Three case studies were conducted – in Bangladesh, Burkina Faso and Uganda – to provide a holistic picture of how commitments support countries’ efforts to improve women’s and children’s health. These case studies analysed the extent to which the implementation of the commitments to the Global Strategy supports country progress towards achieving MDGs 4 and 5 through aligning with national plans, addressing health and development gaps and ensuring accountability for results and resources. Summary findings of each case study are presented below.

8.1 Bangladesh

Finding 1: Commitments to the Global Strategy are well integrated in the national health sector plan.

Twenty-five commitments to the Global Strategy included specific support to Bangladesh. Figure 19 includes a breakdown by stakeholder category, while Web-Annex 3 lists the commitments.

Analysis shows that the Global Strategy has led to commitments being placed at the core of the country’s reproductive, maternal, newborn and child health (RMNCH) policy and investments. Commitments are well embedded in the new Health Population and Nutrition Sector Development Plan (HPNSDP) 2011-2012, and highlighted in the foreword by the Minister of Health. The plan includes new or added value elements for addressing maternal and newborn health and nutrition. Individual or partial commitments in these areas are stated.

The HPNSDP also includes interventions that are intended to add value to the plan. Among those most relevant to the Global Strategy are:

- Mainstreaming gender, equity and voice in core programmes such as MNCH and nutrition;
- Improving management information systems with information and communication technology (ICT) and establishing monitoring and evaluation (M&E) systems;
- Increasing coverage and quality of services by strengthening intersectoral coordination and private sector collaboration.

Implementation of these commitments has resulted in progress towards achieving MDGs 4 and 5 through alignment with national plans and by addressing health and development gaps. Against the backdrop of the accelerated efforts to achieve the MDGs, key informants found it difficult to gauge accurately the role of the Global Strategy in driving the emerging emphasis on RMNCH at country level.
**FINDING 2: Political leadership and support has been an important factor.**

High-level leadership from the Prime Minister has been crucial in ensuring that line directors and programme managers in the Ministry of Health (MOH) actively engage with the implementation of commitments. The fact that country commitments were made at the highest level, by the Prime Minister, was seen to “drive the government machinery into action” (quote by government key informant and endorsed by others). Those interviewed showed a clear understanding of strategies and implementation challenges.

An intensive consultation process among the government, development partners and other stakeholders has resulted in increased harmonization at the policy level. Ongoing collaboration takes place through several forums, such as the health consortium (government and donors), local consultative groups, task groups and working groups (all stakeholders).

Stakeholders perceive that the Global Strategy has been particularly effective in accelerating efforts to achieve MDG 5. The government has facilitated stakeholder dialogue and technical input on commitments. This has generated evidence for commitments – for example, the calculation of the number of midwives required to meet a specific service delivery need by 2015.

**FINDING 3: The Global Strategy is perceived as adding value, but respondents also identified a number of constraints.**

The launch of the Global Strategy was seen as the event that gave extra momentum to existing RMNCH efforts and kept them at the forefront of attention. There has been an increased willingness of the government to collaborate with the many NGOs delivering services and supporting service delivery, which has helped to offset weaknesses in government capacity. In addition, the forums mentioned above are effective for identifying programmatic gaps and weaknesses, and for sharing information on successful innovations. The culture of Bangladesh was also seen as a driver of innovation, illustrated by women activists who are a force within community groups.

Respondents also identified a number of constraints, including slow release of funds (but not lack of them) due to inefficiencies, bureaucracy and over-tight regulations. This is illustrated by the large amounts of unspent funds, which are detailed in the annual health sector programme reviews. Another key constraint is the lack of skilled staff and unwillingness of medical staff to work in rural areas (both are related to broader health system weaknesses, including poor pay and constraints on service delivery).

**FINDING 4: Commitments made to the Global Strategy are accounted for through national policies and plans.**

There is no separate or distinct accountability framework for commitments made to the Global Strategy and the embedding of commitments in the HPNSDP contributes to promoting accountability for results and resources, for example through the mechanisms of the Sector Wide Approach (SWAp). The majority of donors have pooled resources in a multi-donor trust fund governed by the SWAp process. Annual Programme Reviews (APRs) involve multiple stakeholders and help to generate accountability on both the operational and financial aspects of implementation. The APR process includes monitoring, review and remedial action.

Ten of the 11 core indicators for RMNCH recommended by the COIA are already reflected in the evaluation framework of the Health Sector Strategy 2011-2016, and are included in the Demographic and Health Survey. However, the HPNSDP identifies an urgent need to strengthen the monitoring capacities within the MOH and the directorates to use the routine data for decision-making efficiently. It states the need for an overall M&E strategy and workplan to guide the improvement of the system.
A number of organizations make specific commitments to holding the government accountable for results, including the H4+. The White Ribbon Alliance, for example, commissioned an historical analysis study on *Allocation of Funds for Maternal Health in Bangladesh*, published in January 2012. This has been presented to the government as an advocacy tool to hold government accountable for commitments made.

**FINDING 5: The Global Strategy promotes the use of innovative solutions.**

The analysis shows that the Global Strategy is giving leverage to the implementation of innovative approaches. For example, in September 2011 the country received the United Nations Digital Health for Digital Development award for its outstanding contribution to successfully using ICT for development of health and nutrition. Examples of innovative approaches include a mobile messaging service (called Aponjon) for new mothers, pregnant women and their families. It sends weekly messages timed to pregnancy stage or age of newborn, on topics such as care during pregnancy, warning signs, breastfeeding practices, nutrition, immunization reminders, and connecting with local health services. Another example is the MaMoni project, which is a partnership of several organizations working with the government of Bangladesh on an integrated package of services (maternal, newborn, family planning and nutrition package). Its activities place community action groups at the heart of the rural health services. NGO workers liaise with frontline health workers to raise awareness and identify and address health issues with their own resources.

**8.2 Burkina Faso**

Fifteen commitments to the Global Strategy included specific support to Burkina Faso. Figure 20 includes a breakdown by stakeholder category, while Web-Annex 4 lists the commitments. The commitments made to the Global Strategy in Burkina Faso cover most elements of the continuum of care. Although the government’s specific commitments to the Global Strategy were rather vague, these are complemented by the specific objectives and strategies in the National Health Development Plan (PNDS), which include specific targets for maternal and child mortality reduction.

**FINDING 1: Commitments to the Global Strategy are well integrated in the national health sector plan and there is high-level political leadership and support.**

The general impression is that maternal and child health was high on the agenda before the launch of the Global Strategy in 2010. High-level initiatives – such as the 2006 Maputo Plan of Action, and the 2010 African Union Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) – were mentioned as key influences that have led to increased commitment to maternal and child health by senior decision-makers in the government. The Global Strategy was not intended to replace existing initiatives, but rather to build on, and to consolidate, regional and national initiatives that are driving progress in RMNCH. The commitments to the Global Strategy were drawn from the PNDS and are therefore well aligned.

Most respondents noted that the level of coordination and cooperation is unique in Burkina Faso. There is high-level commitment from the President, the First Lady and the Minister of Health to better coordinate the sector and align the various actors. A number of thematic working groups have been set up, both with the government and between the development partners (including on nutrition). A monitoring committee for implementation of programmes and strategies for RMNCH was created in January 2012. It includes broad representation and is presided over by the First Lady and the Minister of Health. The committee’s purpose is not only to monitor the implementation of programmes and strategies, but also to make suggestions to strengthen different interventions (see also Chapter 9).

Despite this, some development partners expressed concern that, while all these mechanisms exist on paper, their implementation is sometimes poor. Development partners did not all agree on the degree to which health sector planning, implementation and evaluation processes are participatory.

**FINDING 2: The Global Strategy is perceived as adding value, but there are some constraints to implementation.**

Burkina Faso, which remains one of the world’s poorest countries, has made considerable progress on RMNCH over the last two decades. Key informants suggested that the benefits of the Global Strategy were:
Reminding the government and other actors of the promises they made, reinforcing the obligation to improve maternal and child health, and ensuring that it stays high on the agenda;

Contributing to increases in funding, particularly through the Muskoka Initiative and the H4+ initiative, and with particular benefits for reproductive health;

Improving coordination between development partners, in particular among H4+ partners;

Reminding key stakeholders of the importance of cross-cutting themes, such as integrated health care and health systems support.

In addition, many see the introduction of subsidized emergency obstetric and newborn care (EmONC) in 2006 (to complement free antenatal and neonatal care) as probably the biggest contributor to the drop in maternal and neonatal mortality that Burkina Faso has seen over the last 10 or so years. Geographical barriers to care have also been reduced through decentralization of the health sector and the creation of health clinics in all districts. However, it is not clear how or whether the Global Strategy has contributed to this.

Despite this progress, Burkina Faso remains off track for both MDG 4 and 5. Respondents identified several bottlenecks to implementation of commitments, which include:

- Lack of quantity and quality of human resources for health – a bottleneck raised by all key informants. Overall, the number of health workers is far below the minimum WHO recommendations. In particular, there is a shortage of skilled birth attendants, midwives and obstetricians/gynaecologists. Concerns were also raised about the quality of training and education, as well as motivation and mobility of health workers.

- Financial resource constraints. Almost all key informants raised the issue of financial resource constraints. This seemed to be largely related to the intention of expanding the 80% subsidy of EmONC to make it completely free. However, there were also calls for increased funding to enhance capacity both at the national and peripheral levels. Some informants insisted that what is needed is more efficient management of existing funds and argued that the 80% subsidy would probably be enough to cover almost all maternal health services if it were efficiently managed.

- Access to care. Geographical distance and financial access to care were identified as two key bottlenecks for improvements to RMNCH.

- Lack of equipment and medication. The number of stock-outs of the essential package of 20 medicines has increased over the last few years in Burkina Faso. Similarly, lack of equipment is an issue even at the referral level at the University Hospital.

- Limited coordination and collaboration. Multisectoral and inter-ministerial collaboration and coordination form a major bottleneck for continued improvement in RMNCH. Improvements in health require coordinated efforts between the education, finance, women’s promotion, social action, transport and infrastructure and water and sanitation sectors, among others. Vertical initiatives and fragmentation within the health sector further constrain implementation. There are many different international initiatives and partnerships in Burkina Faso, all of which require reporting to different bodies and compliance with a range of obligations.

- Social norms and practices. Several key informants indicated that social norms and practices remain an obstacle to health improvements. The first of the “three delays”, namely the decision to seek care, is often significant, particularly in the case of pregnancy and childbirth. Similarly, care is often only sought for children when they are very ill.

- Poor communication. Communication between all key stakeholders could be improved, as poor communication leads to duplication and fragmentation, causing unnecessary complications. For example, some NGOs are proposing to train more auxiliary midwives, even though the government has decided to remove this cadre of health workers.
**Limited knowledge of the Global Strategy.** Few informants outside of the United Nations organizations and the government were able to identify any of its detail. There was limited awareness of Burkina Faso’s commitment to the Global Strategy and many organizations had little knowledge of each other’s commitments.

At the same time, a number of initiatives have been used to overcome the above bottlenecks. These include: ensuring a skill mix and enhancing the role of health workers; recruitment of additional health workers; contracting and coordination of NGOs to deliver services in specified regions and districts; provision of selected free health services; subsidizing EmONC; and strong leadership of the government.

**FINDING 3: Commitments made to the Global Strategy are accounted for through national policies and plans.**

Burkina Faso’s commitments to the Global Strategy were drawn from the national plan PNDS. Most interviewees said they are accountable for reporting against this. The perception among respondents of the level of accountability varied significantly. Some stated it as an area of strength while others said accountability, monitoring and reporting was a key weakness within the MOH that needed to be addressed.

Analysis shows there was essentially no knowledge of the recommendations of the COIA; either the content or the time frame. However, a number of the recommendations are in the process of being implemented. Burkina Faso is making good progress with the incorporation of the 11 key RMNCH indicators and on transparency. For example, across all the different surveys and databases, all but one of the indicators is included. Furthermore, Burkina Faso is making progress with reviews of spending and resource tracking and the government is in the process of developing a registration system and a health information database, which will make valuable contributions once completed.

However, a number of problems affect the quality of data collection, which is carried out by different agencies at different times, and the data reported are often stored in different locations, making them difficult to synthesize and analyse. Different definitions and methods are used, and data are therefore often not compatible or comparable. While there is some evidence that efforts are being made in Burkina Faso to bring the different data collection mechanisms in line with each other, accountability mechanisms need further alignment and strengthening.

**FINDING 4: Innovations are underway and are being tried out.**

A number of innovations have been tried and implemented in Burkina Faso to accelerate the improvement in women’s and children’s health. Innovations and best practices include the use of radio entertainment to broadcast educational messages about daily activities that can affect health and to encourage people to use health services. In addition, some NGOs have piloted free health-care initiatives for mothers and children under five (including EmONC and antenatal and neonatal care), with promising results. This has led to significant lobbying of the government to remove the remaining fees paid by mothers. Similarly, Population Council International has started to create safe spaces for women and girls, where they can meet and get to know other girls of their own age, share experiences and receive information on options for contraception, as well as sexual and reproductive health and rights.
8.3 **Uganda**

Twenty-one commitments to the Global Strategy included specific support to Uganda. Figure 21 includes a breakdown by stakeholder category, while Web-Annex 5 lists the commitments. Uganda made eight commitments to the Global Strategy in 2011 focusing on issues including EmONC, skilled birth attendants, family planning and the three major causes of death for children under five – diarrhoea, pneumonia and malaria. Although these commitments were already priority intervention areas before the launch of the Global Strategy, the Global Strategy has provided an additional “boost” to already ongoing RMNCH processes.

**Finding 1:** Global Strategy commitments have added impetus to progress on RMNCH targets in Uganda, but there are also constraints.

Information by government representatives suggest that Uganda is on track to achieve the four core recommendations of the COIA at country level for 2012. A positive output from the commitments is, for example, that it has rallied all actors in the RMNCH subsector behind common goals and targets, and increased support for and engagement in a shared platform for planning, implementation, reporting and measurement of results. In addition, Uganda has initiated action on a number of other COIA recommendations that have a 2013 and 2015 time target. These include using information technology innovations in national health information systems, and creating Reproductive Health and Child Health subaccounts within National Health Accounts. Uganda is also collecting data on all 11 Global Strategy Indicators, most of which are core indicators in its Health Sector Strategic and Investment Plan 2010/11 – 2014/15.

This study also documented many examples of progress made on RMNCH. For example, Child Days Plus (outreach events) has contributed to the increase in immunization coverage, and coverage of other preventive health interventions such as vitamin A supplementation, deworming and distribution of insecticide-treated nets. Also, infant and young child feeding has been integrated into different programmes such as prevention of mother-to-child transmission (PMTCT), reproductive health and the expanded programme on immunization. These country-level programmes have contributed to a significant reduction in under-five and infant mortality rate.

Other examples include the engagement of local leaders, the introduction of insurance schemes, and the introduction of maternity waiting homes or birth shelters. At the latter, mothers close to giving birth are sheltered to ease the pressure of transportation once labour pains begin and to reduce the negative impacts of obstetric emergencies.

Despite the fact that Uganda is on track to achieve a number of core commitments, there are also constraints to implementation of commitments. These include:

- **Major gap in human resources.** The majority of respondents mentioned a severe shortage for all critical cadres of health workers. Current estimates are that about 2000 more midwives are required to fill existing gaps. Besides numbers, prevailing HRH gaps pertain to an adequate “skill mix”, particularly the clinical specialization required for Comprehensive EmONC, and the knowledge and skills required for various management roles at both national and district levels.

- **Inadequate funding for RMNCH** and associated difficulties translating RMNCH policies into effective programmes.

- **Supply chain management** especially as it affects the lower levels of health care and commodity distribution.

- **Gender inequalities.** While Uganda is a signatory to various international commitments to gender equality, including MDG 3, and has a Gender Policy that provides a framework for gender-responsive development, gender inequalities still remain and consistently contribute towards stalling progress on many MDGs. These include high levels of sexual and gender-based violence, limited access to justice for victims of violence, and weak prevention and treatment services. It is particularly worrying that the first sexual encounter of 25% of girls is associated with the use of force.

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**Figure 21:** Commitments to Uganda by stakeholder category

- Private sector: 1
- Commitment by national government: 1
- Global Partnerships: 1
- Multilateral organizations: 1
- Foundations: 1
- Academic and research institutions: 1
- Health care professional associations: 1
- High-income countries: 2
- NGOs: 12
- **Low coverage of HIV counselling and care services**, including limited access to EmONC. Respondents also noted marked disparities in coverage of interventions across geographical settings, between rural and urban populations and within wealth and education quintiles.

- **Limited access to and utilization of bed nets** (despite gains in coverage of PMTCT services).

**FINDING 2: Strong parliamentary engagement with the RMNCH agenda has proven effective.**

Prominent parliamentary figures have been effective champions of the RMNCH agenda, especially a core group within the Uganda Women’s Parliamentary Association (UWOPA). This includes influential personalities such as the Ugandan First Lady and the Speaker of Parliament. Examples of high-level involvement with maternal and child health include a presidential directive made in 2008 that obligates notification of all maternal and perinatal deaths within 24 hours of occurrence, as well as a recent presidential directive that called for recruitment of midwives to staff all health centres. Furthermore, Uganda is the lead sponsor of the ground-breaking Inter-Parliamentary Union (IPU) resolution on MNCH, adopted in Kampala in April 2012. The IPU itself made a commitment, of which this resolution was a concrete outcome. The exemplary parliamentary effort on the RMNCH agenda is to a great extent a result of a sustained advocacy push from multiple players over the past few years. Parliamentary engagement has also involved a few male MPs and also traditional institutions, and especially the Queen of Buganda. Data collected also shows challenges in parliamentary advocacy on RMNCH, such as the need to sustain the political commitments made and build an economic case for RMNCH as an investment in health.

**FINDING 3: CSOs and the media make a strong contribution to the RMNCH agenda in Uganda.**

There have been several CSO campaigns in Uganda between 2010 and 2012 in support of RMNCH. Many of these seek to draw the attention of the government to cases of preventable maternal deaths, caused by capacity constraints, medical negligence, lack of supplies at health centres, or lack of midwives. Examples include the petition in September 2011 by the White Ribbon Alliance for Safe Motherhood Uganda and others to urge the government to commit to the Global Strategy, and the Child Health Now campaign, launched by World Vision Uganda in 2010. The latter is an integrated campaign model that links grassroots voices to national policy engagements.

The media has contributed greatly by constantly keeping track of activities and incidents around RMNCH. A recent examples of media coverage includes an article in *The Daily Monitor* of 9 May 2012 highlighting the increasing incidence of fistulas due to prolonged or obstructed labour. Some NGOs have focused on training journalists, and this has increased their understanding of the issues and their ability to cover maternal health issues comprehensively.
**Finding 4:** There are a number of structures in place for accountability.

There are a number of accountability mechanisms in Uganda, although it is important to underscore that many of these were in place before Uganda signed commitments to the Global Strategy. For example, a country compact was signed by the government and health partners in June 2010 based on principles that include ownership and leadership by government, alignment of all partner programmes to the priorities of the Health Sector Strategic and Investment Plan (HSSIP), and a common management and accountability platform. It contributed significantly to coordination of health sector activities (including RMNCH), ensuring effective use of all available health sector funds from all sources – thus avoiding duplication of efforts and wastage of resources – and to providing ownership of the programme and common targets by all actors in the health sector. Furthermore, a monitoring and evaluation plan for HSSIP was developed in close consultation with stakeholders in May 2011. This provides overall guidance for the health sector and a platform for all stakeholders to report, review progress and plan jointly. In addition, a country accountability assessment and score card meeting was held in February 2012, which was attended by the MOH, WHO and UNFPA.

**Summary**

The three country case studies suggest that although the Global Strategy has in many cases contributed to increased funding, more funding is needed to ensure effective scale-up of RMNCH efforts, while the main issue in Bangladesh is slow release of funds. Other constraints to the implementation of commitments highlighted by all three case studies include: major gaps in human resources for health; lack of equipment and medication; social norms and practices (as well as gender inequality); and lack of access to counselling and care services, particularly in rural areas. In addition, key informants found it difficult to estimate the level of progress in the field of RMNCH that can be directly attributed to the Global Strategy.

The case studies also demonstrate that the Global Strategy has rallied actors working on RMNCH behind common goals and targets and has given a boost to ongoing RMNCH processes. The Global Strategy has served as a reminder to governments and other actors of the promises they made, thereby reinforcing the obligation to improve RMNCH, and ensure that it stays high on the agenda. It has also leveraged the use of innovative approaches to RMNCH. The country case studies further show that commitments made to the Global Strategy are well aligned with national health plans and that they are accounted for through national policies and plans – which were in most cases already in place before countries signed commitments to the Global Strategy.
The Global Strategy highlighted the need for an effective accountability mechanism to track progress on women’s and children’s health. Subsequently, the Commission on Information and Accountability (COIA) developed a framework to strengthen reporting and oversight as outlined in the 10 main recommendations of its report (see Box 9). In response to the final recommendation of the COIA, the independent Expert Review Group (iERG) was established to report annually to the United Nations Secretary-General on progress on women’s and children’s health.

The COIA defined accountability as a process encompassing three inter-related ideas: monitoring, review and action. It is a cyclical process that assesses progress, recognizes success, identifies challenges, takes action where indicated and holds all parties to account. Accountability should be a constructive and balanced process. An effective accountability mechanism should be transparent and inclusive, ensuring the meaningful participation of all key stakeholders, and particularly affected communities, civil society and parliamentarians.

The chapter draws its information from the online questionnaire, the country case studies and a commissioned review of accountability mechanisms.

**Box 9: Recommendations of the Commission on Information and Accountability**

**Better information for better results**

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

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

3. **Innovation:** By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.
The latter was informed by key informant interviews and desk review, in response to the request of the iERG request for more information about existing accountability mechanisms. The chapter analyses awareness of and progress on the implementation of the 10 COIA recommendations, highlights examples of how countries and development partners are attempting to strengthen accountability for commitments to women’s and children’s health by building on existing mechanisms, and suggests additional mechanisms that could be considered.

**Finding 1: Relatively low awareness of the COIA recommendations among implementing countries.**

The online questionnaire asked implementing countries and other stakeholders about their awareness of the COIA recommendations. Of the 46 implementing countries that responded, 26 (57%) indicated awareness of the COIA recommendations. By contrast, all high-income countries (HiCs) and multilateral organizations indicated they know about the recommendations (Figure 22).

**Figure 22: Level of awareness of the COIA recommendations**

<table>
<thead>
<tr>
<th>Category</th>
<th>Awareness (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low- and middle-income countries</td>
<td>57%</td>
</tr>
<tr>
<td>High-income countries</td>
<td>100%</td>
</tr>
<tr>
<td>Foundations</td>
<td>73%</td>
</tr>
<tr>
<td>Multilateral organizations</td>
<td>100%</td>
</tr>
<tr>
<td>Global Partnerships</td>
<td>67%</td>
</tr>
<tr>
<td>NGOs</td>
<td>61%</td>
</tr>
<tr>
<td>Private sector</td>
<td>42%</td>
</tr>
<tr>
<td>Health care professional associations</td>
<td>67%</td>
</tr>
<tr>
<td>Academic and research institutions</td>
<td>56%</td>
</tr>
</tbody>
</table>

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

4. Resource tracking: 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: (i) total health expenditure by financing source, per capita; and (ii) total reproductive, maternal, newborn and child health expenditure by financing source, per capita.

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

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

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

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

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

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

10. Global oversight: Starting in 2012 and ending in 2015, an independent “Expert Review Group” is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission’s recommendations.
FINDING 2: Mixed progress on implementation of the COIA recommendations.

The countries that were aware of the COIA recommendations reported the following average rate of implementation:

- Achieved – 20%;
- In an advanced stage of implementation – 41%;
- In the inception phase – 33%;
- Not yet started – 6%.

As shown in Figure 23, there were considerable differences in progress of implementation by recommendation. More than one-third of the countries reported they had achieved recommendations related to country compacts and registration of vital events. However, progress was much slower on the recommendations related to resource tracking and innovation. Almost 90% of respondents mentioned financial and human resource constraints as the main barriers to implementation of the COIA recommendations.

FINDING 3: A majority of implementing countries have taken specific action to monitor the implementation of their commitments to the Global Strategy.

Almost two-thirds of countries (63%) reported that they monitor and assess the impact of their commitments to the Global Strategy. In Afghanistan, for example, a report on the main achievements, challenges and recommendations is presented to the parliament and, through the media, to the people. Another example is provided from the Burkina Faso country case study (see Box 10).

In addition to implementing countries, other stakeholders are also taking action to monitor the implementation of their own commitments. One example is provided by Save the Children (Box 11). Another NGO, World Vision International, has commissioned a mid-term review of its commitments. The private sector is also taking steps to monitor its commitments to the Global Strategy. Johnson & Johnson is developing a reporting system to capture the outcomes of its commitment and Merck plans to use an independent organization to monitor and evaluate its efforts.

FINDING 4: Existing national and regional mechanisms can provide a platform for strengthening accountability for women’s and children’s health.

The review of existing accountability mechanisms commissioned for this report found that the health sector review (HSR) may be the most appropriate starting point for accountability for RMNCH. However, the importance of other sectors in improving RMNCH outcomes should be recognized, and meaningful participation ensured to promote greater legitimacy of the process. HSRs are most often conducted by the Ministry of Health (MOH) with development partners, and involve an annual or biannual review of progress on implementation of the national health plan. These are most often developed in countries that have adopted a
A report is being made public, also including recommendations. Some of the findings include:

- Regarding the first commitment of reaching an annual target of US$ 500 million, the assessment concludes that, while there was a significant increase in expenditure on MNCH programmes between 2009 and 2010, current projections suggest that the first commitment may not be met by 2015 without a sustained focus on resource mobilization. Strategies are being developed to close this gap, including a more coordinated approach by Save the Children’s members towards institutional donors, and a joined up investment in programme evaluation and learning.

- An extrapolation of the results from the first year suggests that the NGO will reach the target of training and supporting 400,000 health workers in developing countries by 2015 to ensure better availability of life-saving services. However, the organization should have a breakdown of how this figure is going to be reached by the country programmes.

- As Save the Children is performing a significant amount of advocacy and community mobilisation across the globe, the auditors conclude that the organisation is continuing to address the commitment of helping to mobilize communities in the countries with the highest child mortality, to hold governments to account.

- In addition, findings show that Save the Children has developed and implemented a range of effective partnerships across the globe. In this way, it is actively and successfully working to address the commitment of engaging with partners from the corporate sector, governments, media, academics, sport, entertainment and civil society at a national and international level, to help deliver life-saving programming and engage hundreds of millions in the movement to end needless deaths of mothers and children.
Accountability can also be strengthened by linking with regional mechanisms and processes, such as the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), the African Leaders Malaria Alliance (ALMA), the Abuja Declaration, and the Joint Declaration on the Attainment of the Millennium Development Goals in the Association of Southeast Asian Nations (ASEAN).

The online questionnaire asked respondents to suggest opportunities to strengthen accountability for women’s and children’s health. A few countries, such as Mauritania and Senegal, highlighted the need to develop networks or frameworks to engage civil society formally in accountability mechanisms. Others, like Afghanistan and Indonesia, noted that media and information systems create opportunities and should be better used. Chad mentioned the importance of gender-focused strategies to improve the education of girls and the autonomy and leadership of women.

**Finding 5: Countries’ human rights obligations and international and regional human rights mechanisms provide opportunities to strengthen accountability.**

Outside the health sector, there are other mechanisms and processes that should be utilized to promote accountability for women’s and children’s health. For example, countries’ human rights obligations provide opportunities for improved accountability. The COIA built its accountability framework on the right to health, equity in health and gender equality. The right to health is one of the fundamental rights of every human being and has been defined as “the enjoyment of the highest attainable standard of health” (International Covenant on Economic, Social and Cultural Rights, Article 12). Rights to sexual and reproductive health are vital components of the right to the highest attainable standard of health.51

Every country in the world is now party to at least one international human rights treaty that addresses health-related rights and some of them explicitly establish obligations in the area of maternal health.

States are responsible for reporting on their human rights commitments periodically to the treaty monitoring body (for example, parties to the International Covenant on Economic, Social and Cultural Rights report every four years on its implementation to the Committee on Economic, Social and Cultural Rights). The right to health is also recognized in regional human rights treaties. Examples are the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights and the Maputo Protocol on the Rights of Women in Africa. States also report to other bodies such as the United Nations Human Rights Council through the Universal Periodic Review, which provides an opportunity to promote accountability for women’s and children’s health.52

Many States also have obligations to realize the right to health under national legislation and policy and there are many national human rights institutions with the mandate to look at women’s and children’s health (Box 12 provides an example from Kenya). The right to health is also enshrined in some national constitutions worldwide, for example Ecuador, Kenya and South Africa. Realization of the right to health involves devoting the maximum available resources to the health system and investing to address the health needs of the population. While the state remains ultimately accountable for guaranteeing the realization of the right to health, it is important to engage civil society as supportive but critical friends and contributors to a collective process of constructive accountability.

When national accountability mechanisms do not provide satisfaction, people may turn to the courts as a last resort. Some national courts have made rulings on cases related to RMNCH awarding redress for victims and have

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**Box 12: Promoting accountability for reproductive and maternal health – the Kenya National Commission on Human Rights**

The Kenya National Commission on Human Rights (KNCHR) is an independent national human rights institution established in July 2003 and enshrined in the constitution. It has two roles: to act as a watchdog in monitoring and documenting perceived violations of human rights, and to act in an advisory role to government and parliament on issues related to legislation. Reports and recommendations are submitted to parliament and made widely accessible. Among key achievements of the new constitution is the guarantee of the right to health including the right to reproductive health.

KNCHR has acted on a complaint by the Federation of Women Lawyers on alleged violations of women’s reproductive human rights in Kenyan health facilities. Their investigations into Pumwani Maternity Hospital and other facilities were described in the report “Failure to Deliver”.53 Pumwani Hospital is in the centre of Nairobi and its clients are mostly the very poor and vulnerable. The report pointed to under-funded services and a government failure to provide quality health care as factors that contributed to high maternal mortality.

A review concluded that such violations were common in many government hospitals and institutions. KNCHR initiated a national public enquiry covering all regions of Kenya. This will provide a forum to raise public awareness and debate, identify root causes of poor quality and inadequate services and seek practical solutions to address the issues. Findings will be compiled into a report with clear analysis and recommendations and submitted to the President of Kenya and to parliament.
ordered States to improve the health care services they provide. This is the case of some state-courts in India that set important precedents and help strengthen health systems.

International mechanisms can enhance accountability where national mechanisms are inaccessible, ineffective or absent. Some United Nations treaty monitoring bodies, such as the committee of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee and regional bodies such as the Inter-American Commission of Human Rights, can also review and make rulings on individual complaints.

In September 2011, the United Nations Human Rights Council (HRC) passed Resolution 18/2 on Preventable maternal mortality and morbidity and human rights.54 To implement the resolution, the Office of the High Commissioner for Human Rights (OHCHR) coordinated the development of technical guidelines on the application of a human-rights-based approach (see Box 13).

**Finding 6: Parliamentarians have a crucial role to play in holding the government and other stakeholders to account and giving a voice to women, children and their communities.**

Parliamentarians are widely recognized as being central to the accountability process for RMNCH, through their role in allocating resources through the budget process, enacting laws, overseeing implementation and reflecting the views of citizens about their health services. They potentially play a crucial role as advocates for women’s and children’s health, in partnership with communities, civil society and the media.

There are many examples of the positive results of strong engagement by parliamentarians in RMNCH. For example, in Viet Nam and Rwanda, the parliaments have passed legislation to ensure free care for children under six. In Uganda, the parliament held up the budget until the RMNCH allocation was increased.56

A resolution by the Pan-African Parliament (PAP), the legislative arm of the African Union, adopted in October 2011, urges speakers of Parliament in Africa to prioritize the implementation of MNCH policies and programmes, supported by adequate budgets. Presiding over the adoption of the resolution, the Pan African Parliament President Hon. Dr. Moussa Idriss Ndélé emphasised that “parliamentary support is crucial for successful implementation of African Union Summit Decisions and African development priorities”.

In April 2012, delegates to the Inter-Parliamentary Union (IPU) in Kampala passed a resolution calling for members of parliaments to take all possible measures to achieve Millennium Development Goals (MDGs) 4 and 5 by 2015 (Box 14). Delegates called upon parliamentarians to scrutinize all government health interventions to ensure they are evidence-based, conform to international human rights standards and are responsive to regular and transparent performance reviews. They stressed the need for strengthened partnership between parliamentarians, CSOs, media, the private sector and all other relevant actors.

**Box 13: Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality**

In 2011 the United Nations Human Rights Council requested the Office of the High Commissioner for Human Rights (OHCHR) to elaborate this tool to provide guidance to policymakers and other relevant actors on how to design, monitor and implement policies and programmes to reduce maternal mortality and morbidity in accordance with human rights principles and standards.

The technical guidance is based on the premise of the full respect and protection of women’s sexual and reproductive rights, as recognized in international human rights law and political commitments, particularly the Programme of Action of the International Conference on Population and Development (ICPD).

The technical guidance highlights the importance of addressing maternal mortality and morbidity through comprehensive interventions that focus not only on the medical causes but also on the underlying causes and the fulfilment of women’s economic, social, cultural, civil and political rights. The document establishes that any effort to reduce maternal mortality should promote women’s empowerment, which entails treating women as active agents who are entitled to participate in decisions that affect their health. It also highlights that applying a human-rights-based approach requires strengthening the capacities of both rights-holders to make their claims and duty-bearers to meet their obligations, as well as paying particular attention to marginalized groups of women.

This document stresses that the accessibility, availability, acceptability and quality of sexual and reproductive health goods, services and information should be understood by health care providers and policymakers as human rights and not as charity. A very important part of the technical guidance is devoted to the issue of accountability as a critical element of every stage of human-rights-based interventions. It establishes that accountability should include appropriate monitoring mechanisms based on human rights indicators (qualitative and quantitative). It addresses the type of accountability mechanisms that can be established to identify obstacles, hold institutions, providers, donors and other actors accountable and provide effective remedies.

The technical guidance emphasizes the need to adopt a national health plan, which should include a sexual and reproductive rights strategy encompassing maternal health. This plan should be elaborated with the participation of the affected communities and based on a situational analysis. The plan should have appropriate budget based on the human rights principle of maximum available resources. The design of this plan should be followed by the repeal of all laws and policies that undermine access to sexual and reproductive health services.

The technical guidance could be a very useful tool for policy-makers, health care providers, parliamentarians, judiciaries, inter-governmental agencies, national human rights institutions and donor states. Its application could have a very positive impact on the effectiveness and sustainability of policies and programmes aimed at reducing maternal mortality and morbidity.
Finding 7: Civil society and media have a powerful accountability role to play; their capacity needs to be reinforced.

Social accountability is a bottom-up approach in which citizens as service users can change the behaviour of service providers through their collective voice and influence.

While recognizing the necessary participation of men in promoting women's and children's health, giving voice to women is particularly important; 40% of implementing countries report that they have feedback mechanisms that allow women to assess the implementation of commitments.

In recent years, scorecards, social audits and new information technologies have been used increasingly to contribute to social monitoring. Participation may include campaigns to inform citizens about their rights and what services they are entitled to, and performing third-party monitoring through processes such as social audits and analysis. Box 15 provides an example of the use of scorecards, social audits and other elements of social accountability.

Other powerful accountability tools used by civil society are budget analyses and public expenditure tracking surveys to “follow the money” from central government budgets through to service providers, or surveys to monitor attendance of service providers in health facilities. Box 16 illustrates how the power of budget monitoring was used in Mexico to ensure that maternal and newborn health services were included in the benefit package of the national health insurance scheme.

Social accountability can be reinforced through partnership with the media, which has an important role to play in increasing awareness of RMNCH and disseminating information to inform the population and stir debate. It can present a human face to statistics and provide a public platform for citizens. It can be an important ally in holding government to account for meeting commitments and a powerful advocate for social change.

Through their commitments to the Global Strategy, and other initiatives, stakeholders can invest in building the capacity of parliamentarians, the media and CSOs to better monitor and use more effectively the evidence for advocacy, and to hold governments to account on RMNCH commitments. By strengthening parliamentary oversight and building partnerships with the media, stakeholders can improve accountability to citizens, expand social accountability and improve monitoring of human rights treaty obligations.

Box 14: The power of parliamentary action – the Inter-Parliamentary Union resolution on women’s and children’s health

The Inter-Parliamentary Union (IPU), an international organization bringing together national parliaments of 157 countries and nine regional parliamentary assemblies, is playing an increasing role in promoting the health of women and children. In April 2012, the IPU adopted a resolution entitled “Access to Health as a Basic Right: The Role of Parliaments in Addressing Key Challenges to Securing the Health of Women and Children”. The resolution places parliaments at the heart of national accountability efforts. It calls on parliaments to monitor the national implementation of commitments made at national, regional and global levels to improve health through the development of expert committees, requests for annual reports, budgetary oversight, organization of constituency meetings and field visits. The resolution also explicitly calls on parliaments to ensure that all commitments made to the Global Strategy are fulfilled, and that the recommendations of the Commission on Information and Accountability are implemented.

Hon. Safia Nalule Juuko, Member of Parliament from Uganda, illustrates the contribution of the IPU resolution to fostering accountability, using exclusion as an example: “The exclusion and marginalization of women with disabilities is a critical problem in many countries. The IPU resolution urges parliaments to pay special attention and make budgetary provisions for the sexual and reproductive health needs of women and children with disabilities. I believe that by so doing, the IPU resolution goes a long way towards ensuring the well-being of women and children with disabilities and, ultimately, accountability for their inclusion.”

The IPU resolution is already making a difference. Hon. Kyei Mensah-Bonsu, President of the IPU Third Committee and Member of Parliament in Ghana, notes that: “In Ghana we have already begun to see the value addition of the IPU resolution. Parliament shared the resolution with the new Ministry for Women’s and Children’s Affairs. The ministry responded by setting up a committee to peruse the IPU resolution and identify opportunities for collaborating with parliament to promote accountability for improved maternal, newborn and child health.”

The resolution has also galvanized attention to women’s and children’s health in regional parliamentary bodies, as illustrated by the Speaker of East Africa Legislative Assembly (EALA), Rt. Hon Abdirahim Abdi: “The IPU resolution has placed the issue on the radar of EALA for urgent action and provides EALA with a renewed mandate to tackle the issue of accountability for maternal, newborn and child health.”

The resolution is the result of sustained and committed efforts by the IPU, over several years, to place women’s and children’s health at the centre of the development agenda and as a key priority of parliamentarians.
Box 15: Giving children and communities a voice – social accountability in action

World Vision has developed a social accountability methodology that seeks to improve services such as health and education by transforming the dialogue between communities and government. Citizen Voice and Action (CVA) mobilizes citizens, gives them tools to monitor government services and facilitates a process to improve services that directly affect children and their families. It is designed to sustain a long-term working relationship between communities and governments. CVA combines several elements of social accountability into one package: civic education, community score cards, social audits and an interface meeting, which brings all stakeholders together.

World Vision launched CVA in Brazil and Uganda in 2005, and has since scaled up implementation across other countries, including India. CVA has become World Vision’s primary approach to local-level advocacy in more than 20 countries.58

Impact in Uganda and India

In Uganda, CVA is used to monitor health clinics in 20 districts across the country, where people use score cards to record the most pressing health needs in their communities. Feedback at the local and district levels has led to measurable improvements in the delivery and quality of health care services. Although other factors may have contributed, the health workers and district government staff at these clinics credit CVA for significantly improving outcomes.

In India, CVA enables children to assess their local health and education facilities. An example is the Fully functional school or Anganwadi campaign, which involved over 20,000 children and allowed them to give feedback using pictorial score cards designed for easy use by children. CVA gives Indian children a voice at local and national level. It has empowered them and their families with knowledge about their entitlements in areas such as the quality of infrastructure in schools and nurseries and the quality and availability of food for children.

Summary

This chapter has highlighted implementing countries’ low awareness of the COIA recommendations for strengthening accountability. It also shows mixed progress on implementing the COIA recommendations, suggesting a need for additional efforts and investment, both from the international community and the implementing countries’ decision-makers.

The chapter has also shown that there is considerable scope for strengthening accountability for women’s and children’s health. This can be done by: building on existing mechanisms, including health sector reviews and human rights obligations; expanding social accountability approaches to improve accountability to citizens and communities; building capacity for parliamentary engagement and oversight; and fully utilizing the power of the media. 

Box 16: Maternal health and budgets in Mexico59

From 1998-2002 the Mexican government implemented several targeted programmes to offer maternal and newborn health (MNH) services to poor communities. However, the budget was insignificant and per capita expenditure was lowest where the concentration of poverty was highest, so failed to address inequality. Targeted programmes did not contribute to improved infrastructure nor increase the number of available physicians in poor states. Using budget analysis supported by the national NGO Fundar Center for Analysis and Research, civil society put pressure on the government to increase and earmark decentralized funds for MNH. When the government created the Popular Insurance, a health protection scheme for unemployed and poor people, emergency obstetric care (EmOC) was initially not covered. The Fundar Center for Analysis and Research costed the provision of EmOC and demonstrated the financial viability of its inclusion. It was included in the benefit package of the health insurance scheme in 2005.
Conclusions

Although it is premature to identify the impact on health outcomes of commitments to the Global Strategy, this report has attempted to assess the added value of the Global Strategy and progress on implementation of the commitments. The findings are encouraging, but challenges and gaps remain.

There is evidence that the Global Strategy has been a catalyst for more focused and coordinated efforts for women’s and children’s health. It has generated high-level political support and built consensus on the key needs and principles in accelerating action towards achieving MDGs 4 and 5. In addition, it has provided a platform for action, contributed to aligning disparate efforts of national, regional and global actors, and promoted public-private partnerships. As reported by stakeholders, implementation of commitments is well underway but constraints have been identified, in particular financial and human resources.

Although significant new and additional funding – at least US$ 20 billion – has been mobilized as a result of the Global Strategy, there is a need to lever significant additional financial commitments to meet the US$ 88 billion gap in funding (for 2011-2015) for the 49 countries highlighted by the Global Strategy. As pointed out previously, however, the US$ 20 billion estimate does not comprise the entire effort related to women’s and children’s health and other investments would contribute to reducing the funding gap. In addition, it has not been possible to estimate the significant financial value of all the policy, advocacy, service delivery and other commitments that were not expressed in explicit financial terms, and which would also contribute to narrowing the financing gap.

While the report demonstrates that most commitments are focused on the 49 Global Strategy countries, there is still concern about geographic targeting – with some countries with high mortality rates and/or off-track on MDGs 4 and 5 receiving relatively little attention. In addition, some key intervention areas recognized as major threats to maternal and child health – such as those related to the prevention and treatment of diarrhoea, pneumonia and malaria – have as yet received relatively little support.

Awareness of the COIA recommendations for strengthening accountability is low among implementing countries, and countries that were aware reported mixed progress on implementing the COIA recommendations. The report has shown that there is considerable scope to improve accountability for women’s and children’s health by building on existing mechanisms, strengthening health information systems, increasing the use of human rights instruments, and fully realizing the potential of parliamentary engagement and social accountability approaches.
Improving the health of women and children cannot be resolved by the health sector alone, and needs to become part of a much larger intersectoral and political agenda. However, actions to address determinants of health that are traditionally not perceived as being within the domain of the health sector – such as safe drinking water, sanitation and hygiene, nutrition and food security, transportation and ICT – are under-represented in the commitments to date.

**Recommendations**

To improve targeting and implementation of the commitments:
- Provide additional support to countries receiving little attention although being either off-track for MDGs and/or with high-mortality rates, so as to close the remaining geographical gaps.
- Focus commitments more strongly on those interventions that are receiving less attention even though they address conditions responsible for significant morbidity and mortality; this is particularly true for interventions against pneumonia, diarrhoea and malaria.
- Continue the increased attention and resources to previously neglected interventions, such as family planning, skilled birth attendance and PMTCT.
- Pursue development of partnerships for development, an MDG in itself (MDG8) but also crucial to achieving MDGs 4 and 5.
- Provide additional technical support to countries to identify priorities and resource needs.

To secure sufficient resources to bridge the financing gap and align commitments with needs:
- Leverage additional financial resources, including from domestic sources. The financial commitments made to the Global Strategy are considerable, yet many implementing countries report that they are still insufficient.
- Allocate existing and additional funding to close the remaining geographical and intervention gaps.
- Improve value for money, not only by prioritizing cost-effective essential interventions, but also by taking action to reduce inefficiencies in resource allocation and use.
- Take action to accelerate the release of funds, and improve the ability of countries to receive and administer funds.

To harness catalysts and mitigate constraints:
- Take advantage of the catalytic effect of the Global Strategy to maintain high-level political support and involve additional stakeholders around the key needs and principles of the GS framework.
- Address the critical human resources challenges, not only shortages but also geographical disparities, retention problems, low motivation and inadequate skills.
- Take other health systems weaknesses, such as poor infrastructure and shortage of commodities, by supporting the implementation of the recommendations of the Commission on Life-Saving Commodities for Women’s and Children’s Health.
- Consider gender and sociocultural issues when designing policies and programs, and allocating resources. Involve men and youth in RMNCH initiatives.

To integrate efforts with other sectors also critical to women’s and children’s health:
- Focus efforts more strongly on other sectors that are critical to improving women’s and children’s health – such as agriculture and trade – and on the integration of nutrition, food safety, safe water, sanitation and hygiene with health.
- Improve enabling infrastructure – for example transportation and ICT – which, in addition to health infrastructure, is critical to improved access.

To advance accountability and strengthen governance for women’s and children’s health:
- Strengthen health information systems to enable more accurate reporting on RMNCH outcomes.
- Sustain the implementation of the recommendations by the Commission on Information and Accountability.
- Ensure alignment and consistency of reporting requirements and mechanisms across existing accountability mechanisms to mitigate the reporting burden of countries.
- Reinforce efforts to track international and domestic financing for RMNCH, for example through reporting of official development assistance using the approach agreed by members of the OECD Working Party on Statistics.
- Promote the role of civil society and parliamentarians, for example through PAP and IPU, in strengthening accountability. In addition, the Global Strategy effort should strengthen and embrace national and regional efforts, such as CARMMA, more profoundly.
- Make better use of human rights instruments and frameworks as they can promote accountability for women’s and children’s health and should be an integral part of tracking commitments.
- Collect more detailed information on the implementation of commitments, when possible, for example disbursement of financial commitments to specific countries and interventions.
- Tailor data collection tools to constituency groups given that commitments sometimes differ in nature between different categories of stakeholders.
- Make future commitments more specific by including deliverables, time-lines and indicators to track progress. The lack of such information has presented serious challenges in assessing progress on implementation so far.