Country Accountability Frameworks. The remaining funds have been distributed to WHO and partners for implementation of the programme of work, as outlined in the strategic workplan. This includes the multi country workshops where all 75 countries were oriented to the Commission recommendations and started the process for developing Country Accountability Frameworks.

**Funding Gap**

There is a funding gap resulting from the increased demand. There is currently USD 5.8 million remaining until the 2015 project end date. Yet, there USD 10.6 million in immediate commitments for 2014-2015, for countries that will be submitting accountability frameworks, the iERG costs and programme management costs including reporting. This leaves an immediate **funding gap of USD 4.8 million for country catalytic funds**. However, to implement the full range of activities in the strategic workplan, there is a funding gap of USD 50.5 million.

**Future Funding**

This funding gap does not include additional demands for countries implementing their country accountability frameworks. The countries that have fully implemented (or close to fully implemented) the accountability framework will require support to continue the trajectory of strengthening accountability and measurement. The priority for 2014 and 2015 would be to support those countries in a Phase 2.

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2 The strategic workplan amounting to USD 96.5 was revised after the 2012 stakeholder meeting to accommodate additional country demand and iERG recommendations.
Annex 1:

**Commission on Information and Accountability Recommendations**

**Better information for better results**

1. **Vital events**: By 2015, all countries have taken significant steps to establish a system for registration of births, deaths and causes of death, and have well-functioning health information systems that combine data from facilities, administrative sources and surveys.

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

3. **Innovation**: By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.

**Better tracking of resources**

4. **Resource tracking**: By 2015, all 75 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: 1) total health expenditure by financing source, per capita; and 2) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.

5. **Country Compacts**: By 2012, in order to facilitate resource tracking, “compacts” between country governments and all major development partners are in place that require reporting, based on a format to be agreed in each country, on externally funded expenditures and predictable commitments.

6. **Reaching women and children**: By 2015, all governments have the capacity to regularly review health spending (including spending on reproductive, maternal, newborn and child health) and to relate spending to commitments, human rights, gender and other equity goals and results.

**Better oversight of results and resources: nationally and globally**

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

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

9. **Reporting aid for women’s and children’s health**: By 2012, development partners request the OECD-DAC to agree on how to improve the Creditor Reporting System so that it can capture, in a timely manner, all reproductive, maternal, newborn and child health spending by development partners. In the interim, development partners and the OECD implement a simple method for reporting such expenditure.

10. **Global oversight**: Starting in 2012 and ending in 2015, an independent “Expert Review Group” is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission’s recommendations.