TRANSLATING THE RECOMMENDATIONS INTO ACTION

WORKPLAN

September 2011
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Background

The UN Secretary-General’s Global Strategy for Women’s and Children’s Health (hereafter referred to as the Global Strategy) was launched in September, 2010. At least 40 countries and partners have responded to the UN Secretary-General’s call to action with specific declarations of commitment by May 2011. Delivering on these commitments, and motivating other countries and organizations to make similar pledges, is critical for the achievement of the MDGs. At the request of UN Secretary-General, WHO established a Commission on Information & Accountability for Women’s and Children’s Health which aimed to propose ways to encourage countries and their partners to be more accountable for women’s and children’s health.

The Commission has put forward an accountability framework which places accountability soundly at the country level with the active engagement of national governments, parliaments, communities and civil society. It defines accountability as a cyclical process of monitoring, review, and remedy/action. This process is required to assess progress in relation to original commitments and targets, recognize successes and identify problems that need to be rectified in order to more rapidly improve women’s and children’s health. The framework also makes strong links between country-level and global mechanisms and holding donors accountable.

An advance copy of the report of the Commission was released in May 2011 and the final version will be launched on 20 September 2011 by the chair persons of the Commission, President Kikwete from the United Republic of Tanzania and Prime Minister Harper from Canada. The report includes ten recommendations that seek better information for better results, better tracking of resources for women’s and children’s health and stronger oversight of results and resources, nationally and globally. Even though almost all actions have a global and a country component, the recommendations can be organized into actions that are either primarily country or global level. This overall workplan outlines the objectives, main approach, specific country and global actions, roles and responsibilities of partners, and ways to monitor progress of the implementation of the workplan. The draft version of the workplan benefitted greatly from a consultation of stakeholders on 14-15 July 2011, in Geneva.

Objectives

The overall objective is to implement the ten recommendations of the Commission and realize the accountability framework at the country and global levels. The specific objectives are:

- To strengthen country mechanisms and practices to enhance accountability for women’s and children’s health in the 74 countries, referred to in the Commission’s report, during 2011–2015.
- Enhance global accountability mechanisms and practices.

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Approach

The accountability framework of the Commission embraces the Global Strategy’s key accountability principles including:

- focusing on national leadership and ownership of results;
- strengthening countries’ capacity to monitor and evaluate;
- reducing the reporting burden by aligning efforts with the systems countries use to monitor and evaluate their national health strategies;
- strengthening and harmonizing existing international mechanisms to track progress on all commitments made.

The efforts to strengthen monitoring, review and remedy/action should as much as possible be based on ongoing work, aiming to strengthen country and global processes and catalyse further action where needed. At country level, this includes the general work done in the context of IHP+ and related initiatives, focusing on strengthening a comprehensive, integrated and inclusive policy dialogue and robust national health strategies, as well as specific efforts made by maternal, newborn and child health programmes.

Although the Global Strategy focuses on the 49 lowest income countries, the accountability framework aims to apply to all countries and associated stakeholders. Certain recommendations are aimed at the 74 countries that account for more than 98% of maternal and child deaths (see Annex A for list of countries). Countries that have made commitments in the context of the Global Strategy and have expressed an interest and intent to strengthen their accountability processes will be prioritized for support by global partners.

The implementation of the recommendations at the global and country levels will require involvement of a large number of partners. This includes the H4+ agencies (UNAIDS, UNICEF, UNFPA, WHO and the World Bank), bilateral donors, academic and research institutions, projects such as Options, DHIS and MEASURE, private sector and international civil society organizations, and partnerships such as PMNCH and HMN. At the country level, the implementation of the agenda will require participation of governments, statistical offices, civil society organizations, academic and research institutions. In addition, there will be an independent expert review group, which will be supported by a small secretariat at WHO.
1. Areas for action – Country level

At the country level, accountability implies the existence of well-established transparent processes of monitoring, review and action. Monitoring of progress and performance is only possible with a well-functioning health information system to collect, analyze and report health and expenditure data. Reviews should be based on the evidence gathered through monitoring processes and require national institutional mechanisms involving multiple stakeholders. Such reviews need to be systematically linked to actions in-country and provide the basis for mutual accountability between country citizens, country decision-makers and the international community.

The efforts to strengthen country systems should build upon the guidance for Monitoring, Evaluation and Review of National Health Strategies that has been developed by WHO in close collaboration with GAVI, Global Fund and World Bank and many partner and country representatives during the past years in the context of IHP+ and related initiatives. Support to countries to scale up resource tracking for women's and children's health should also be consistent with ongoing efforts to scale up support to countries to track health resources in general.

1.1 Country accountability framework

*Develop framework to enhance accountability based on an assessment of the current situation and building upon ongoing processes in-country.*

*(Commission recommendations 1-6)*

A common framework for the analysis and identification of the gaps and weaknesses in health information systems has been developed and used in the context of IHP+ country situation analyses, including the development of plans for strengthening of country practices in terms of accountability. The general guidance for the assessment and strengthening of country monitoring and review processes is based on a general IHP+ common framework and platform for monitoring and review of health progress and performance, as was used in the country case studies prepared for the Commission. The approach can be used to assess and monitor progress towards greater accountability in the health sector as a whole, as well as for women's and children's health in particular.

Several countries have already conducted such analyses and set priorities for strengthening of the monitoring and review systems relating to health outcomes. Some of these are specific to reproductive, maternal, newborn and child health, such as the MDG4 and MDG5 acceleration frameworks, roadmaps and action plans. Others are focused on the monitoring, evaluation and review of the national health sector strategic plan, as part of a multi-partner effort (e.g. Mozambique, Kenya, Uganda, Sierra Leone, Benin, Nepal). In these countries it will be relatively straightforward to expand the work to include a greater focus on women and children's health, linked to the Commission's recommendations. Monitoring frameworks also need to be expanded to include greater focus on resource tracking and accountability, and capacity should be strengthened to support budgeting and expenditure tracking for reproductive, maternal, newborn and child health as well. In addition, the framework should also

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http://www.who.int/topics/millennium_development_goals/accountability_commission/Summary_report_country_case_studies.pdf
cover specifics on how the information and communication technologies (ICT) can be used most effectively. In addition, the establishment or strengthening of the institutional, political and legal mechanisms is critical to ensure the accountability of key stakeholders for balanced priority setting, mobilizing resources and delivering results.

Key steps to developing the country framework to enhance accountability in the targeted countries are:

- **Country commitment to Global Strategy**: declaration of commitment (with specific goals) by countries in the context of the Global Strategy: over 40 countries have already made written commitments to the Global Strategy. In many cases, these commitments are coming from the national MDG4 and MDG5 acceleration plans. In other cases, they include reinforcement of previous general commitments such as those made in the Abuja declaration on targets for government health spending.

- **Country commitment to enhancing accountability**: highest level of political engagement is required to forward this agenda. Partners strongly recommended that the co-chairs of the Accountability Commission write to the political leaders of countries listed in the Global Strategy and seek their engagement. This letter shall present the report, refer to the recommendations of the Commission and invite countries to implement those recommendations. The letter may also refer to current high level statements to promote maternal and child health such the action plan agreed upon at the 15th African Union summit in Kampala, July 2010.

- **Assessment, framework, roadmap**: the country framework and roadmap will be based on a brief systematic assessment of the monitoring, review and remedy/action practices and mechanisms, if such an assessment has not yet been done. In many countries, pulling together the existing assessments and activities would provide an excellent basis. The gaps will be identified using a common approach based on the global accountability framework and form the basis of country action to improve accountability during 2011–2015. The framework and roadmap development will involve consultation with the relevant partners in-country, building upon existing efforts.

- **Fragile contexts**: global partners will make a special effort to engage fragile states and countries with low government capacity to ensure that those countries - where the burden of maternal and child mortality is often highest – are well represented.

- **Regional processes**: to accelerate the process of development and stimulate a process of regional peer review among countries regional workshops will be organized. It is noted that if there are existing mechanisms for regional interaction these should be used. In a workshop teams from 5-7 interested countries will be invited. The aim is to assess the country situation using the overall accountability framework, set priorities, and develop a roadmap 2011–15 with proposal for catalytic funding, as well as facilitate a regional peer review process. Each country should be presented by a team including representatives of Ministry of Health, relevant other sectors (e.g. Ministry of Finance), and academic or other institutions; development partner community and/or from an international organization (H4+); leading civil society organization active in women’s and children’s health.6 The country framework and roadmap should be finalized in country by the team.

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6 The workshop will be organized by WHO, with technical facilitation by key partners including regional institutions and expertise linked to development partners (e.g. Options, CDC/MEASURE, IDRC, University of Oslo). The country teams will come prepared with the relevant documentation. The workshop will cover:
- accountability framework and practices in relation to the national health sector strategic plan
- practices and capacity to track resources and expenditure on health; registration of births, deaths and causes of death; monitoring health progress and performance, with special reference to RMNCH
- identification of the priority gaps and challenges and
- development of a roadmap with priority areas for a roadmap.

At the end of the workshop, a draft document will be ready and taken to the respective countries for further discussion with key partners and completion. A consultant (member of the country team) will be responsible for leading this process and the production of the final document within 4 weeks after the end of the workshop.
that attended the workshop, after consultation of key actors in country. The workshops will be organized by WHO in close collaboration with partner organizations.

**Catalytic core funding:** the framework and roadmap will be developed by the country in consultation with partners. Catalytic core funding can be requested. The selection of proposals for funding will be facilitated by a small committee including multiple partners and coordinated by WHO. Much of the funding for the country activities however will have to come from domestic and external in-country sources. In many countries, there are funded existing project activities that are contributing significantly to the enhancement of accountability.

**Peer review:** the processes also aim to develop a mechanism for regional peer review mechanism which could include a web-based review system and regional meetings in which countries may hold each other accountable for progress. The regional processes will also be an important input into the global review process.

### 1.2 Better monitoring

*Strengthen country health information systems, including strengthening of civil registration of births and deaths and financial tracking systems, supported by innovative ICTs.*

*(Commission Recommendations 1-6)*

#### 1.2.1 Monitoring the 11 core result indicators

The Commission proposed to focus reporting requirements on the core set of coverage, outcome and expenditure indicators to reduce duplicative reporting requests and allow countries to better measure progress against Millennium Development Goals 4 and 5 by 2015, enabled by strengthened health information and financial reporting systems. Currently, there are major gaps in data availability and quality in many countries.

Strengthening country health information and financial reporting systems will be essential for accountability. The HMN/WHO framework for health information systems provides a good starting point for the consideration of the different elements of an effective system for tracking results and can easily be applied to women’s and children’s health issues.

A recent review of the general situation in countries has been completed and a specific report on the situation with regard to health information for MNCH will be released in September. The review showed that multiple weaknesses in country health information systems continue to hamper the accurate monitoring of progress and performance, and reinforced the relevance of previous recommendations to strengthen such systems, made by the heads of eight global health agencies (the H8) and the Global Health Information Forum in 2010.

Accountability for results requires a mix of reliable, regular disaggregated administrative, facility and survey data presented in a transparent manner with data quality issues systematically addressed, including independent verification of the quality. Innovation through the appropriate use of ICT will be essential to strengthen the facility and administrative data sources, which are needed for annual reporting of progress of health service delivery and coverage, including some of the priority indicators selected by the Commission. Also effective dissemination of results to all stakeholders can greatly benefit from ICT.

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Prevention of mother to child transmission of HIV is one of the 11 indicators. The recent launch of the "Countdown to zero", which describes the global plan on elimination of HIV transmission to children, will have implications for monitoring efforts at the country level. This provides a unique opportunity to link between MDG6 and MDG 4 and 5, between HIV/AIDS and MNCH, and address information and accountability more broadly.

The 11 core result indicators are intended as tracer indicators of progress in women's and children's health. For more detailed progress monitoring and programme management additional information will be required, including other proven indicators of reproductive, maternal, newborn and child health as well as investments in better measurement of the quality of care. Quality means safe and effective care that is a positive experience for the user. Disaggregated data should also be collected as they are especially important for a complete assessment of equity and the right to health of all women and children.

The key activities will focus on implementing the country plan with the country priorities. The priority activities required to improve monitoring may vary between countries. The activities should be part of the country framework and roadmap and may include:

- **M&E system**: development of strong national monitoring and evaluation component for the health sector strategic plan with appropriate focus on women’s and children’s health that meets the main criteria for accountability, including information on coverage as well as quality of healthcare services.

- **Data quality**: strengthening the data quality assessment and adjustment mechanisms by regular independent verification through a facility record review and service delivery assessment (e.g. prior to an annual health sector review), and use of transparent analytical methods. Independent assessments of data quality to objectively inform the reviews are important and should be institutionalized (recommendation 7).

- **Equity**: enhancing the disaggregation of data and statistics better track and target disadvantaged populations, including gender, age, residence, geographic location, socio-economic position and ethnicity, and where feasible and appropriate, other demographic characteristics and HIV status.

- **Capacity**: building analytical capacity to conduct a stronger annual health sector review, involving multiple country institutions, using data from multiple sources including facility and survey data, budget and expenditure data. At all levels of the health system, especially districts, there needs to be greater capacity for health information, including collection and use of information.

- **Transparency**: development of a national health data repository or warehouse, to enhance data sharing and transparency.

- **Harmonization and alignment**: strengthening one country-led M&E platform to which all partners adhere and invest in.

- **ICT**: development and implementation of a comprehensive eHealth strategy to improve monitoring. This includes development and use of standards and focus on the issue of interoperability of records and data sets.
1.2.2 Strengthen registration of births and deaths

Counting of births and deaths with a cause of death is a critical element of accountability for many reasons. Countries should develop plans to improve reporting of births, deaths and causes of death. Political commitment to strengthen a civil registration and vital statistics system will be critical. Innovation through information technology can help overcome some of the traditional obstacles.

The Commission called for the development of country plans to strengthen civil registration and the collection of vital statistics supported by innovative approaches. These plans should be an integral part of country framework to augment accountability. The efforts to strengthen registration of vital events should be based on a detailed assessment of current practices and a large number of stakeholders in-country. HMN has begun to work with countries and partners on catalyzing such systems through the Monitoring of Vital Events for the MDGs through Innovation initiative (MoVE-IT)\(^\text{11}\), while the UN Statistical Division has also put the strengthening of civil registration vital statistics systems higher on the agenda. The efforts will need to be expanded, so that recommendation 1 (by 2015 all countries have taken significant steps to establish a system for registration of births, deaths and causes of death) will be achieved.

This will require development of standards and tools in support of system building, data collection and analysis. The UN Statistical Division is leading the work on birth and death registration, in close collaboration with WHO/HMN which guides the cause of death recording and reporting work. It will also involve support to policy, legal and institutional reforms that provide the underpinning of country civil registration systems; and harnessing of innovation in registration, data collection and analysis.

A specific improvement that all countries should aim for is the establishment or strengthening of a system of maternal and perinatal death audits. A system of audits or reviews is primarily aiming at improvement of the quality of care. It can however contribute to better statistics on maternal mortality and morbidity. This requires a comprehensive reporting to national levels through ICT and a sound system to respond with effective action to such reports. National and district capacity for such a system will need to be strengthened.

Key activities include:

- **Assessment and plan**: countries should complete a systematic assessment of the current status of the system to monitor birth, death and causes of death, using a standardized tool.\(^\text{12}\) The assessment should form the basis for a civil registration and vital statistics system plan that leads to significant progress by 2015 and a fully functioning system by 2020. The HMN MoVE-IT initiative has initiated this work in selected countries and should expand the support of countries. This involves a wide range of partners, including statistical offices, Ministries of Health, UN agencies and academic institutions.

- **Innovation**: application and evaluation of innovative techniques, including ICT, to ensure that every birth and every death, including cause, is registered, certified and accounted for, and that registration systems yield reliable statistics.

- **Capacity building**: country plans and global support should include capacity building, e.g. for application of WHO standards including ICD codes, accurate identification/compilation and analysis of causes of deaths, especially in relation to deaths of women of reproductive age.

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\(^{11}\) The first phase of HMN’s MoVE IT involves innovative and policy-related projects and processes in 13 countries in Africa and Asia, supported by a $3.6 mln investment by HMN.

Advocacy and social mobilization: while the focus initially may be on those countries where governments are committed to and investing in strengthening civil registration and vital statistics systems, advocacy will be needed to bring other countries on board and sustain the process. This would involve many global and country actors such as UNESCAP, UNECA, HMN, civil society, UNICEF etc.

Maternal deaths reviews: implementation of direct accountability and improvement mechanisms including, regular reviews and confidential enquiries into maternal (and perinatal) mortality in order to identify key actions that will help avert such premature and avoidable deaths. Where possible, the system should also include reviews of "near misses" which will further help focus actions on service access and quality of care issues.

1.2.3 Strengthen resource tracking

Monitoring of results and resources is a function of a country’s health information system. Data on both results and resources are needed for the accountability process of monitoring, review and action. Financial data however are often derived from different data sources and undertaken by different people than those involved in tracking results, so they are presented separately in this work plan.

Only 130 countries have produced health expenditure estimates using the set of consistent methods found in the system of health accounts, and only a third of them have adequate capacity to do this consistently. Few of those are among the 74 countries targeted by recommendation 4. The other countries report some expenditure data annually, largely restricted to budgets and audited accounts for central government departments. Each year WHO works with its country resource tracking contacts and other agencies to identify as much data as possible and collates this into its resource tracking data base which shows variables such as total health expenditure and government health expenditure for all 193 Member States. A selection of the indicators in the full data base is published annually in World Health Statistics and in the Global Health Observatory. The IMF also collates and reports government expenditures, including for health, in many (though not all) of its member countries while various agencies such as the World Bank and the regional development banks support countries to undertake various forms of public expenditure reviews.

However, frequently it is difficult to obtain information on health expenditure by lower levels of government, by government departments other than health, by external partners in the country, or in the private sector (NGOs, private enterprise and households). This is one of the reasons for recent strengthened collaboration between IMF and WHO to review the information on government expenditures on health each receives and reports, and for the activities by WHO, the World Bank and USAID, for example, to support countries to develop the capacities to track and review overall health expenditures.

Few countries have been able to report expenditures on women's and children’s health using consistent methods, even once, let alone routinely. For example, only seven countries have produced estimates of spending on child health to date through child health sub-accounts. Often external consultants have been important in undertaking the work and country capacities to replicate this are weak. Recent efforts by WHO to collect information on government expenditure and budget allocation to reproductive, maternal, newborn and child health through a country survey also had limited success with only 15 out of the 74 priority countries being in a position to report some estimates of their expenditures. Accordingly, some 22 countries will be reviewing preliminary data on

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14 www.who.int/nha

their government expenditures on child, maternal health and family planning expenditures at regional workshops organized by WHO later in 2011 involving technical experts from other agencies.

It is, therefore, a very ambitious target set by the Commission in recommendations 4 and 6, that the 74 countries accounting for the major part of maternal and child mortality should have the capacity to track and report overall expenditures, by source (e.g. government, households, NGOs, private sector and external partners), including expenditures on maternal and child health.

Key activities to address these issues:

- **Resource tracking in country plans.** Reviews of county capacities to collect information on health expenditure in general have been done already for most of the 74 countries as part of ongoing work involving the World Bank, WHO, USAID and more recently, OECD, with the BMGF. However, their capacity to collect, review and act on information relating specifically to budgets and expenditures on women’s and children’s health should be an integral part of the framework. The aim is to help countries take the driving seat, identifying what they need for their own policy purposes, and what they can do in the area of resource tracking as well as for results.

The situation and the subsequent need for technical support, will differ markedly across the 74 countries. Countries begin at different starting points, and their ability to scale up rapidly to track all health expenditures, and those on women’s and children’s health, differ markedly. A few have already undertaken full national health account studies, so they would be able to begin to undertake “sub-accounts” for women’s and children’s health quickly with relatively limited technical support. Others have less capacity, but could start by tracking government budgets and expenditures (not just the ministry of health, but all central ministries that provide or fund health services and sub-national levels of government) before they are able to allocate them to women’s and children’s health. Still others will need support to undertake the part of the activities dealing with expenditures to understand the options for collecting the necessary expenditure information and how it will contribute to country policy objectives and the process of accountability.

- **Technical support to countries.** The specific needs for technical support will emerge from the situation assessment and priority setting. It is proposed that a person from the health accounts team in WHO would take responsibility for coordinating with the key agencies already involved in resource tracking in low- and lower-middle income countries (e.g. World Bank, USAID) to identify which countries need support to undertake the resource tracking component of the roadmap, what support is requested, and then to ensure that each country obtains the support they need from an appropriate source. Some countries would be in a position to identify the technical experts they want to support them and the country catalytic funding could pay for this. Others will request the coordination person to identify appropriate support. In order to ensure that the target of 50 countries providing estimates within the time frame is met, the participating agencies will need to draw on the support of external technical experts such as those involved in the Countdown initiative.

The principles guiding this work will be:

- Move rapidly but seek to complement ongoing efforts to scale up support to countries to track overall health resources. The first phase of this broader exercise was funded by BMGF and involved mapping out country progress and current capacities to track health resources in general. Proposals for how to meet the identified country needs are now being discussed between the three agencies that have supported country efforts to strengthen over the last decade – WHO, WB and USAID with BMGF and outside technical experts. OECD has recently joined the discussions.
- Adapt subsequent technical support to country needs and capacities shown in the country accountability framework, recognizing that some countries will need support during the exercise. All countries should be able to track government expenditures and expenditures from external sources during the proposed time frame and the goal would be to ensure they can allocate these expenditures to women’s and children’s health as well. Some countries would be able to track private sector (including household) spending as well.

- Use consistent methods to ensure comparability of country data over time. Methods to allocate expenditures to specific diseases or programs have been developed as a collaborative effort between different agencies (e.g. the Reproductive Health Resource Tracking Guide was prepared by WHO, USAID, UNFPA, NIDI, IDB and PMNCH)\(^\text{16}\), and these guidelines should be used. Ongoing work is required to further refine and harmonize existing tools to collect the required data, such as WHO’s annual reporting survey that collects information on expenditure on reproductive, maternal and child health, and UNFPA’s support to NIDI surveys for reproductive health.

- Build capacity to routinely undertake this type of analysis. A multiagency strategy is currently planned to organize intensive capacity building workshops during which countries are supported to estimate current spending on child and reproductive health using available data, but this requires the support of all key partners if results are to be achieved in the short run (2011 and 2012), while the in-depth technical studies are carried out in selected countries over the longer run. The workshops are planned specifically with the main focus to build Ministry of Health (MOH) capacity on expenditure tracking mechanisms including the collection of data through the use of the survey tool that has been developed, and extracting relevant data from other sources available, including other tools such as the UNFPA/NIDI surveys for reproductive health.

- **Tracking country promises**: Over 40 countries with the greatest burden of women’s and children’s ill health have made written commitments to the UN Secretary General’s call for action. Some involve explicit or implicit commitments relating to resources. Sorting out what this means in terms of expenditures can be complex, and the PMNCH has an ongoing activity to interpret and report on these commitments to help with the review and action components of the accountability framework.

### Compacts for tracking resources spent by external partners in a country

The resources that donors report to the CRS data base (OECD) showing how much they have committed or disbursed on health for low income countries do not reflect how much money arrives in countries for them to spend on improving health. A considerable portion of donors’ reported development assistant to health does not reach the countries, but is either spent in home country institutions, on technical support controlled by the donor, and on their own administration expenses. In some countries, however, these are the only data that are available because external donors have been reluctant to report to the host country how much they spend in that country, and on what. Rwanda has been very successful in developing a method of “mutual accountability” through which the host government and external partners report and discuss their proposed expenditures each year, then report on actual expenditures at the end. This experience needs to be replicated for countries to have the data they need to track expenditures on women’s and children’s health in their settings. This will require sharing the Rwanda methods and experience, and empowering countries to strongly require this ethical behaviour from external partners. A full sub work plan needs to be developed.

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1.3 Reviews and action

Establish/scale up of country review and action mechanisms
(Commission recommendations 5 and 7)

The Commission urged the establishment or scale up of national level accountability mechanisms that are transparent and inclusive of all relevant stakeholders for national level review and action on women’s and children’s health, including the engagement of parliamentarians in these efforts, by 2012.

The engagement with countries (activity 1.1) will provide an assessment of current practices in terms of using monitoring data in country review processes for action. It should include an assessment of current mechanisms for review and subsequent action or remedy to address deficiencies. In line with the Commission’s principles, the primary aim is to strengthen existing processes and only to encourage the development of new processes where there are current mechanisms are inadequate.

Many countries already regularly review progress and performance in the health sector against country health plans and international goals. Existing mechanisms for review and action are often based on many years of experience with Sector Wide Approaches (SWAp) in the health sector. The involvement of higher political levels generates better progress on women’s and children’s health and helps strengthen crucial political will. Any approach should ensure that the health sector strategy is well-linked with the broader development goals and planning processes, notably the national strategies for growth/development and poverty reduction. This may imply structural involvement in the health sector accountability processes of, for instance, the prime minister’s or the president’s office.

The Commission’s report also provided potential options to strengthen review mechanisms in countries, including the establishment of a national commission for women’s and children’s health and the engagement of a health ombudsman in reviews. Other options include strengthening the engagement of ministries of finance and other financial decision makers, such as the parliamentary budget and finance committee, by enhancing their capacity to catalyse efforts towards more efficient health spending and, sometimes, more health spending. The involvement of the Head of State in issues related to women’s and children’s health will be critical.

Country health sector reviews and planning summits are often conducted on at least an annual basis with variable, and at times insufficiently inclusive stakeholder involvement. Development partner participation is often prominent, but the civil society role may be less clear and needs to be strengthened and formalized. Given the need to address the social determinants of health, actors outside of the health sector, such as water & sanitation and nutrition, also need to be involved. An increasing number of development partners are committed to aligning themselves with an inclusive and country-led monitoring and review platform as part of the national health strategy, which is promoted as part of the IHP+ principles.

Improving women’s and children health, and especially goals and indicators linked to the health MDGs, is prominent in health sector strategic plans. Often, more than half of the indicators are related to reproductive, maternal, newborn and child health. Most countries have established accountability mechanisms for national level review and action on women’s and children’s health as an integral part of the health sector reviews, given the emphasis on the MDGs. Many countries have developed roadmaps and plans to accelerate progress towards MDG4 and particularly MDG5. The commitments to the Global Strategy are linked to these national strategies and are perceived as an additional opportunity to strengthen the implementation of these strategies.

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17 Report of a meeting on “Increasing health outcomes in countries by engaging and developing stakeholder (MOH, MOF, parliamentarian budget and finance committee) to capacity to catalyse efforts toward efficient health spending, Oslo 14-15 May 2011.
Key activities to strengthen review and action would include:

- **Strengthening of health sector reviews** to include a broader array of stakeholders, including users and health workers, informed by objective well-communicated assessment of progress, and leading to effective translation of the results into action for the coming year(s).

- **Improve capacity** to correctly use monitoring data on results and resources, including equity issues, for decision making and health policy. Programme managers should be supported to link outcomes to expenditure data and programme process indicators. National peer review mechanisms, such as expert review group, would be supported by international practitioners, who do this work routinely, through technical support to discuss how the data were obtained, and what could be done better.

- **Enhance capacity of financial decision makers**, including Ministry of Finance and parliamentary budget and finance committees to catalyse efforts towards overall efficient health investment (and women’s and children’s health in particular) through evidence based and results oriented budgeting. This has to be part of overall improvements in the policy dialogue between Ministry of Health, Ministry of Finance and other decision makers.

- Establishment or strengthening of fora where users, health workers, authorities and other stakeholders can voice their respective concerns and engage in a meaningful ongoing social dialogue about the performance and strategic directions within the health sector.

- **High level political events** focusing on women’s and children’s health to gain further support and accelerate progress for RMNCH and ensure for instance greater engagement of parliamentarians. A country Countdown 2105 or similar event in which monitoring data are presented in a powerful manner to key decision makers and politicians in such an event which should be held at least once every two years in every country. Involvement the head of state is critical.

- **Greater transparency and documentation** of the process of decision making through publications and web-sharing of documents.

### 2. Areas for action – Global level

The global accountability agenda should support the implementation of the recommendations in countries. In addition, several of the Commission’s recommendations are specifically addressed to the global level including recommendations (2) harmonization of reporting around core indicators with appropriate disaggregation by gender and other equity issues, (8) public sharing of commitments, resources provided and results achieved, (9) improved reporting on reproductive, maternal, newborn and child health spending by development partners, and (10) establishing an independent Expert Review Group.

#### 2.1 Global monitoring

*Develop/strengthen global databases, improve data access and produce progress reports (Commission recommendation 8)*

Several national and international interagency groups, technical organizations and academic institutions publish regular reports that address many elements of global oversight. They monitor and review different aspects of women’s and children’s health and recommend action. This work should continue and be strengthened.
UN agencies, in close consultation with external expert groups, compile and analyze data from countries, develop estimates for key health indicators, and report on a regular basis about progress towards the MDG and other goals. These efforts result in the publication of, for instance, UNICEF's State of the World's Children and WHO's World Health Statistics. These reporting processes will benefit from further investments in better country data and reporting as proposed above, aiming to minimize the extent to which progress monitoring relies on predictions rather than actual data. Global processes can benefit country monitoring of progress.

At present, household surveys, notably MICS and DHS, are the mainstay of monitoring progress in most countries. Only for some indicators such as DTP3 coverage extensive use of facility reported data is made by WHO and UNICEF. To improve and expand monitoring regular disaggregated and facility data are required on for instance skilled birth attendance in addition to regular household survey data. Such data are collected by countries, but often not stored, analysed and disseminated effectively. Global partners, notably the UN partners, should work with countries to improve these functions and compile and analyse such data globally in addition to existing work.

The Countdown for Maternal, Newborn and Child Health to 2015 consists of representatives of academic and research institutions, civil society organizations and UN agencies. The Countdown was created as an independent technical process synthesizing the progress in coverage of interventions aimed at reducing maternal, newborn and child mortality, disseminate the information and advocate for MNCH among key policy makers at national and international levels. Bi-annual progress reports and occasional in-depth analyses are produced. In addition, academic institutions produce monitoring reports or academic publications, either in collaboration with the UN (e.g. Johns Hopkins University, Imperial College, or London School of Hygiene of Tropical Medicine) or independently (e.g. Institute for Health Metrics and Evaluation).

In order to improve the global monitoring and inform the review process the following activities are required:

- Strengthening of country health information systems (see first section).

- Intensified collaboration between global partners and countries and among global partners including key UN agencies to strengthen country monitoring and make data available to the global level, including disaggregation where possible and relevant.

- Expand global databases: the current focus is predominantly on national statistics, often with only limited disaggregation, internationally available survey data (notably MICS and DHS) and on predicted estimates (which should be used to monitor progress). Expanded databases should include facility and disaggregated data on the core indicators based on a continuous working relationship with the countries, which required to feed into regular progress monitoring and data use processes.

- Access: Improve access to data and metadata through existing and new dissemination platforms.

- Enhance analysis and reporting: the analysis function of the Countdown 2015 needs strengthening to allow it to produce more regular (annual or bi-annual) reports and more in-depth analysis.

- ICT: Acceleration of the processes required to develop required standards for increased interconnectivity and common standards, requiring close collaboration between existing initiatives and bodies to support such as Broadband Commission, Digital Health Initiative, the World Bank, the Innovation Working group, UN-DESA, etc.
2.2 Resources

Financial tracking/tracking commitments
(Commission recommendation 9)

The Commission recommended that global partners support efforts by the OECD to improve the creditor reporting system (CRS) to better capture aids flows and financial data on maternal, newborn and child health. This will require investment and political commitment. For example, the Geneva consultative meeting on this work plan suggested that the countries that support the Commission recommendations will need to inform the statisticians of their own bilateral agencies that this change should be supported. These statisticians are members of the OECD Working Party on Statistics which will need to agree to the proposed changes.

In addition, methods will need to be developed to allocate expenditures to women’s and children's health, while also being able to identify expenditures on the other priority conditions such as HIV, TB and malaria. The OECD may well need financial support to modify its CRS, while the current players in the area of national health accounts methods will need to contribute to methods for allocating donor expenditures to women's and children's health so that all countries and agencies who report to the OECD (including those who report voluntarily) have a stake in changing the way they report aid disbursements.

Given that this will take time, some estimates of donor commitments and disbursements to women's and children's health will still need to be made using ad-hoc methods. At the recent UNGASS session three sets of estimates of these expenditures were presented, all based on the same information. They were quite different. This does not reflect a lack of skill on the part of the people who produced the estimates, but the lack of information in donor reporting to the CRS data base. Many assumptions need to be made, and 100 experts will come up with 100 differing estimates. Accordingly, in the interim period, it would be best that one group does the ad hoc estimates annually, and preferably, the same person/people each time to ensure consistency of assumptions. Otherwise, any change from year to year may reflect only the differences in assumptions made about uncertain data.

Key activities:

- Invest in revising the CRS with the aim to have complete reporting on maternal and child ODA by donors by 2013.

- Cross agency contributions to the development of methods for allocating donor commitments and disbursements to women's and children's health.

- One group has been responsible for the ad hoc estimates: Countdown to 2015, with support from PMNCH, has been coordinating this work, and might wish to continue this process.
2.3 **Independent Expert Review Group**
*(Commission recommendation 10)*

In response to Recommendation 10 (Global oversight), starting in 2012 and ending in 2015, the independent Expert Review Group (ERG) 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.

The independent ERG members are recruited and selected through a transparent process as acknowledged experts from around the world in the fields of, health information systems; health financing; particularly practical experience in tracking resources; maternal and child health; and human rights, equity, and transparency. The membership of ERG shall seek to reflect a representation of national and international public sector, civil society and the private sector. Members will be selected on the basis of their qualification and ability to contribute to the accomplishment of global oversight’s objectives.

The following criteria will be used to assess candidates:

- relevance of education, technical background and related knowledge and skills;
- depth and breadth of experience;
- demonstrated leadership in the fields of accountability.

Members of the ERG have a responsibility to provide high quality, well considered advice and recommendations. In fulfilling its mandate, the ERG will draw extensively on existing data, reporting and assessments at country and global levels, in particular through national accountability frameworks, to avoid duplication, fragmentation and increasing transaction costs. The group will synthesize available information and evidence, and draw its own conclusions in order to make recommendations in an Annual Report.

Annual Report of the ERG, of approximately 25 summary pages plus annexes, will highlight the key areas of progress and challenges in implementation of the accountability framework as part of the Global Strategy and identify areas that need greater attention and support.

Key principles underpinning the work of the ERG are partnership, independence, transparency, credibility and efficiency. As much as possible, the public will be provided with the opportunity to participate in the review process.

Members of the ERG shall be appointed to serve for the entire life cycle of ERG, (2011–2015). The Chair will be selected from among the ERG members and may serve for a maximum of two years in
Chairmanship capacity. The list of ERG members and related biographical information will be made publicly available on the Commission's website.

The ERG will be supported by a small secretariat hosted by WHO. While the plan of work will be established once the members are confirmed, it is foreseen that the Annual Reports of the ERG will be made public in September of each year in order to be available for consideration in advance of the UN General Assembly.

An evaluation of the ERG mechanism in 2014/15 would be desirable to learn and assess its performance and relevance beyond 2015.

2.4 Outreach and engagement

Outreach is required to promote the implementation of the Global Strategy and Accountability Framework, and steps that should be taken in order to implement the broad agenda for action. The likelihood that recommendations will be taken up is directly proportional to the number of people who are informed and who can discuss them. Commissioners have a critical role to play. They can be spokespersons for the implementation of the recommendations at the highest level. However, there is a role in outreach for many of the stakeholders.

There are many high level political and other events that will be used to advocate for women's and children's health and the accountability agenda:

- An outreach and communication strategy will need to be developed. A calendar of events is one of its components. The PMNCH and Every Women and Every Child website already have such calendars of events. PMNCH will play a critical lead role in the action item.

- Among key meetings at which the Commission's recommendations should be on the agenda are:
  - World Health Assembly: in May a resolution was adopted
  - G8 meeting: was on the June agenda
  - Africa Union
  - World Bank: constitutional meeting of the World Bank are an important avenue to tap since it involves ministers of finance. A next high level event is the meeting of the high level task force on health financing in Busan, Korea.
  - Human Rights Council has maternal mortality on the agenda for its next meeting and the report of the Commission will be presented.

- The Inter Parliamentarian Union is a key partner to influence the role of parliaments and build capacity of parliamentarians for promoting investment in RMNCH and providing oversight. This also includes the global Countdown conference in 2012, organized with the IPU.

- Collaboration should be extended to other sectors, such the nutrition community. Outreach should involve organizations like WFP, UN Foundation and others.

- Further engagement has to be sought in the community that deals with tracking resources, e.g. USAID, World Bank, OECD, Bill and Melinda Gates Foundation, and academia.

- Technical guidance should be developed for countries that will not fall within the direct remit of the Global Strategy but who are still ready to commit and follow-up on the recommendations. This is critical for, for instance, the countries in Latin America and the Caribbean.

- There are many opportunities for advocacy at national and regional level and it is important to keep sight on these, in addition to the global level. A concrete example are WHO regional committees.
3. **Roles and responsibilities**

3.1 **Country governments**

- Make explicit high level/head of state commitments to the Global Strategy goals and intent to improve accountability.

- Complete a brief situation analysis and develop a country plan for augmenting accountability (1a), including monitoring, review and action.

- Develop a plan and take concrete steps towards the improvement of civil registration and vital statistics.

- Develop comprehensive plans and monitor progress towards the core indicators, including the 11 core indicators, and making effective use of ICT.

- Institutionalize maternal and perinatal death audits in health facilities and communities and establish a mechanism to review findings and take appropriate action, supported by a national policy on maternal death notification.

- Establish a system of monitoring, review and remedy/action that meets the IHP+ criteria as formulated in the IHP+ Guidance for monitoring, evaluation and review of national health strategies document.

- Organize events that keep RMNCH high on the political agenda during 2011–15, such as a country countdown.

- Prepare a plan to assess, collect and analyse health expenditures in general and MNCH expenditures in particular.

- Develop a compact with bilaterals and other development partners operating in the country for them to report on their health aid expenditures in the country, particularly those that are off budget.

3.2 **Bilateral donors, foundations, global initiatives and other global stakeholders**

- Make explicit high level/head of state commitments to the Global Strategy goals and intent to improve accountability.

- Support the work plan to implement the Commission's recommendations.

- Convene a coalition of partners to develop a plan for assisting countries in monitoring and evaluation through strengthened health information systems.

- Ensure transparent reporting of commitments and disbursements at the global level and expenditures at the country level.

- Provide support to the revision of the OECD CRS revisions.

- Collaborate with development partners to reduce the reporting burden on countries.

- Support one country-led monitoring, evaluation and review platform as part of country national health strategies, as advocated through IHP+ compacts.
3.3 **Civil Society Organizations**

- Support the work plan to implement the Commission's recommendations.
- Convene a coalition of partners convened to develop a plan for assisting countries in strengthening health information management systems.
- Ensure transparent reporting of commitments etc.

3.4 **PMNCH**

- Facilitate inclusion of all stakeholder groups in global and national policy and accountability processes through the multi-stakeholders platform.
- Countdown to 2015 (secretariat hosted by PMNCH): Assist interested countries to request national Countdown exercises, to link national and global Countdown actors and to advocate for Global Strategy monitoring; provide support to the advocacy and analysis work of the Countdown 2015.
- Disseminate the Commission report and facilitate debate and consensus-building, as well as consideration of the perspectives of all relevant stakeholders in follow-up processes to the Commission, through the PMNCH advocacy network and multi-constituency platform.
- Facilitate partner support in strengthening the capacities of Ministries of Finance and Parliaments to budget for health, and to monitor expenditure.
- Catalyze annual reporting on the implementation of commitments to the Global Strategy through the PMNCH 2011 Report.18
- PMNCH, with partners, is developing an innovation framework to highlight areas where ICT is most needed to improve RMNCH and to guide stakeholders’ engagement and development of public-private partnerships.

3.5 **Health Metrics Network**

- Galvanize and support the country and standards work on strengthening civil registration and vital statistics systems through its MoVE-IT initiative, in the context of strengthening of country health information systems.
- Contribute to the development of country plans to augment accountability and regional country peer review processes.

3.6 **Countdown 2015**

- Produce regular analyses and progress reports on the 74 countries with the highest burden, including the 49 lowest income countries.
- Analyse and report country specific information on resources for the 74 countries.
- Enhance dissemination, interpretation and use of data at the country level and global level.
- Conduct cross cutting and in-depth analyses of progress towards the MDG goals, including a focus on the Commission indicators.

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3.7 **WHO, UNICEF, UNFPA, World Bank, UNAIDS**

- Run secretariat and provide support to the ERG (WHO).

- Lead/contribute to the development of country framework and roadmap to enhance accountability and regional peer review processes (WHO/all).

- Coordinate and provide country technical assistance to improve monitoring of results and resources, and strengthen country reviews (all).

- Improve country data availability and analysis, e.g. through MICS (UNICEF), facility assessments and better analysis including data quality control (all).

- Strengthen current data bases on MNCH core indicators with more disaggregated data and more intensive interaction with countries (UNICEF, WHO, UNAIDS, UNFPA).

- Provide annual updates of progress for the core indicators through regular analyses as appropriate and statistical reports (WHO, UNICEF).

- Ensure strong linkages between M&E of HIV/AIDS and MNCH at country level, especially in the context of the global elimination of mother to child transmission of HIV (UNAIDS, WHO, UNICEF, UNFPA).

- Coordinate the work to build country capacity to track resources and to improve the quality of data and ensure the necessary technical support to countries is available (WHO, World Bank with USAID).

- Review existing approaches and further develop methods to track resources for specific diseases or programs at country and global levels (with OECD as well for global tracking) and support countries doing this.

- Report annually on health expenditures, including those related to women's and children's health.

- Help countries to "encourage" external partners in the country to report to the host country on their expenditures.

3.8 **OECD**

- Revise system of tracking external resources (particularly disbursements) for MNCH; facilitate complete reporting by all development partners including private foundations.

- Continue to expand coverage of the donor community reporting their contributions to the CRS data base, particularly private foundations.
4. Monitoring progress: indicators and targets

The following table presents the indicators, targets, lead partners by the ten recommendations of the Commission.

Table 1. Commission’s recommendations with primary focus areas

<table>
<thead>
<tr>
<th>Action Item</th>
<th>Indicator / targets</th>
<th>Lead partner</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop country plans to augment accountability that are based on a rapid assessment and address priority areas for strengthening national accountability processes</td>
<td>At least 50 countries have made commitments and completed COPAAAs by 2013</td>
<td>Countries: governments, other institutions</td>
<td>(Workplan 1.1)</td>
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<td></td>
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<td>With TA from UN, bilaterals, academic institutions</td>
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<td>Partnerships, CSO</td>
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<tr>
<td>1. By 2015, all countries have well-functioning health information systems, including surveys, facility and administrative sources, and have taken significant steps to establish a system for registration of births, deaths and causes of death</td>
<td>At least 50 countries have completed an assessment and developed a plan, and have taken significant steps towards implementation by 2015 (&gt;20 by 2013)</td>
<td>Countries, multiple sectors involved</td>
<td>Strong country commitment to CRVS strengthening critical;</td>
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<td></td>
<td></td>
<td>HMN/WHO and UN Statistical Division</td>
<td>Expanding the HMN MoVE-IT initiative</td>
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<tr>
<td>Strengthening of country civil registration and vital statistics systems (CRVS), to better count maternal, newborn and child deaths</td>
<td>At least 50 countries have timely and accurate core coverage indicators data to inform annual reviews, with appropriate data quality controls (20 by 2013)</td>
<td>Countries, health and statistical sectors</td>
<td>(Workplan 1.2.2)</td>
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<td></td>
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<td>UN</td>
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<td>HMN, PMNCH</td>
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<td>2. By 2012, a core set of 11 indicators on reproductive, maternal and child health, disaggregated for gender and other equity considerations, are being used for the purpose of monitoring progress towards the goals of the Global Strategy.</td>
<td>At least 50 countries use and have up to date accurate data on the core indicators, disaggregated, as part of their M&amp;E systems by 2013</td>
<td>Countries, health and statistical sectors</td>
<td>Comprehensive plans developed and implemented for countries with highest burden for monitoring progress towards the core indicators</td>
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<td></td>
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<td>Partnerships (GAVI, Global Fund, HMN, PMNCH)</td>
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<td></td>
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<td>UN</td>
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<tr>
<td>The core indicators included in monitoring systems in countries</td>
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<td>Additional information and new resources required to institutionalize quality of care assessments in countries.</td>
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<td>Monitoring incorporates equity, including main stratifiers (gender, socio-economic position, sub-national data) to track and target disadvantaged populations</td>
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3. **By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.**

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<tr>
<th>Action item</th>
<th>Indicator / targets</th>
<th>Lead partner</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Innovation through ICT is used to improve the performance of the health</td>
<td>At least 50 countries have developed and are implementing national eHealth</td>
<td>Countries</td>
<td>(workplan 1.2.1)</td>
</tr>
<tr>
<td>information system, including surveillance of maternal death), facility</td>
<td>strategies, including specifics on how this benefits information and accountability</td>
<td>Private sector, CSO/NGO, ITU, WHO, other UN agencies, PMNCH</td>
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<tr>
<td>reports, and administrative data, and data sharing, supported by national</td>
<td>for women's and children's health, by 2015</td>
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<td>eHealth strategies involving all relevant stakeholders</td>
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<td>Accelerate the consultation process to develop required standards for</td>
<td>Improved coordination between existing initiatives and bodies to support such as</td>
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<td>increased interconnectivity and common standards</td>
<td>Broadband Commission, Digital Health Initiative, the World Bank, the Innovation</td>
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<td>Working group, UN-DESA, etc.</td>
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4. **By 2015, all 74 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: 1) total health expenditure by financing source, per capita; and 2) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.**

<table>
<thead>
<tr>
<th>Action item</th>
<th>Indicator / targets</th>
<th>Lead partner</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Increase country capacity to routinely track health expenditures in ways</td>
<td>At least 50 countries use and have up to date and accurate data on the two</td>
<td>WHO, World Bank, USAID with Countdown to 2015, PMNCH, technical experts</td>
<td>Tracking private sources would be difficult on annual basis, but</td>
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<tr>
<td>consistent with the national health accounts framework</td>
<td>indicators, as part of their M&amp;E systems by 2013</td>
<td>(academia, regional networks, other organizations)</td>
<td>government and donor expenditures could be tracked annually.</td>
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<tr>
<td>Build capacity for RMNCH specific expenditure tracking at global, regional</td>
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<td>(workplan 1.2.3)</td>
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<td>and country levels</td>
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5. **By 2012, in order to facilitate resource tracking, “compacts” between country governments and all major development partners are in place that require reporting, based on a format to be agreed in each country, on externally funded expenditures and predictable commitments.**

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<th>Action item</th>
<th>Indicator / targets</th>
<th>Lead partner</th>
<th>Comments</th>
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<tbody>
<tr>
<td>H4 and UN support countries in developing country agreements with external</td>
<td>At least 50 countries have formal agreements with donors by 2015</td>
<td>H4 and UN support countries. IHP+ playing a role in several countries.</td>
<td></td>
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<td>partners, and external partners encouraged to comply.</td>
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<td>Bilaterals and CSO/NGOs encouraged to support the process through their</td>
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<td>country representatives.</td>
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<td>PMNCH can facilitate participation by other key stakeholders, e.g. health</td>
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<td></td>
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<td>care professionals,</td>
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<td>Action Item</td>
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<tr>
<td>6. By 2015, all governments have the capacity to regularly review health spending (including spending on reproductive, maternal, newborn and child health) and to relate spending to commitments, human rights, gender and other equity goals and results.</td>
<td>Development partners will commit to strengthen capacity related to accountability processes in an additional 10 countries each year, prioritizing those with the highest burden of women's and children's ill health.</td>
<td>All development partners, linking recommendations 2 and 4 above.</td>
<td>(workplan 1.2.3)</td>
</tr>
<tr>
<td>7. By 2012, all countries have established national accountability mechanisms that are transparent, that are inclusive of all stakeholders, and that recommend remedial action, as required.</td>
<td>Plans for national accountability mechanisms established all countries building on existing initiatives and inclusive of all stakeholders</td>
<td>Countries</td>
<td>(workplan 1.2.3)</td>
</tr>
<tr>
<td>All countries will report on the chosen mechanism to the ERG</td>
<td>At least 50 countries have regular national health sector review processes that meet basic criteria including broad stakeholder participation</td>
<td>CSOs, UN, PMNCH, Countdown to 2015</td>
<td></td>
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<tr>
<td>From 2011, countries with support of development partners will obtain their own baseline data for the indicators recommended in the Commission report.</td>
<td>At least 20 countries have made progress in engaging political leaders and financial decision makers in health</td>
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<td>At least 50 countries have held at least one Countdown event</td>
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<td></td>
<td>All countries provide relevant information to the ERG for review on an annual basis starting 2012</td>
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<tr>
<td>8. By 2013, all stakeholders are publicly sharing information on commitments, resources provided and results achieved annually, at both national and international levels.</td>
<td>H4 will work with other UN partners to further develop current databases on key indicators and disseminate effectively</td>
<td>At least 50 countries have effective data sharing and dissemination mechanisms</td>
<td>(workplan 2.1)</td>
</tr>
<tr>
<td>From 2011, monitoring of adherence to the IHP+ principles will also be an integral part of accountability for the Global Strategy and IHP+ reports will be made public on the global website Every Women, Every Child</td>
<td>Global partners have up to date databases on women's and children's health and effective dissemination of country level and global data on the core indicators</td>
<td>H4+ Academic and research institutions Countries Donors CSOs</td>
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</tr>
<tr>
<td>Action Item</td>
<td>Indicator / targets</td>
<td>Lead partner</td>
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<tr>
<td>9. By 2012, development partners request the OECD-DAC to agree on how to improve the Creditor Reporting System so that it can capture, in a timely manner, all reproductive, maternal, newborn and child health spending by development partners. In the interim, development partners and the OECD implement a simple method for reporting such expenditure.</td>
<td>By 2012, development partners agree on the method</td>
<td>Global level: OECD DAC for the data base, with inputs from EC, WHO, World Bank, USAID on methods.</td>
<td>Development of improved Creditor Reporting System</td>
</tr>
<tr>
<td>10. Starting in 2012 and ending in 2015, an independent Expert Review Group is reporting regularly to the UN Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission’s recommendations.</td>
<td>By Sep 2011 the members have been appointed</td>
<td>WHO</td>
<td>WHO will facilitate an open and transparent process to solicit nominations for an expert review group to review progress against the Global Strategy and the implementation of the Commission’s recommendations.</td>
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<td></td>
<td>From September 2011, ERG members with support of the WHO secretariat will start preparing for a first meeting of the ERG in the second quarter 2012</td>
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<td>(workplan 2.3)</td>
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</tbody>
</table>
5. **Action plan and budget**

An illustrative budget for country level action is attached in Annex B. This budget shows the average catalytic resources required to improve information and accountability during 2011–2015. Core domestic and external sources will provide the bulk of the resources, but are not included. This work will include regional activities, technical assistance, and in-country costs to enhance monitoring, review and action. The average budget for a single country has been put at $1.4 million for four years of which two thirds will be in-country resources. The country agenda includes the development of the country plans, support to NHA institutionalization and subaccount for RMNCH, strengthening of monitoring practices, improving birth and death registration and special efforts to improve maternal death reviews, comprehensive and powerful national review mechanisms, and country action and advocacy.

Annex C presents the action items with a budget for 2011–2015 encompassing country and global level actions. The overall budget is $88 million, of which about $45 million is for implementation of country activities, about $25 million to directly provide international support country activities, and $18 million to global activities including the ERG. The country budget is catalytic as additional domestic and partner investments are required to enhance information and augment accountability. The global activities are also building upon ongoing work by agencies, partnerships and collaborations.

The main contributors to the workplan resources will have to be generated by bilateral donors presented at the partner consultation in July 2011, including Norway, Canada, UK, Japan, Germany, France and others, as well as Foundations. Global Health Partnerships such as PMNCH, HMN, GAVI, Global Fund, Unitaid and others are also expected to contribute to the resources, as well as international agencies (WHO, UNICEF, World Bank etc.). The latter are expected to contribute through particularly staff time. The workplan is based on the assumption that each year, at least $15 million of resources can be raised to support the implementation. The aim is that an additional $25 million or more for the four year period can be generated at country level through harmonization of available partner funding, such as from the GFATM, GAVI and other partners.

At WHO the funds earmarked for Commission follow up work will be kept in a separate account from which different clusters and partners will be provided with the resources according to the workplan.
Annex A: Countries

Countries that have made commitments to the Global Strategy (by June 2011)

- Afghanistan, Bangladesh, Cambodia, India, Kyrgyz Republic, Lao PDR, Mongolia, Myanmar, Nepal, Papua New Guinea, Tajikistan, Republic of Yemen, Viet Nam.


- Haiti.

49 countries in Global Strategy


Additional countries in the Countdown 2015 (25)

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

A "prototype" for country engagement can be described as follows:

**Overall goal**

To improve country accountability for health by better monitoring, review and action.

**Core principles**

- focusing on high level political commitment, national leadership and ownership;
- strengthening countries’ capacity to monitor, evaluate and review;
- building on ongoing efforts and country priorities;
- focusing on strengthening a comprehensive, integrated and inclusive policy dialogue and robust national health strategies, as well as specific efforts made by maternal, newborn and child health programmes;
- using context-specific approaches.

**Investments**

The general COIA follow up plan provides for catalytic funding, which aims to include core country funding up to $1 million for 2011–2015, and technical assistance from partners. The core resources for the priority activities will have to come from domestic sources and country partners.

**Contents**

The post-Commission workplan identifies several priority areas for country engagement. Countries will prioritize these activities according to the current situation:

1. Assess the current situation and set priorities for the accountability framework implementation for 2011–15 ("roadmap")

2. Strengthen monitoring
   - Resource tracking: NHA institutionalization and subaccounts for RMNCH
   - Improving results monitoring: regular data quality ascertainment and transparency; equity including gender, poverty etc. and disaggregated data
   - Monitoring births, deaths and causes of death: take steps to improve monitoring of births and deaths, with cause of death
   - Maternal death reviews: including quality of care assessments in health services

3. Strengthen reviews of progress and performance and policy dialogue through country processes such as annual health sector reviews.

4. Action and advocacy: Ensure high level political engagement; e.g. high level "Countdown to 2015 for maternal newborn and child health" events.
Process

The first step is a letter sent to the Prime Minister or the President of the Country and co-signed by the co-chairs of the Accountability Commission and seeking their engagement. This letter will present the report, refer to the recommendations of the Commission and invite countries to implement those recommendations. It may also refer to current high level statements to promote maternal and child health such the action plan agreed upon at the 15th African Union summit in Kampala, July 2010.

The second step envisaged is a national process, to which the country might decide to invite international partners (WHO or other H4+ partners, in-country bilaterals - e.g. CIDA, Norway, and others) with the following aims:

- explaining purpose and approach;
- assessing the situation and identifying gaps and priorities, using the accountability framework;
- developing a framework and roadmap (costed) for the next 4 years outlining how the gaps and priorities will be addressed and implemented;
- assigning roles and responsibilities to country and partner stakeholders, including identifying technical assistance.

Draft national frameworks (with a concrete roadmap) coming out of these workshops could then be presented during a regional or multi-country workshop (e.g. West Africa). This allows greater sensitization and more time for situation assessment and country roadmaps development in especially lower capacity countries.

The third step is to provide the resources to the country through subcontracts for specific products identified in the roadmap. The roles and responsibilities of the partners will vary between countries. The H4+ will form the basis in many countries, and one of the agencies will take the lead in coordinating the implementation of the workplan. Often this would be the agency leading the M&E work for the H4+. Bilateral donors with country presence are also expected to play a major role in moving the agenda.

In terms of technical assistance, multiple partners will be involved, according to areas of expertise. This includes UN agencies, bilateral donor projects and institutions, civil society, private sector and academic institutions.

Monitoring progress will be done using the IHP+ framework as specified in the guidelines for monitoring and evaluation of national health strategies which will also be the core instrument to assess the current status in monitoring, review and action.
Illustrative country budget for one country

An illustrative country budget is shown below. It has the following assumptions:

- Illustrative budget that shows the average **catalytic** resources require to improve information and accountability in one "average" country during 2011–2015. These include regional workshops, global technical assistance, and in-country costs. Roughly, an estimated 60% are in-country expenses.

- For all activity areas there is a need for country level investments, which includes domestic investment and investments by development partners, to achieve information and better accountability for women’s and children’s health.

- The illustrative amounts include a proportion needed for technical assistance by global partners such as the UN agencies and academic institutions.
<table>
<thead>
<tr>
<th>Activity area</th>
<th>Examples of activities</th>
<th>Illustrative budget (USD*1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop COPAA including situation assessment</td>
<td>Regional workshop</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>In-country work</td>
<td></td>
</tr>
<tr>
<td>NHA institutionalization and subaccounts for RMNCH</td>
<td>Capacity building</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthening results monitoring practices</td>
<td>Data quality review (data verification, analytical skills)</td>
<td>75</td>
</tr>
<tr>
<td>(quality control, transparency, disaggregated data,</td>
<td>Data sharing and transparency</td>
<td></td>
</tr>
<tr>
<td>equity etc.)</td>
<td>(data repository, dissemination)</td>
<td></td>
</tr>
<tr>
<td>Plans and improvements of monitoring of births</td>
<td>Stakeholder workshop, national plan 2020, innovative projects</td>
<td>100</td>
</tr>
<tr>
<td>and deaths, with cause</td>
<td>using ICT</td>
<td></td>
</tr>
<tr>
<td>Maternal death reviews and quality of care</td>
<td>Adopt a system of notification and action, using ICT</td>
<td>100</td>
</tr>
<tr>
<td>assessments in health services</td>
<td>Conduct health facility assessments</td>
<td></td>
</tr>
<tr>
<td>Progress review</td>
<td>Strengthening of annual health sector reviews, evaluation</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>as part of M&amp;E of national health strategy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Development of new ways to strengthen country investments</td>
<td></td>
</tr>
<tr>
<td>Action and advocacy</td>
<td>Country Countdown events at least 2 during 2011–15</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>600</td>
</tr>
</tbody>
</table>
### Annex C: Provisional action plan and budget in support of the implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health 2011–2015

<table>
<thead>
<tr>
<th>Activity area</th>
<th>Activities</th>
<th>Lead partners</th>
<th>Budget $ (4 years)</th>
</tr>
</thead>
</table>
| **1. Country plans to augment accountability (COPAA)** | - Convene (sub)regional workshops to orient country teams on the objectives of the accountability framework and facilitate the development of country plans to augment accountability.  
- Develop guidance for a country plan  
- Invite proposals for catalytic funding as part of COPAA; set up committee to assess proposals, select countries and allocate resources  
- Provide additional TA to up to 10 "fragile" countries to conduct a detailed assessment and develop the country plan to augment accountability | WHO in collaboration with Options, CDC/Measure, IDRC, University of Oslo, H4+ and others | **2,500,000** (50k per country, 50 active countries) |
| **2.1 Monitoring of 11 core results indicators** | - Develop a strong national monitoring and evaluation component for the national health sector strategic plan  
- Introduce innovative ways to enhance the collection, analysis and interpretation of routine health information data  
- Conduct periodic health facility record reviews and service delivery assessments to verify data quality  
- Conduct at least 2 large-scale population based survey (MICS, DHS) during 2010-2015 in order to assess the results indicators in a standardized way  
- Enhance the disaggregation of data according to gender, socio-economic status, place of residence, minority and age  
- Develop a national data repository and facilitate open access to data | Ministries of Health, National Statistics Offices in collaboration with H4+, IHP+, HHA, GFATM, GAVI, and other stakeholders | **67,500,000** (1,350,000 average per country, 50 countries) | Includes up to 45 mln in country resources and up to 22.5 mln for technical support by international partners |
| **2.2 Strengthening registration of birth and deaths** | - Assess the current system using standardized tools  
- Introduce innovative techniques including ICT to enhance registration  
- Build capacity for application of WHO standards (ICD codes, accurate identification and compilation of causes of deaths)  
- Facility policy processes to create demand and investment  
- Adopt a policy of immediate notification of maternal deaths | Relevant ministries in collaboration with Health Metrics Network, MoVE-IT partners - WHO, University of Queensland, World Vision, Plan International |  |
| **2.3 Quality of care assessments** | - Conduct maternal (and perinatal) deaths reviews and take action  
- Conduct at least health facility survey to assess the quality of maternal, newborn and child health services and where appropriate, conduct at least one community health worker quality of care assessment | Ministries of Health in collaboration with , Impact, Ipact, AMDD, UNFPA, UNICEF, WHO |  |
<table>
<thead>
<tr>
<th>Activity area</th>
<th>Activities</th>
<th>Lead partners</th>
<th>Budget $ (4 years)</th>
</tr>
</thead>
</table>
| 2.4 Tracking of resources         | ▪ Develop a strong national plan to track overall resources for health, building upon previous reviews of country capacity to collect information on health expenditures  
▪ Introduce consistent methods to ensure comparability of data over time using methods developed as a collaborative effort between agencies (WHO, NIDI, IDB, UNFPA, PMNCH)  
▪ Establish a national compact with development partners to report and discuss committed and actual expenditures each year.  
▪ Build capacity to routinely undertake analysis of expenditure data, including where possible of private sector  
▪ Develop a national data repository and facilitate open access to data | Ministries of Health, Planning, Finance in collaboration with WHO, World Bank, USAID, OECD, BMGF, GFATM, GAVI, and other development partners                                                                                                                                 | 2.4 Tracking of resources |
| 2.5 Digital health strategy       | ▪ Establish public private partnership around use of mobile technology  
▪ Develop a national digital health strategy  
▪ Integrate use of ICT in the health information system, to facility and accelerate recording and reporting, to share data, conduct analysis, and disseminate rapidly and effectively | Ministries of Health, Communications in collaboration with UN Digital Health initiative, ITU, WHO, BMGF and private sector partners                                                                                                                                 | 2.5 Digital health strategy |
| 2.6 Annual review and action      | ▪ Build capacity for stronger annual health sector review, involving multiple stakeholders, using data from multiple sources  
▪ Improve capacity to correctly use data on results and resources, including equity considerations to strengthen national policies and district plans of action  
▪ Ensure highest level political participation e.g. by conducting a high level political event to share the findings of the review and the follow-up actions to be taken  
▪ Provide access to key documents and process of decision making through publications and web-based dissemination  
▪ Provide a detailed report to the ERG through the ERG secretariat | Ministries of Health, Planning, Finance in collaboration with all development partners, civil society, private sector, human rights bodies                                                                                                                                 | 2.6 Annual review and action |
| 2.7 Advocacy                      | ▪ Mobilize commitment and enhance capacity of financial decision-makers including of parliamentarian budget and finance committees towards overall efficient health investments  
▪ Mobilize communities to create demand for adequate health services and improve utilization  
▪ Conduct at least one national Countdown meeting | Ministries of Health, IPU, World Vision, Countdown, PMNCH and other civil society and development partners                                                                                                                                                           | 2.7 Advocacy       |

**Subtotal** 70,000,000
<table>
<thead>
<tr>
<th>Activity area</th>
<th>Activities</th>
<th>Lead partners</th>
<th>Budget $ (4 years)</th>
</tr>
</thead>
</table>
| 3. Galvanizing commitment                         | ▪ Contact heads of state of the 49 countries inviting each country to submit a plan of action to follow-up on the recommendations of the Commission (linked to COPAA development)  
▪ Contact high level policy makers of funding partners and agencies to solicit support for improved reporting on expenditures for RMNCH  
▪ Establish a working group on fragile states to develop approaches for their engagement                                          | Chair persons and co-chair persons of the Commission H4+, IHP+, HHA, World Vision and relevant partners | 3,000,000         |
| 4. Advocacy and outreach                          | ▪ Develop an outreach strategy 2011 - 2015 targeting key constituencies  
▪ Develop advocacy materials and maintain a web-based platform for dissemination  
▪ Maintain a calendar of key events at global, regional and national levels to discuss the Global Strategy for Women's and Children's Health and the Accountability Framework  
▪ Track commitments to the Global Strategy on Women's and Children's Health and prepare reports  
▪ Engage with parliamentarians and support activities of the IPU  
▪ Develop country case studies of successful implementation of the recommendations                                                                 | PMNCH in collaboration with Every Woman, Every Child, IPU, Countdown, H4+, World Vision, and other partners | 4,000,000         |
| 5. Analysis and reporting of country specific information on results for 74 countries with the highest burden of maternal, newborn and child deaths, including the 49 lowest income countries | ▪ Produce country profiles annually, reporting on the status of coverage of high impact interventions across the continuum of care for women and children, with equity analysis and selected indicators of health financing, health policy and health system strength  
▪ Produce complementary data presentation products on the 11 results and 2 financing indicators proposed by the Commission with equity analysis for specific target audiences  
▪ Conduct additional focused analysis of the data to respond to needs of the independent Expert Review Group (ERG) and to regional and global monitoring efforts  
▪ Maintain a global database on available coverage and equity information                                                                 | Countdown to 2015 in collaboration with partners in PMNCH WHO and UNICEF on country disaggregated database with facility data | 3,000,000         |
<table>
<thead>
<tr>
<th>Activity area</th>
<th>Activities</th>
<th>Lead partners</th>
<th>Budget $ (4 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Analysis and reporting of country specific information on resources for 74</td>
<td>▪ Revise the Creditor Reporting System of OECD DAC with the aim to generate complete data on RMNCH ODA by development partners&lt;br&gt;▪ Develop ad-hoc estimates while more robust systems are being developed globally and in countries&lt;br&gt;▪ Produce country profiles annually, reporting on the status of financial flows in the 49 countries&lt;br&gt;▪ Conduct additional focused analysis of the data to respond to needs of the ERG and regional and global monitoring efforts.&lt;br&gt;▪ Maintain a global data base on available financial flows information</td>
<td>Consortium with WHO, World Bank, OECD, USAID, LSHTM, BMGF, Brandeis University, and other partners</td>
<td>3,000,000</td>
</tr>
<tr>
<td>countries with the highest burden of maternal, newborn and child deaths,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>including 49 lowest income countries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Dissemination, interpretation and use of data</td>
<td>▪ Conduct regional workshops in Africa (2), Asia (1) and the Americas (1) to build capacity of country staff to interpret and use the data on results and resources&lt;br&gt;▪ Provide support for national Countdown meetings including in conjunction with the release of new data, e.g. MICS or DHS&lt;br&gt;▪ Conduct cross-cutting analysis of factors affecting progress in achieving improved RMNCH outcomes and publish in peer reviewed journals</td>
<td>Countdown in collaboration with PMNCH, IPU, BMGF, and other partners, and IHP+ collaboration to strengthen M&amp;E and review of national health strategies</td>
<td>3,000,000</td>
</tr>
<tr>
<td>8. Global digital health strategy</td>
<td>▪ Set up working group to bring together different initiatives with a focus on the accountability agenda of the Global Strategy&lt;br&gt;▪ Develop guidance for countries on the use of digital health technologies&lt;br&gt;▪ Facilitate south-south collaboration and public private partnerships</td>
<td>ITU, WHO, UN Digital Health Initiative, BMGF, private sector partners</td>
<td>1,000,000</td>
</tr>
<tr>
<td>9. Expert Review Group</td>
<td>▪ Establish a WHO secretariat with 1 senior staff, 1 mid-level staff, and 1 assistant&lt;br&gt;▪ Facilitate the work of the ERG members&lt;br&gt;▪ Support ERG meetings&lt;br&gt;▪ Coordinate the production, presentation and dissemination of the annual ERG report</td>
<td>WHO</td>
<td>4,000,000</td>
</tr>
</tbody>
</table>

Subtotal 18,000,000

Grand total 2011–2015 88,000,000
## Provisional action plan and estimated budget by year

<table>
<thead>
<tr>
<th>Activity areas</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Country plans to augment accountability (COPAA) Initiate action, form partnerships</td>
<td>√</td>
<td>2,500,000</td>
<td></td>
<td></td>
<td>2,500,000</td>
</tr>
<tr>
<td>2. Implementation of COPAA including technical assistance</td>
<td>25 countries</td>
<td>13,750,000 continued</td>
<td>7,500,000 continued</td>
<td>8,125,000 continued</td>
<td>12,500,000</td>
</tr>
<tr>
<td></td>
<td>Second 25 countries</td>
<td>13,750,000 continued</td>
<td>7,500,000 continued</td>
<td></td>
<td>12,500,000</td>
</tr>
<tr>
<td>3. Galvanizing commitment</td>
<td>√</td>
<td>750,000</td>
<td>750,000</td>
<td>750,000</td>
<td>750,000</td>
</tr>
<tr>
<td>4. Advocacy and outreach</td>
<td>√</td>
<td>750,000</td>
<td>750,000</td>
<td>750,000</td>
<td>750,000</td>
</tr>
<tr>
<td>5. Analysis and reporting of country specific information on results for 74 countries</td>
<td>√</td>
<td>1,000,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
</tr>
<tr>
<td>6. Analysis and reporting of country specific information on resources</td>
<td>√</td>
<td>750,000</td>
<td>750,000</td>
<td>750,000</td>
<td>750,000</td>
</tr>
<tr>
<td>7. Dissemination, interpretation and use of data</td>
<td>√</td>
<td>700,000</td>
<td>300,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Global digital health strategy</td>
<td>√</td>
<td>1,000,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
</tr>
<tr>
<td>9. Expert Review Group</td>
<td>√</td>
<td>1,000,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td>21,450,000</td>
<td>0</td>
<td>26,050,000</td>
<td>19,625,000</td>
<td>20,875,000</td>
</tr>
</tbody>
</table>