National Accountability Mechanisms for Women’s and Children’s Health

Report commissioned by the Partnership for Maternal, Newborn & Child Health (PMNCH) to inform the PMNCH 2012 report on commitments to the Global Strategy for Women’s and Children’s Health

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Acronyms

AIDS  Acquired Immunodeficiency Syndrome
ALMA  African Leaders Malaria Alliance
CARMMA  Campaign on Accelerated Reduction of Maternal Mortality in Africa
CCM  Country Coordinating Mechanism
CEDAW  Convention on the Elimination of All Forms of Discrimination Against Women
CIDA  Canadian International Development Agency
COIA  Commission on Information and Accountability for Women's and Children’s Health
CSO  Civil Society Organization
DHS  Demographic and Health Survey
DPT  Diphtheria, Pertussis and Tetanus
FMoH  Federal Ministry of Health
GFATM  Global Fund to Fight AIDS, Tuberculosis and Malaria
HEPS  [Coalition for] Health Promotion and Social Development (Uganda)
HIV  Human Immunodeficiency Virus
HMIS  Health Management Information System
ICT  Information Communication Technology
iERG  independent Expert Review Group
IHP+  International Health Partnership and Related Initiatives
IMNCI  Integrated Management of Neonatal and Childhood Illness
IPU  Inter-Parliamentary Union
JANS  Joint Assessment of National Strategies
JAR  Joint Annual Review
JFA  Joint Financing Arrangement
KNCHR  Kenya National Commission on Human Rights
M&E  Monitoring and Evaluation
MDG  Millennium Development Goal
MICS  Multiple Indicator Cluster Survey
MNCH  Maternal, Newborn and Child Health
MoH  Ministry of Health
MoHP  Ministry of Health and Population (Nepal)
NAC  National AIDS Commission
NCWC  National Commission for Women and Children (Bhutan)
NGO  Nongovernmental Organization
NMS  National Medical Stores (Uganda)
PMNCH  Partnership for Maternal, Newborn & Child Health
PMTCT  Prevention of Mother-to-Child Transmission
RMNCH  Reproductive, Maternal, Newborn and Child Health
SCF UK  Save the Children Fund, United Kingdom
SUN  Scaling Up Nutrition (movement)
SWAp  Sector-wide Approach
TB  Tuberculosis
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNICEF  United Nations Children’s Fund
WHO  World Health Organization
Executive Summary

This report was commissioned by the Partnership for Maternal, Newborn & Child Health (PMNCH) to inform the PMNCH 2012 report on the implementation of commitments to the Global Strategy for Women’s and Children’s Health. It reviews national accountability mechanisms for women’s and children’s health. It identifies examples of good practice and innovation and continuing obstacles to improved accountability.

The Global Strategy for Women’s and Children’s Health was the most recent of a number of high-profile initiatives in recent years to improve reproductive, maternal, newborn and child health (RMNCH). These efforts have led to major gains in health outcomes and reductions in maternal, newborn and child mortality with rapid progress in many countries; although in others progress has been more limited or has stalled.

There is consensus that effective accountability holds the key to progress, and the Global Strategy highlighted the need for an effective accountability mechanism to track progress. The WHO-initiated Commission on Information and Accountability (COIA) for Women’s and Children’s Health subsequently developed a framework to strengthen reporting and oversight.

Accountability encompasses three interrelated ideas: monitoring, review and action. It is a cyclical process that assesses progress, recognizes success, identifies problems, takes action where indicated and holds all parties to account. Accountability should be a constructive and balanced process.

The country level is where improvements to women’s and children’s health will be made and is the centre of accountability, including reporting against regional and international commitments. An effective accountability mechanism should be transparent and inclusive, ensuring the meaningful participation of all key stakeholders, particularly civil society. Accountability should be informed by subnational reviews that consider data disaggregated by equity concerns. Review should consider data from the widest range of sources and should ideally include independent review.

The RMNCH landscape in many countries is complex and fragmented. In many cases, projects are not aligned to the national plan and monitoring framework and work in parallel to government efforts. This leads to fragmented performance frameworks, and multiple systems. This can hinder government efforts to maintain a comprehensive overview of progress. Managing multiple performance frameworks and reporting requirements can incur high transaction costs for government and divert attention from performance management of the whole sector. Investment in a small number of health issues has often led to an imbalanced health sector with distorted incentives. The above scenario is a not an atypical starting point for efforts to improve accountability for RMNCH.

There are a number of well-established accountability mechanisms relevant to RMNCH at country level. These include health sector reviews, programme reviews, country Countdown to 2015 events, International Health Partnership reviews, a range of civil society approaches (including social accountability mechanisms human rights
treaty approaches), and parliamentary oversight. The media can also play an important role.

Accountability for women’s and children’s health is typically the responsibility of the Ministry of Health (MoH) and many of the core indicators proposed by the COIA are monitored within existing sector results frameworks. However, other sectors of government play an important role in improving RMNCH outcomes, for example ministries of education and agriculture. Reducing deaths of women and children is more than a technical problem for the health sector and needs to be addressed across government. The outcome of reviews should be reported to the head of state and parliament.

Despite challenges the health sector review is the most appropriate starting point to strengthen accountability. The MoH typically leads a review of progress in implementation of the national health plan along with its development partners. This process has been best developed in countries that have adopted a sector-wide approach (SWAp) to health. However, the process can be made more inclusive, transparent and effective with greater attention to accountability to citizens and service users.

Health sector reviews would gain greater legitimacy by ensuring the meaningful inclusion of all RMNCH stakeholders as full partners in the review process. This includes other government departments whose activities impact on health, parliamentarians, health-care professional organizations, civil society organizations (particularly women’s groups), the private sector and academia. There are existing coalitions in some countries that provide a ready forum for this dialogue to take place.

A number of initiatives can complement a health sector review including, for example, a country-specific Countdown event or an independent review as part of the International Health Partnership (IHP+). The potential role of parliament and the media is often under-exploited. The concept of an independent Commission for Women and Children is attractive to many but there appears to be limited experience in the focus countries with the greatest needs, and mixed experience with National AIDS Commissions.

Reviews typically use a mix of routine health facility data and household survey data. Health facility data generated through the health information system (HMIS) is often incomplete and of variable quality. Efforts to strengthen the HMIS and establish vital registration systems are progressing slowly. The review should employ all possible sources of information including that generated through civil society approaches such as service scorecards, social audits and budget tracking exercises, and studies on compliance with human rights obligations.

There are opportunities to improve the analysis and presentation of findings in advance of the high-level review and to make the review more strategic and focused on action. Budget transparency is still a huge challenge in many of the countries with high levels of maternal and child deaths, and is often the weakest part of the accountability cycle. Where health budgets are limited, governments may have limited room for manoeuvre and the Ministry of Finance/Treasury may be resistant to calls to increasing the health budget and having financial targets for RMNCH. Health is one of many competing priorities facing governments of poor countries.
Recommendations to improve national accountability mechanisms

1. Strengthen the health sector review (the most pragmatic accountability mechanism in most focal countries) to make it more inclusive, transparent and strategic in its operations. The outcome and recommendations should be shared with the head of state and parliament, and compliance in implementing recommendations improved.

2. Improve accountability to citizens through expanding social accountability approaches, monitoring human rights treaty obligations, partnership with the media and parliamentary oversight.

3. Consider all sources of information when reviewing progress and increase the quality of preparatory work through appraisals that feed findings and clear recommendations into the review.

4. Increase alignment and integration of all RMNCH support behind a single national plan and monitoring framework that builds upon and strengthens the existing system.

5. Invest in building capacity of civil society organizations (CSO), the media and parliamentarians to better monitor and use evidence for advocacy and to hold governments to account on RMNCH commitments.
1. Introduction

This report reviews country accountability mechanisms for women’s and children’s health. It seeks to identify examples of good practice and innovation and continuing obstacles to improved accountability. It was commissioned by PMNCH to inform the PMNCH 2012 Report on the implementation of commitments to the Global Strategy for Women’s and Children’s Health, and complements a PMNCH-commissioned study on global accountability mechanisms published in 2011.¹

1.1 Methodology

It was anticipated that two concurrent exercises would identify country examples for more detailed study; the call by the Independent Expert Review Group (iERG) for examples of best practice on country accountability; and the online questionnaire sent by PMNCH to all stakeholders that made commitments to the Global Strategy. Unfortunately, responses to both data collection efforts were limited at the time of writing this report and therefore did not provide a steer to good practice. Additional information submitted to the iERG and PMNCH will be presented in the respective reports to be released in September 2012.

The PMNCH Secretariat provided initial guidance on key informants and an initial round of interviews provided links to further informants for follow up and semi-structured interviews. Document search included review of commitments on accountability, responses to the online questionnaire, and review of county self-assessments presented at the series of subregional workshops to develop country accountability roadmaps for implementation of the recommendations by the Commission on Information and Accountability (COIA) for Women’s and Children’s Health.²

2. Background

In September 2010 the United Nations Secretary-General launched the Global Strategy for Women’s and Children’s Health. This call to action aimed to increase visibility and political support, mobilize resources and catalyse a renewed effort to accelerate progress towards the achievement of relevant Millennium Development Goals (MDGs). Thirty-seven heads of state made statements of intent or specific commitments at the launch, and more than 200 specific commitments totalling more than US$ 50 billion have subsequently been made.

The launch was the latest of a number of high-profile initiatives in recent years to improve reproductive, maternal, newborn and child health (RMNCH). These include the Millennium Summit (2000), Countdown to 2015 (2005, 2008, 2010, 2012), the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) (2009), the Women Deliver conferences, and the G8 Muskoka summit (2010). 2012 will see the launch of further high-level initiatives on family planning and child survival. For example, the Commission on Life-Saving Commodities for Women’s and Children’s Health, launched on 23 March, aims to increase access to life-saving medicines and health supplies by addressing barriers that limit access to essential health commodities. The goal of Committing to Child Survival: A Promise Renewed, held on 14-15 June 2012, is to end preventable child deaths. The Family Planning Summit in July 2012 aims to generate political commitment and resources to meet the family planning needs of women in the world’s poorest countries by 2020. The momentum has increased as 2015 approaches and the MDGs and targets related to RMNCH risk not being met.

These efforts have led to major gains in health outcomes and reductions in maternal, newborn and child mortality with rapid progress in many countries, but in others progress has been limited or stalled. There is consensus that accountability holds the key to progress. At the request of the Secretary-General, WHO established the Commission on Information and Accountability for Women’s and Children’s Health (COIA). This group proposed a framework to strengthen reporting and oversight and to encourage countries and their partners to be more accountable for women’s and children’s health. In setting accountability primarily at the country level the Commission highlighted the need for more active collaboration between national governments, development partners, parliaments, civil society and communities.

In relation to the need for better oversight of results and resources nationally and globally the Commission recommended that:

...by 2012 all countries to have established national accountability mechanisms that are transparent, that are inclusive of all stakeholders, and that recommend remedial action, as required.

The Commission recommended the adoption of 11 core indicators (broadly related to better information, better tracking of resources and stronger oversight) to track progress across the continuum of care. An important element was the need to for all data to be disaggregated by key equity considerations.

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The Secretary-General subsequently appointed an independent Expert Review Group (iERG) to report annually on progress in implementing the Commission’s recommendations regarding reporting, oversight and accountability in 75 priority countries – 49 low-income countries and 26 other countries with high maternal and child mortality – and to assess the extent to which all stakeholders honour their commitments to the Global Strategy and the Commission.
3. Accountability

Commitments relating to reproductive, maternal, newborn and child health (RMNCH) date back to the Convention on the Rights of the Child in 1989 and the International Conference on Population and Development in 1994 but have often not been implemented with the necessary urgency and at scale. This has often reflected lack of adequate resources, competing development priorities in the social and other sectors but at times also a lack of leadership and accountability.

Accountability will be key to the success of the strategy. Accountability can push partners to deliver on their commitments and responsibilities, demonstrate how actions and investment translate into tangible results and better long term outcomes, and tell us what works, what needs to be improved and what requires more attention. Accountability mechanisms that give women, girls and communities the ability and channel through which to challenge and demand change can be empowering.

Accountability encompasses three interrelated ideas; monitoring, review and action.\(^5\) It is a cyclical process to assess progress, recognize success, identify problems, take remedial action and hold all parties to account. It looks at commitments and what actually happened and, where appropriate, provides practical recommendations on what might be done better. It should be a combination of political, managerial and social accountability.

*Monitoring* is about finding out what is happening, where and to whom and what is not happening.

*Review* asks whether or not pledges, promises and commitments have been kept and duties discharged. It asks what good practices can be learned. It highlights geographical, political and social differences and inequities. It asks why commitments were not delivered (and there may well be legitimate reasons for this).

*Remedy or action* refers to measures needed to put things right if they have not gone as promised or planned. This can take many forms; perhaps revisions to a policy, programme, project or budget. At times perhaps full disclosure and a public apology.

Informed self-accountability is important but history tells us that it may not be enough. An independent perspective is important to ensure objectivity and to ensure legitimacy and credibility of the process. Ideally an independent body should be involved to provide answers to these questions: a small, trusted, adequately resourced, transparent, review mechanism.

Accountability should be a constructive and balanced process. However, it can at times be seen as a threatening exercise, particularly if there is a history of punitive rather than supportive measures if progress is poor.

The landscape is populated by a number of global, regional and national RMNCH initiatives that are working to similar ends. Throughout this exercise the question was raised, accountability for what and to whom? – delivering the Global Strategy or implementing the recommendations of the COIA, implementing the National Health Strategic Plan or National Development Plan, realizing the MDGs or all of these?

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While global and regional initiatives provide helpful and supportive frameworks, it is action at the country level that will make the difference to the lives of women and children and where accountability for improved outcomes needs to be focused. Enhanced accountability is required at many levels: between both state and non-state providers and women and wider communities and between governments and parliaments and their citizens and civil society; within the health systems for better performance; and across the aid architecture.
4. National accountability mechanisms for RMNCH

The national level is the anchor of all international institutional arrangements including reporting against regional and international obligations. The nature of accountability mechanisms for RMNCH varies from country to country but they should be transparent and inclusive, ensuring that all key stakeholders are adequately represented. Accountability should span subnational, district and local levels. It should allow review of disaggregate data by equity concerns and consider all sources of information.

The iERG established a number of key operating principles to improve accountability:

- To focus on national leadership and ownership of results;
- To strengthen countries’ capacity to monitor and evaluate;
- To reduce the reporting burden by aligning efforts with the systems used to monitor and evaluate national health strategies;
- To strengthen and harmonize existing international mechanisms to track progress on all commitments made.

Accountability for women’s and children’s health is typically the responsibility of the Ministry of Health (MoH). Many of the core indicators proposed by the COIA are monitored within existing health sector performance frameworks. However, other sectors of government play an important role in improving RMNCH outcomes, for example ministries of education, women’s and children’s affairs, justice, finance and community services. A MoH-led review process may be limited to health sector interventions and fail to take a comprehensive overview. There is a need for high-level leadership beyond health and it is important that the outcome of reviews be shared with the head of state and parliament (see Box 1 for an example from Ethiopia). Reducing deaths of women and children is more than a technical problem for the health sector but is also a national development priority that requires action across government.

Box 1 Ethiopia – High-Level Leadership

The Ethiopian context is marked by a strong commitment at the highest levels to address maternal, newborn and child mortality. The Federal Minister of Health, who served on the COIA, is an identified champion for change. The Prime Minister’s office requests regular updates of sector performance reports within two weeks of the end of each quarter. The MoH presents its nine months performance report to parliament each year. The Health Sector Development Plan sets out guiding principles to achieving its strategic aims: government leadership; enhanced responsiveness to community needs; and comprehensive coverage of priority health sector issues (which includes RMNCH).

A culture of accountability exists for RMNCH, particularly in reducing maternal mortality. Each level of health provision is held to account for progress through a series of internal review processes, including the Annual Review Meeting during which data from the health information system are reviewed and progress against national targets openly discussed. Results emerging from the 2011 Demographic and Health Survey (DHS), suggesting stagnation in the country’s maternal mortality rate and continuing low levels of delivery in health facilities by a skilled birth attendant, have led to increased impetus for action. An accelerated RMNCH strategy was issued in response. The FMoH, with the support of its partners, is investing 62% of the MDG performance fund (a pooled fund under government control) in
strengthening the health system, including strengthening the health extension programme, improving maternal health care at facility level and improving referral.  

*Federal Ministry of Health, Ethiopia*

The health and development landscape in many countries may not facilitate a rational and efficient process of accountability. Development partners may work outside the national plan and budget and in parallel with national systems, which can undermine government leadership. This can create a fragmented response with duplication in some areas and gaps in others. It can lead to a complex mix of plans, systems, procedures and monitoring frameworks. Investment in a few important health issues but not others has led to an imbalanced health sector and distorted incentive systems in a number of countries. The coordination and management of many partners can create a major burden for governments. The above scenario is a common starting point in a number of focal countries when improving accountability for RMNCH. The International Health Partnership+ (see below) mobilizes partners around a single country-led national health strategy with accountability at the centre.

Where a number of initiatives have overlapping goals there is benefit in integrating efforts. In March 2012 over 140 partners gathered in Kampala to implement the Integrated Strategy for Reproductive, Maternal, Newborn and Child Health (RMNCH), led by the African Union. Participants included parliamentarians, representatives of ministries of health, NGOs, health-care professional associations, the media, the private sector, United Nations agencies, academia, donors and youth representatives. The strategy promotes alignment of several African and global frameworks for women’s and children’s health, including the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA),6 the Maputo Plan of Action7 and the Global Strategy. Partners committed to launch country Countdown to 2015 events (see below) to underpin national advocacy efforts. They noted the importance of key stakeholders, especially parliamentarians, media and youth, in ensuring accountability for results and resources and committed to support capacity-building efforts targeting these groups.

A number of well-established accountability mechanisms exist at country level. These include health sector reviews, health and disease specific reviews that may be linked to funding sources, civil society approaches around citizen voice and social accountability including budget tracking and human rights based approaches. Each has an important role in enhancing accountability.

**4.1 Annual Health Sector Review**

A common approach is the health sector review whereby government, most often through the MoH together with development partners, leads an annual/biennial review of progress of implementation of the national health plan. These are often most developed in countries that have adopted a sector-wide approach (SWAp) to

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6 The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) is an African Union Commission (AUC) and UNFPA initiative to intensify the implementation of the Maputo Plan of Action for the reduction of maternal mortality in the Africa region. Launched by the African Union (AU) Ministers of Health in May 2009. see http://au.int/pages/carmma/whatis

7 The Maputo Plan of Action to curb maternal deaths in Africa was launched in September 2006 by Ministers of Health and delegates from 48 African countries in Maputo, Mozambique where they adopted a plan of action to ensure universal access to comprehensive sexual and reproductive health (SRH) services on the continent. See http://au.int/pages/carmma/maputo
health (see Box 2). The SWAp stresses the importance of country leadership, a single sector policy, expenditure and monitoring framework, and use of common approaches across the sector. It accommodates different funding instruments but progresses towards reliance on government systems to disburse and account for funds. The performance of reviews has evolved in many countries over a decade and moved from a government (MoH)–donor relationship to a more inclusive forum that commonly includes representatives of civil society, parliament and the private sector.

**Box 2 The Sector-wide Approach in Ghana, Rwanda and Tanzania**

Ghana, Rwanda and Tanzania have developed systems of monitoring, review and based on many years of experience with sector-wide approaches (SWAp) in the health sector. The health sector strategy is linked to the national strategies for growth and development and poverty reduction. There is a consistent link between reviews and resource allocation through medium-term expenditure frameworks and annual planning cycles and subnational processes of review and action.

National monitoring of progress and performance focuses on a core set of indicators: 18 in Rwanda, 37 in Ghana and 40 in Tanzania. RMNCH indicators account for at least half of these and are also prominent in the monitoring component of overall development plans.

Data availability and quality have improved during the past decade, mainly due to more frequent health surveys. The monitoring input in annual reviews is largely based on facility and administrative data sources with problems of availability, completeness and quality of data. Data on births and deaths/cause of death is lacking in all three countries. Off-budget spending by development partners is not routinely tracked.

The institutional mechanisms to support critical elements of monitoring, including data quality assessments, data sharing, analysis and synthesis, and communication of results are recognized to need strengthening in all three countries. These functions are concentrated in the MoH where there is limited capacity. The involvement of key country institutions and independent assessment should be an integral part of the monitoring process.

Health sector reviews and planning summits are conducted on at least an annual basis with broad stakeholder involvement. Development partner participation is prominent, but the civil society role is less clear. Many, but not all, development partners have aligned themselves with these country-led monitoring/review processes.

Maternal, newborn and child health (MNCH) appears high on the political agenda in the three countries. All three countries have roadmaps and plans to accelerate progress towards MDGs 4 and 5. Commitments to the Global Strategy are linked to national strategies and seen as an additional opportunity to strengthen implementation. The MNCH reviews include programme specific reviews and are embedded in the well-established national system of reviewing progress and performance.

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8 Accountability for women's and children's health in countries - Current practices and challenges in Ghana, Rwanda and Tanzania - A case study prepared for the Commission on Information and Accountability for Women's and Children's Health. WHO, 20 April 2011.
There are many common features of the sector review that countries identify as requiring strengthening. This section draws on the country self assessments presented during the series of subregional workshops to develop country accountability roadmaps (see Box 3).

**Wider and more meaningful participation**

Sector reviews demonstrate varying levels of inclusion – for example, participation of other government sectors whose activities impact on health such as education or women and children’s affairs. Dialogue can be too focused on development partners and government and meaningful participation of CSO and the private sector may not be encouraged. Parliamentarians’ role, while increasing, may also be limited. The participation and representation of women’s groups in the reviews can be improved in many countries. Many countries have parliamentary committees, networks or caucuses on health, reproductive health, population and development, or gender and poverty alleviation with opportunities for closer collaboration. Not all development partners are engaged in the process.

**Improved quality of information and more robust analysis of data**

Routine data collection through the routine health management information system (HMIS) is often weak and may not be linked to the Central Statistical Office and other involved ministries. The HMIS has many gaps; in management, staffing and infrastructure. Despite the presence of a single monitoring framework partners may continue to employ a multiplicity of tools to monitor progress. In many cases the validation, disaggregation and coverage of data need improvement.

**Better preparation and more strategic review process**

The health sector review takes a comprehensive overview of the sector at a high level. More detailed preparatory appraisal processes for RMNCH can condense main findings to enable the review to focus on action points. Reviews are informed by analysis of qualitative data (e.g. policy changes, public opinion, service provider opinions) and quantitative (HMIS, survey) data but analysis could be more systematic and include information from the widest range of sources.

**Greater attention to action**

Challenges remain in translating the review findings into at all levels and in monitoring compliance with recommendations.

**Greater transparency and improved dissemination of information**

Review reports can be made available online, and packaged in accessible formats for different audiences including parliament and the media.

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Box 3 Countries develop country accountability roadmaps

A series of regional workshops is under way involving the 75 priority countries and regional and global partners to develop country roadmaps to strengthen national accountability and action for improving women’s and children’s health. The work is part of the action plan to implement the recommendations of the Commission on Information and Accountability and organized by WHO. Country participants assess their situation and develop draft roadmaps for enhancing accountability in seven key areas: monitoring of results, tracking resources, civil registration and vital statistics, maternal death reviews, strengthening the use of information and communication technology (ICT) and advocacy and action. A country accountability tool with suggested criteria for progress in each area is used by delegations to identify strengths and weaknesses and define appropriate actions for their country. The draft will be further developed through wider consultation in each country and funding provided to support the process. Feedback on the workshops and the assessment tools has been positive. While focused on strengthening accountability for women’s and children’s health, the framework will complement and strengthen accountability across the wider health sector.

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4.2 National Commissions for Women’s and Children’s Health

A potential option to strengthen review mechanisms in countries is to establish a national commission for women’s and children’s health along the lines of a National AIDS Commission (NAC). Such a body would be independent, chaired by a respected senior individual and would report to parliament. It would be inclusive of all relevant government departments, and would engage nongovernmental organizations. The concept of an independent Commission for Women and Children is attractive (see Box 4) but there appears to be limited experience in the focus countries with the greatest needs.

Box 4 The Bhutan National Commission for Women and Children (NCWC)

Established in 2004, the National Commission for Women and Children (NCWC) is an autonomous institution of the Government of Bhutan. The NCWC is the national mechanism for coordinating and monitoring activities related to women’s and children’s rights, and reporting to treaty bodies. It is governed by a Chairperson, the Minister of Education, and a Board of Commissioners from the police, judiciary, NGOs, civil society, academia, private sector and line ministries. The Commission has a cross-sectoral and mixed representation of members from the government, law enforcement, judiciary, social sector and civil society, including the media and the business sector.

National Commission for Women and Children, Royal Government of Bhutan

The COIA considered the experience of NACs in leading the multisectoral response to HIV/AIDS. A suggestion was made to extend the remit of NAC to encompass RMNCH. The NAC took many years to establish and many have since been disbanded. Experience of the NAC mechanism has been mixed with evaluation highlighting a number of concerns. Although the NAC was responsible to coordinate
the national response across sectors, including civil society and the private sector it was often seen as a public sector body with minimal or tokenistic representation of interest groups. The creation of a multisectoral institution did not necessarily foster a multisectoral approach. The NAC promoted the “three ones” concept which subsequently had to adapt to the separate mechanism related to Global Fund grants—the Country Coordinating Mechanism. The lack of lines of accountability to ministries and the establishment of the NAC as standalone institutions created political tensions with the MoH and undermined the ability of the MoH to deliver the health sector response to HIV. The leadership of the AIDS response has often returned to the MoH. The World Bank OED 2005 evaluation concluded that “evidence to support the effectiveness of institutions to manage the AIDS response outside of the MoH from the World Bank’s experience is scant”.

Lessons from the AIDS response of relevance to RMNCH are the success of in-country processes such as common planning and reviews around the “three ones” concept the inclusion of civil society and their prominent role in the response, and the reporting obligations against international commitments to United Nations General Assembly Special Sessions on HIV/AIDS. The NAC model did manage to engage the highest level of government in the response, a vital link that the health sector review has failed to achieve in some countries.

4.3 Country Countdown event

Launched in 2005, Countdown is a global movement of academics, governments, international agencies, health-care professional organizations, donors and NGOs with The Lancet health journal as a partner. Countdown gathers household survey data (Demographic and Health Surveys [DHS], Multiple Indicator Cluster Surveys [MICS]) from the 75 countries where 95% of MNC deaths occur. It provides a regularly updated snapshot of coverage levels of effective interventions, health systems functionality, health policies, financing, and equity. The latest Countdown report was released in June 2012.

Countdown supports countries in utilizing Countdown data, methodological approaches, reports, and conferences as a means of catalysing national progress and ensuring accountability. Senegal held the first national Countdown conference in 2006, bringing together government leaders, private and public partners, and the research community to review progress in child survival. Zambia held a national Countdown event in 2008, resulting in significant actions to improve maternal, newborn, and child health by the government and other stakeholders. Nigeria has embarked on an Integrated Maternal, Newborn and Child Health Strategy that includes the regular production of up-to-date child and maternal health profiles for each of its 36 states, modelled on the Countdown country profiles. More countries plan to hold country Countdowns from 2012.

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10 Three Ones: One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners, one National AIDS Coordinating Authority, with a broad-based multisector mandate, one agreed country level monitoring and evaluation system.
12 UNAIDS interviews.
4.4 The International Health Partnership and Related initiatives (IHP+)

IHP+ was launched in 2007 with the objective to accelerate progress towards the health related MDGs through a commitment of developing country governments and development partners to “work effectively with renewed urgency to build sustainable health systems and improve health outcomes” in low and middle income countries. It mobilizes partners around a single country-led national health strategy with accountability at the centre. The initiative is essentially about improving the effectiveness of aid and implementing the Paris/Accra principles in the health sector (national ownership, alignment with national systems, harmonization between agencies, managing for results, mutual accountability).

IHP+ includes 25 development partners and 24 countries (see Box 5 for an example). Partners commit to annually undertake an independent evidence-based assessment of results at country level and of the performance of each partner individually and collectively. It has developed well received common tools such as Joint Assessment of National Strategies (JANS). Data is presented as a set of accessible performance scorecards for each country and partner. IHP+ highlights the impact of fragmented performance frameworks, information systems and project based monitoring in hindering government efforts to maintain a comprehensive overview of progress. The management of such multiple performance monitoring reports incurs high transaction costs for government. Despite countries having a single performance assessment framework including a mix of health and system indicators this has not reduced requests for additional indicators. It is too early to judge if the IHP+ is contributing to stronger health systems or improved health outcomes.

Box 5 Nepal- IHP+ Independent monitoring of progress

Since the MoHP and external development partners signed the 2004 Statement of Intent to guide the Partnership for Health Sector Development, Nepal's health partnership and performance review mechanisms have evolved considerably. Joint annual reviews of health sector performance have been held since 2005. Partnership agreements, or compacts, have become progressively more explicit. The 2010 Joint Financing Arrangement (JFA), signed by the government and 10 development partners, emphasized the Joint Assessment Review (JAR) as the single joint review mechanism for all partners to monitor progress against agreed priorities and results. It contained common procedures for monitoring and reporting. Preparation for the JAR is becoming progressively more systematic, and discussions during the JAR more strategic. Improving maternal and child health is a major priority in the current National Health Sector Development Programme 2010-15, and in the 2012 JAR the priority topics were maternal and child health, health workforce, monitoring and evaluation, financial management and medicines procurement and distribution. In the 2012 JAR external development partners reported back on progress on their own commitments in partnership documents for the first time. The government of Nepal confirmed that the Ministry of Finance’s new Aid Management Platform, which will contain external development partner and NGO data, is to be extended to sector level during 2012 and will be publicly available. The 2012 JAR Aide Memoire stated that an holistic costed M&E plan would be ready by mid-2012. An additional route to increasing accountability is the independent monitoring of progress by IHP+ Results against commitments made by signatories to the IHP+ Global Compact: Nepal has participated in 2010 and 2012.
4.5 Health issue-specific and disease-specific reviews

The health sector review is the main national accountability mechanism for overall performance against the national health plan. However, there are parallel accountability mechanisms that are related to specific health issues, diseases or funding sources. In recent years major effort and resources have been directed to HIV/AIDS, TB and malaria and childhood immunization which have separate accountability mechanisms that involve a wide range of stakeholders. The Country Coordinating Mechanism (CCM) for Global Fund Grants has increased local ownership and participatory decision-making. These country-level partnerships develop and submit grant proposals to the Fund based on priority needs at the national level and oversee progress during implementation. The CCM includes representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, nongovernmental organizations, academic institutions, private businesses and people living with the diseases. While increasing inclusion and participation they have added substantially to transaction costs for government.

Since 2010 high-profile initiatives have been launched against noncommunicable diseases¹⁴ and under-nutrition (Scaling Up Nutrition-SUN).¹⁵ Advocates for each argue rationally for the need for accelerated attention for a long neglected issue of global importance and call for the need for substantial resource mobilization. Plans include a new accountability framework. Multiple, often-competing initiatives with separate accountability mechanisms and data collection systems that may work in parallel to the HMIS is a problem for ministries as they strengthen their national systems. There is no ready solution as support is often linked to performance and the requirement for high-quality data.

In 2012, three linked initiatives take up key challenges set out by the Global Strategy: The United Nations Commission on Life-Saving Commodities for Women and Children aims to ensure better access to life-saving commodities for women and children; A Promise to Keep: Ending Preventable Child Deaths is a new movement calling for better accountability and targeted life-saving interventions for children over the next two decades. A Family Planning Summit will aim to generate unprecedented political commitment and resources from developing countries, donors, the private sector, civil society and other partners to meet the family planning needs of women in the world’s poorest countries by 2020. It will be important to ensure that the focus on particular elements of the overall RMNCH strategy does not divert attention from the need to implement the whole strategy for women and children and in doing so undermine the consensus that has been built up around the continuum of care over recent years. It will be important that accountability and reporting related to these initiatives is consistent with national accountability mechanism and follows the principles set out by the COIA.

One targeted initiative has engaged heads of states in the accountability process. The African Leaders Malaria Alliance (ALMA) was launched in 2009 to reach

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¹⁵ Scaling Up Nutrition (SUN); www.scalingupnutrition.org
universal prevention and coverage of malaria interventions by 2010 and eliminate preventable deaths by 2015. The stated aims include keeping malaria high on the political and policy agenda at all levels. ALMA employs a visual scorecard to enhance accountability and track progress. The scorecard includes four MNCH indicators (PMTCT, skilled attendance at birth, exclusive breast feeding, immunization coverage with DPT3). While this is a bonus for the visibility and focus on malaria it may divert attention from wider health challenges.

4.6 Civil society approaches

Accountability is commonly viewed as a government–donor and donor–government relationship but is also about government accountability to its citizens and responsiveness to populations’ expectations of the health service. Enhanced accountability is required at many levels: between both state and non-state providers and women and wider communities and between governments and parliaments and their citizens and civil society.

Civil society has a powerful potential accountability role as a watchdog in holding government to account and a role in advocacy and campaigning (see Box 7). Civil society organizations (CSO) support service delivery, help build capacity in critical skills and pilot new approaches. CSOs are increasingly involved in health planning and review mechanisms and contribute to policy development and debate in some countries but in others are not engaged in a meaningful way. There is scope for stronger partnerships with government but CSO can be perceived as a threat, particularly when challenging government over perceived human rights violations.

4.6.1 Social accountability approaches

Social accountability is a bottom up approach in which citizens as service users can affect social services and change behaviour of service providers through their collective voice and influence. There has been increasing interest in recent years in the potential of individuals and communities as users of services and as citizens, as a key force for change. There is increasing use of scorecards and social audits, and use of new information technologies to contribute to social monitoring (see Box 6). Their participation may include initiating campaigns to inform citizens about their rights and what services they are entitled to, performing third-party monitoring through processes such as social audits, and conducting analyses. They may undertake budget analysis and public expenditure tracking surveys to “follow the money” from central government budgets through to service providers, or absenteeism surveys to monitor attendance of service providers in health facilities.

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16 ALMA is an alliance of African Heads of State and Government working to end malaria-related deaths. This body was founded by African Heads of State to utilize their individual and collective power across country and regional borders; see http://www.alma2015.org/

17 See Annex 1 for examples of social accountability interventions

18 Citizens and Service Delivery; Assessing the Use of Social Accountability Approaches in the Human Development Sectors. Dena Ringold, Alaka Holla, Margaret Koziol, Santhosh Srinivasan. World Bank 2012
Box 6 Uganda’s Coalition for Health Promotion and Social Development (HEPS)

The Coalition for Health Promotion and Social Development (HEPS) is part of the Stop Stock-outs Campaign, an effort that began in response to a finding that less than half of Ugandan public health facilities were stocked with the necessary medications, with average stock-outs lasting 2.5 months. HEPS encourages citizens to use text message technology to report stock-out rates to HEPS, which aggregates the information into interactive maps. The maps serve as a tool for informing policy makers and service providers of medicine shortages across the country. Wide media coverage generated a public debate on medicine stock-out and led members of the Social Services Committee of parliament to take up the issue. The National Medical Stores (NMS) has since been given more responsibility for procurement and distribution of medicines, while the responsibility of the district local governments has been reduced. In August 2009, parliament approved a separate vote for NMS in the national budget. The President has established a Drug Monitoring Unit in the President’s Office, with a mandate to investigate and curb theft of medicines in government hospitals. The Stop Stock-outs campaign raised awareness about the right to health and to access essential medicines, increased public engagement in reporting stock-outs and in holding institutions to account. The Government responded to the campaign in a positive way with changes under way at policy and implementation level.

Uganda Coalition for Health Promotion and Social Development (HEPS)

It can be difficult for citizens to assess the performance of providers. Users of services may lack information about service delivery, or an understanding of how to interpret information, such as budgets and financial reports, and the capacity to act on such information. People may misunderstand service delivery and act in a way that does not improve its quality or may even undermine it. Individually, citizens and service users may be reluctant to challenge the authority of providers. People may think they do not have the right or knowledge to question health workers because of the professionals’ status or credentials. They may be concerned about the repercussions of giving negative feedback. Moreover, citizens simply may not have time to give feedback on service delivery by filing a complaint or attending a health meeting. The political and social setting in a country – and the associated power relationships among poor citizens, providers, and the state – may greatly influence the capacity of citizens to use information to hold providers accountable.

Box 7 India – effective advocacy for maternal health

In India, studies in the 1990s suggested the persistence of high maternal mortality, but it was the power of a few key focusing events, facilitated by advocates and political entrepreneurs, that created political prominence. The first was a White Ribbon Alliance-organized march to the Taj Mahal, the second the hosting of World Health Day when the Prime Minister met with Directors-General of WHO and UNICEF. Later, the Prime Minister expressed deep concern over India’s very high maternal mortality rate. Extensive dialogue resulted in a national consensus on an intervention strategy providing workable solutions. Evidence on the problem as well as programmatic successes continued to be generated. State governments were

engaged and civil society organizations worked with the media and parliamentarians, promoting accountability at various levels. The political window arrived with the 2004 parliamentary elections, after which spending on health increased, with maternal mortality reduction as a core priority. Many challenges remain, but the appearance of maternal mortality reduction on the national political agenda has improved its prospects.

The White Ribbon Alliance for Safe Motherhood

Individually, social accountability mechanisms may be ineffective. Passing a right-to-information law does not guarantee that information will be made available to citizens unless information campaigns are undertaken to let people know how to file a request. Citizens need both information and the channels to use it. It is therefore important to consider how social accountability tools interact with each other.

Policy-makers can create or hinder incentives for service providers to adapt behaviours and performance in response to citizen demand. Participatory monitoring tools can generate evidence for citizens to engage policy makers. Examples include use of report cards and scorecards where users report levels of satisfaction with services followed by review and discussion between clients and service providers to develop an improvement plan where indicated. Social audits use the community to check information reported by providers with information collected by users; for example do allocated funds reach the facility, do eligible people receive benefits such as fee waiver. Results are discussed in a public gathering with officials.

Box 8 Peru – Participatory Voices: accountability though monitoring 20

Improving the Health of the Poor: A Rights Based Approach aimed to improve the health of the poor and marginalized in Peru through creation of greater accountability of health workers. Strategies were developed to make health sector policies and institutions more responsive to the health rights of the poor through participatory mechanisms for planning, provision and evaluation of health services. An important mechanism for accountability has been the strengthening of citizen monitoring of health services. While important advances had been made in health there was still need to ensure effective implementation of policies.

An alliance was established between ForoSalud Puno, the Regional Ombudsman’s Office, and networks of community women leaders. Following a capacity building intervention, 47 women were selected as monitors and with the regional representative of the Ombudsman’s office, visit the local authorities and local health teams to introduce the initiative. The women, working in pairs introduce themselves to health staff. They monitor health facilities over three to eight hours, review admissions, maternity and child health consultations, and the administrative health insurance section. The women consult users about the quality of the services and how they were treated. They speak with health-care providers, watch procedures, observe both good and bad practice and note names of health workers involved in each case. Once a month there is a meeting with the regional Ombudsman’s office, where the women report their findings. The Ombudsman’s office representative records the information and reports findings to the health-care facility manager and health team.

20 http://righttomaternalhealth.org/resource/hr-based-approaches
Monitoring provided evidence of reduced hours of health service provision as a mechanism to deter women from using the health services and charging for medicines that should be free. But there was also evidence that attitudes are changing and improvement in the quality of health service provision (e.g. explanation of the condition and treatment prescribed). Evaluation demonstrated many benefits to both civil society and health workers who now have a greater understanding of health rights. Health-care workers demonstrated improved attitudes and greater responsiveness to the needs of the poor. Evaluation demonstrated increased numbers of births in health facilities (from 9,183 to 12,184), increased access to culturally appropriate childbirth i.e. vertical birth (from 194 to 437) between 2008 and 2009. The work contributed to institutionalization of citizen surveillance as part of Peru’s national health policy and the launch in 2010 of national policy guidelines to promote citizen surveillance.

CARE

4.6.2 Budget tracking

The budget is the government’s single most important overarching policy instrument. It shows the priorities and values of government. It affects the lives of all citizens. A government commitment without a budget allocation cannot be implemented. Civil society’s engagement with budgets aims to demystify the idea that budgets are a government’s business with no role for citizens (see Box 9 and 10). It brings citizens closer to the decisions that affect their everyday lives. The poor and most vulnerable are often the most dependent on the public health system, and may thereby be most affected by how public resources are allocated. Even if funds are allocated to pro-poor policies, weak financial management – and a lack of political power among the poor – can mean that money does not always reach the intended beneficiaries. Civil society organizations track national budgets to assess government’s priorities and funding commitments. However, specific data on domestic expenditure on the MDGs and RMNCH are not readily available. The COIA has recommended improved resource tracking of overall health expenditure and expenditure by RMNCH by financing source per capita by 2015.

Box 9 Ask Your Government Initiative

The Ask Your Government initiative asked 84 governments for specific MDG-related budget information on: expenditures on training midwives and procurement of drugs to reduce maternal mortality; the predictability and volatility of development aid; expenditure on environmental protection agencies and fossil fuel subsidies. Most governments in the study could not specify how much they spent on interventions to reduce maternal mortality. Many governments did not consider that citizens were entitled to know about expenditure.21 The initiative tested access to budget information on development investments. It led to a campaign to encourage governments to publish timely, accessible and useful budget information and for people to ask their governments what they are spending on development.

International Budget Partnership

Civil society engagement in budget work can help citizens promote their right to health. Analysis of the government’s budgets, and relating them to commitments and plans, as well as the disease burden, can empower civil society through evidence to

advocate on national and local planning and budgeting priorities and to participate in these processes. This work can enable civil society to initiate a dialogue with government about resource allocation and to inform policy decisions. The process demands greater transparency, accountability and citizen participation in government budgets.

Box 10 Maternal health and budgets in Mexico

From 1998-2002 the Mexican government implemented several targeted programmes to offer MNH services to poor communities. However, their 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 activists pressured 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 not covered. Activists costed the provision of EmOC and demonstrated the financial viability of its inclusion. It was included in the service package of the health insurance scheme in 2005.

International Budget Partnership

Budget work can be a powerful way to communicate issues to the public, helping ordinary citizens to understand how the government is performing in delivering essential services, and mobilizing them to hold the government accountable. SCF UK has developed a budget tracking guide that can be used at different levels and with various entities to track health allocations and expenditure (see Box 11). It makes the case for why civil society should engage in health budget advocacy and provides an introductory guide for how to do this.

Box 11 Budget monitoring in Sierra Leone

Save the Children (SCF) UK have produced materials to introduce civil society to budget work, to aid their understanding of the value of budget monitoring and guide them through the steps to maximize the impact of budget analysis and advocacy. The guide was piloted in the Sierra Leone office and SCF worked with a local CSO network, the Budget Advocacy Network (BAN), to build capacity.

The analysis demonstrated a substantial decline in the 2012 health budget. SCF, in collaboration with partners, initiated a number of activities to influence the President’s office. This involved a range of public activities including work with the media and lobbying of the government and key development partners. In the weeks that followed, the President announced a supplementary budget for health for 2012, bringing it back up to the previous level of 11% of total government budget.

SCF and BAN plan to scale this work up in 2012, to influence the 2013 budget. Sierra Leone is a country with little centralized information on health budgets and expenditures, so there is wider interest in government in this work. Other partners have been engaged, including World Vision and Oxfam, and plans made to undertake budget advocacy in a consistent way across all districts and at the national level, building a more complete picture of public resource flows for health.
4.7 Human rights based approaches

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. This fundamental right is recognized in the majority of the core set of international human rights treaties, including the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities. It is also reflected in the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). All states have ratified at least one international treaty recognizing the right to the highest attainable standard of health. This human right is also recognized in regional human rights treaties and in numerous national constitutions worldwide.

States 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. They provide an independent perspective. South Africa, Kenya and Ecuador have the right to health enshrined in their constitutions. Realization of the progressive right to health will involve adequate resourcing of the health system and investment to address the health needs of the population. The state remains ultimately accountable for guaranteeing the realization of the right to health. Box 12 provides an example from Kenya of how the government has established a mechanism to ensure the right to maternal health.

Many countries, particularly young democracies can regard “rights based approaches” as a threatening and perhaps hostile process. Governments have obligations to international treaties but can regard civil society groups, often supported by international NGOs who raise concerns as opponents. The challenge is to shift this perspective to one in which they are seen as a supportive but critical friend and contributor to a collective process of constructive accountability.

The COIA recommendations pose a clear challenge to civil society to become more robust in holding governments to account. In linking accountability with human rights, the Commission built its accountability framework on the right to health, equity in health and gender equally.

Box 12 Maternal Health in Kenya

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 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.* Pumwani Maternity Hospital is situated in the centre of Nairobi and its clients are mostly the very poor and vulnerable. The report pointed to underfunded services and a government failure to provide quality health care that contributed to high maternal mortality.

A preliminary review concluded that such violations were common in many government hospitals/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 the Republic of Kenya and to parliament. *Kenya National Commission on Human Rights*

When national accountability mechanisms do not provide satisfaction people may turn to the courts as a last resort. International mechanisms can enhance accountability where national mechanisms are inaccessible, ineffective or absent. For example, United Nations treaty monitoring bodies, which independently oversee the implementation of international human rights treaties, review national reports periodically submitted by states parties and issue recommendations accordingly. Some of them, like the CEDAW Committee, also oversee complaints procedures such as the one described in Box 13. The message to governments is to set up independent non-judicial accountability arrangements to avoid recourse to courts.

**Box 13 Maternal mortality and human rights: landmark decision by United Nations human rights body.**

In August 2011, the Committee on the Elimination of Discrimination against Women, charged with overseeing obligations under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), became the first United Nations human rights body to issue a decision on maternal mortality. *Alyne da Silva Pimentel v. Brazil* established that states have a human rights obligation to guarantee women of all racial and economic backgrounds timely and non-discriminatory access to appropriate maternal health services. The Committee also established that governments outsourcing services to private health-care institutions remain directly responsible for, and must regulate and monitor the actions of, these institutions.

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22 For details see the publication *Failure to Deliver* at [www.fidakenya.org](http://www.fidakenya.org) or [www.reproductiverights.org](http://www.reproductiverights.org).

Alyne da Silva Pimentel, a Brazilian woman of African descent, died from pregnancy-related causes after her local health centre misdiagnosed her symptoms and delayed providing her with emergency obstetric care. Her mother took the case to the CEDAW Committee, arguing that national authorities had made no effort to establish professional responsibility and that she had been unable to obtain justice in Brazil. The Committee found violations of the right to access health care and effective judicial protection in the context of non-discrimination. These rights are guaranteed by the CEDAW in the 187 countries that are party to it and legally bound by its provisions, as well as by most countries' constitutions and laws. Cases of this kind furnish opportunities for international and domestic accountability.

The Committee illustrates how a human rights approach can strengthen accountability for maternal deaths at the national level. The case has global significance and may have global repercussions. Nationally its impact will be felt in the extent to which Brazil complies with the Committee’s recommendations. The Committee requested that Brazil submit within six months a written response detailing any action taken in response to its views and recommendations.

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4.8 Parliament

Parliamentarians play a critical role in allocating resources, enacting laws, overseeing implementation, and reflecting the views of citizens about their health services. Parliamentarians represent the people, they shape policies, approve budgets and hold the executive branch of government to account – all vital components of the concerted needed to improve RMNCH. They potentially play a crucial role as advocates for women’s and children’s health. They can create enabling environments through legislation and through policy and budget support, and most importantly they can promote accountability of the executive and political arms of government for women’s and children’s health.

However, this ideal is not easily accomplished. Parliamentarians can face problems when trying to take part in the dialogue on international agreements; others face limited resources and capacity and given their wide responsibilities may not be familiar with the issues. The PMNCH has worked closely with the Inter-Parliamentary Union (IPU) and host parliaments in organizing panel discussions, site visits, research reports and information summaries to increase knowledge and awareness among parliamentarians, focusing on their important roles in allocation, oversight, representation and accountability for women’s and children’s health. The IPU holds a biannual general assembly for members, and during the most recent one in March 2012 an important resolution on MNCH was passed (Box 14). Examples of how parliamentarians have engaged in MNCH are provided in Box 15.
Box 14 Inter-Parliamentary Union makes landmark resolution on MNCH

In March 2012 delegates to the Inter-Parliamentary Union (IPU) in Kampala passed a resolution calling for all member parliaments to take all possible measures to achieve Millennium Development Goals (MDGs) 4 and 5 by 2015. This is the first time that the world’s parliaments, acting through the IPU, have passed a resolution on this issue. Over 1500 members of parliament and parliamentary staff from 119 countries attended the assembly and the debate on the resolution featured more than 50 interventions.

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, civil society organizations, media, the private sector and all other relevant actors.

The IPU intends to support this effort through development of tools that parliamentarians will be able to use in their efforts to promote accountability for better results. The resolution gives IPU a renewed mandate to work with its partners to strengthen parliamentary capacity in support of maternal, newborn and child health.

Box 15 Parliaments in action on MNCH

The Vietnam and Rwanda parliaments passed legislation to remove financial barriers that prevented universal access to healthcare and introduced legislation to ensure free care for children under six years.

In Zambia and Uganda the women’s caucuses were instrumental in the process leading to legislation to protect women during and after pregnancy through provisions in the National Employment Act and Labour Act.

The Uganda Parliament held up the budget until the RMNH allocation was increased.

The Rwanda Parliament requested a progress report on RMNCH.

In Cambodia the women’s caucuses in the Senate and National Assembly work together on women’s and children’s issues.

4.9 The Media

The media has an important but often unexploited role to play in increasing awareness 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’ voices. It can be an important ally in holding government to account for meeting commitments and a powerful advocate for social change (see Box 16 and 17).
Box 16 Nigeria: Accountability Campaign for Gender Equity and Safe Motherhood

In 2011 *Friends in Life Education Peer Club* (FLEP Club) in Imo State, Nigeria, led efforts to encourage the Governor to publicly declare support for the Gender Equity Law. This law safeguards the right to quality maternal care, family planning and safe abortion under certain circumstances. Although the law was passed in 2007, it had not been publicized or implemented and services remain out of reach of most women and maternal mortality remains high. The campaign aimed to hold policy-makers and community leaders accountable for MNH commitments. FLEP Club launched a petition to demonstrate public opinion in support, partnered with local media and convened political and civil society leaders, public servants and other interested partners to push for implementation of the law.

FLEP Club was successful in raising public awareness and letters to the Governor’s office urging action on implementing the law. Media outlets drew attention to the issue through radio, television and newspapers. Local newspapers agreed to publish regular columns on safe motherhood and accountability and to launch a quarterly newsletter titled *Mandate and Accountability*. The increased support and attention resulted in public expressions of support by senior political leaders and led to revitalization of the dormant Federation of Imo NGOs.

This project exposed the influence of religious and cultural sensitivities, and the effect of a change of government on policy implementation. Civil society had established a close relationship with the administration that passed the law. In 2010 a new Governor was appointed who while discretely expressing support he refrained from any public proclamation. The campaign and grassroots support proved powerful. Moving forward it will be critical to engage religious and traditional leaders, and youth groups. The most effective media in stimulating a community reaction were radio and television and future campaigns must consider how best to reach rural and illiterate communities.

*The White Ribbon Alliance for Safe Motherhood*

Box 17 Advocacy & the Media: Launch of Born Too Soon: The Global Action Report on Preterm Birth

The launch of this report in May 2012 resulted in the largest-ever media reach for an RMNCH event. More than 45 partners coordinated a traditional media and online strategy that resulted in the an estimated 1 billion media consumers, 70 million Twitter impressions and coverage on the front page of the New York Times. Coordinated subgroups on media messaging and outreach (chaired by Hoffman & Hoffman), events (chaired by PMNCH), Twitter (chaired by Save the Children), online video (chaired by March of Dimes), and Facebook/web production (including an interactive map, chaired by March of Dimes).

Follow-on advocacy included a breakfast briefing to ministers at the World Health Assembly. USAID spoke to the need to incorporate preterm birth in the June 2012 Call to Action for Child Survival in Washington DC. The Ministry of Health, China, is to host a Beijing launch of the report tied to its first-ever International Symposium on Maternal and Infant Health in July 2012.

*PMNCH*
4.10 Common challenges to stronger accountability

The RMNCH landscape in many countries is complex and fragmented with many projects. These may not be aligned to the national plan, may not be reflected in the national budget, and may work in parallel to government efforts. This leads to fragmentation of effort and information systems and when associated with weak coordination and integration can hinder government efforts to maintain a comprehensive overview of progress and lead to high transaction costs for government.

**Monitoring**

Progress is slow in strengthening health management information systems. Data is often incomplete and of variable quality, with reliance on periodic household surveys. As the quality, completeness and timeliness of facility data improves, the gap between routine and survey data is likely to narrow. Data collection often misses the private sector contribution and excluded populations and disaggregation of data remains limited.

The potential of mobile- and IT-based information systems in health remains unexploited at scale despite promising pilots. The establishment of civil registration and vital events systems is a long-term process and as with efforts to strengthen information systems will require a comprehensive and coordinated approach.

There is need to make greater use of the widest range of data sources including civil society monitoring in preparation for review. There are opportunities to improve the analysis and presentation of findings in advance of the high-level review.

There is room to improve the transparency of the budget, which is seen as the weakest part of the accountability cycle. Public expenditure studies and budget tracking by civil society will complement government efforts. Better tracking of resource allocations (for health and for RMNH) is progressing slowly and countries will rely on periodic national health accounts exercises to provide data.

**Review**

The health sector review covers a very broad agenda, and is not as inclusive or transparent as it could be. Reviews in some countries are becoming progressively more systematic and discussions more strategic. The absence of independent monitoring potentially undermines the credibility and legitimacy of the process. Compliance with recommendations of the review can be strengthened. Governments need to see civil society as a supporter rather than an opponent and parliament as an ally in the budget process.

**Action**

Governments in many of the focal countries may have limited budgetary room for manoeuvre. Budgets for health are limited in low-income countries and the Ministry of Finance/Treasury may resist calls to increase the health budget and to set financial targets for RMNCH. Health is one of many competing priorities facing governments.
A large proportion of external resources is often earmarked for a limited number of health issues and can create an imbalance in the sector and distort incentive structures.
5. Conclusions and recommendations

Better data is essential for accountability with need to make the maximum use of all data sources; routine data from health facilities, from population level surveys, and from social accountability and human rights based approaches. There is a particular need for greater transparency around the budget.

While the health sector review is the most appropriate starting point for better accountability for RMNCH there are many areas where the process can be improved: to become more inclusive and encourage meaningful participation of all stakeholders, civil society, parliament, and other government departments. This will require greater efforts to strengthen community systems and participation with communities seen as active participants in health and development and in realization of rights.

It will be important to ensure that that accountability and reporting related to new RMNCH initiatives is consistent with national accountability mechanisms and follows the principles set out by the iERG.

While the specific recommendations of the COIA appear not be widely known it is clear that the principles of improved accountability are well understood and there is wide recognition of the benefits of efforts to establish vital registration systems, to strengthen health management information systems and roll out maternal death surveillance.24

Recommendations to improve national accountability mechanisms

- Make the health sector review (the most pragmatic accountability mechanism in most focal countries) more inclusive, transparent, and strategic in its operations. The outcome and recommendations should be shared with the head of state and parliament and compliance with implementing recommendations improved.

- Improve accountability to citizens through expanding social accountability approaches, monitoring human rights treaty obligations, partnership with the media and parliamentary oversight.

- Consider all sources of information when reviewing progress and increase the quality of preparatory work through appraisals that feed findings and clear recommendations into the review.

- Increase alignment and integration of all RMNCH support behind a single national plan and monitoring framework that builds upon and strengthens the existing system.

- Invest in building capacity of CSO, the media and parliamentarians to better monitor and use evidence for advocacy and to hold governments to account on RMNCH commitments.

24 Feedback from subregional workshops to develop country roadmaps for accountability.
**Annex 1: Examples of social accountability mechanisms**

**Information Interventions**

*Access to information* A legal framework for public provision of information.

*Information campaigns* Efforts to inform citizens about their rights to services, quality standards and performance.

*Report cards* A type of information campaign that provides information about service performance of providers sometimes in the form of a ranking of providers. Some report cards may include facilitated discussions with citizens.

*Scorecards* A quantitative survey of citizen satisfaction with public services that includes a facilitated meeting between providers and beneficiaries to discuss results and agree on follow up actions.

*Social audit* A participatory audit in which community members compare stated expenditures or services with actual outputs.

**Grievance action mechanisms**

*Action in line ministries* Various venues established at the policy, programme and project level for collecting feedback, grievances and complaints.

*Independent Institutions* Structures outside government agencies, including tribunals, ombudsmen, public enquiries, civil society organizations, and a variety of sector-specific entities such as labour relations boards.

*Courts* Legal action mechanisms through the court system.
## Annex 2: List of individuals consulted

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abduljelil Reshad</td>
<td>Federal Ministry of Health Ethiopia</td>
</tr>
<tr>
<td>Bradley Hersh</td>
<td>UNAIDS</td>
</tr>
<tr>
<td>Carole Presern</td>
<td>PMNCH</td>
</tr>
<tr>
<td>Elizabeth Mason</td>
<td>WHO</td>
</tr>
<tr>
<td>Fatoumata Nafo-Traore</td>
<td>WHO Representative Ethiopia</td>
</tr>
<tr>
<td>Geoff Black</td>
<td>CIDA</td>
</tr>
<tr>
<td>Heather Cameron</td>
<td>CIDA</td>
</tr>
<tr>
<td>Henrik Axelson</td>
<td>PMNCH</td>
</tr>
<tr>
<td>Jane Thomason</td>
<td>WHO</td>
</tr>
<tr>
<td>Kadi Toure</td>
<td>PMNCH</td>
</tr>
<tr>
<td>Louise Holly</td>
<td>SCF UK</td>
</tr>
<tr>
<td>Manuela Garza</td>
<td>International Budget Partnership</td>
</tr>
<tr>
<td>Paul Hunt</td>
<td>Essex University</td>
</tr>
<tr>
<td>Phyllida Travis</td>
<td>WHO</td>
</tr>
<tr>
<td>Ramesh Shademani</td>
<td>iERG Secretariat</td>
</tr>
<tr>
<td>Stefan Germann</td>
<td>World Vision International</td>
</tr>
<tr>
<td>Tessa Edejer</td>
<td>WHO</td>
</tr>
<tr>
<td>Ties Boerma</td>
<td>WHO</td>
</tr>
<tr>
<td>Tim Martineau</td>
<td>UNAIDS</td>
</tr>
<tr>
<td>Untung Sutarjo</td>
<td>MoH Indonesia</td>
</tr>
<tr>
<td>Wendy Graham</td>
<td>Aberdeen University</td>
</tr>
</tbody>
</table>
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