INTRODUCTION

Progress in reducing child deaths and maternal deaths over the past years has been accelerated by the UN Secretary-General’s Global Strategy for Women’s and Children’s Health (the Global Strategy) and the related Every Woman Every Child movement. As part of the Global Strategy, the UN Secretary-General called for a process to ensure global reporting, oversight and accountability. This led to the creation of the Commission on Information and Accountability for Women’s and Children’s Health (CoIA) in 2011, co-chaired by President Jakaya Mischao Kikwete of the United Republic of Tanzania and Prime Minister Stephen Harper of Canada. The Commission put forward ten ambitious yet practical recommendations to strengthen this accountability (see Annex 1). Countries translated the recommendations into Country Accountability Frameworks (CAFs), with prioritized work areas that follow the cycle of “monitoring, review, and remedy or action”.

Regional leadership has also contributed to implementing the Global Strategy. At the African Union Heads of State Summit in January 2013, heads of state and governments made new commitments to speed up the reduction of newborn, child and maternal mortality in Africa, and to reinforce the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA). The WHO Eastern Mediterranean Region agreed to the Dubai Declaration that outlines concrete actions to be taken by all countries in the region to increase the access of women and children to the health services they need, and to accelerate progress towards Millennium Development Goals (MDGs) 4 and 5. Governments, the private sector, donors and NGOs have made nearly 400 commitments to advance the Global Strategy. Other parallel global initiatives are tackling different dimensions of the Global Strategy goals, and demonstrate the high-level commitment. These initiatives include: the Child Survival Call to Action (June 2012), Family Planning 2020 (July 2012), the United Nations Commission on Life-Saving Commodities for Women and Children (September 2012), the Global Vaccine summit (April 2013), Global Action Plan for Pneumonia and Diarrhoea (April 2013) and most recently the Every Newborn Action Plan (May 2014).

The 2014 Progress Report describes the evolution of the accountability work up to May 2014, and marks the end of the first phase of implementation. The report summarizes progress made globally and by countries towards implementing the Commission’s ten recommendations. It also presents lessons emerging from mid-term reviews in selected countries. Progress in implementing the recommendations of the Commission presents a mixed but encouraging picture. There is an overwhelmingly positive response of countries to both the Commission’s recommendations and to the country accountability framework. Accountability and transparency are recognized by countries and donors alike as critical elements for reaching MDGs 4 and 5. In virtually all countries, actions that improve accountability for women’s and children’s health can be observed. At the same time, it is clear that much more remains to be done. A summary of progress is presented in the box (next page).
Summary of Progress to May 2014

Better information for better results

- Civil registration and vital statistics (CRVS): 51 countries have conducted an assessment of their CRVS systems; 25 countries also have a multisectoral plan and high-level steering committee; several have developed long-term investment plans. Political momentum for CRVS is growing in many countries, supported by UN Regional Commissions and other partners.

- Maternal death surveillance and response (MDSR): 45 countries now have maternal death notification policies, 46 have facility-based death reviews, and 23 have community-based death reviews; all of these lead to a greater emphasis on the quality of care.

- The 11 Commission indicators are used in almost all countries for tracking progress. Web-based facility information systems are now implemented in 40 countries, and 20 have conducted facility assessments. Leaders of the global health agencies are working together to reduce the reporting requirements for countries and to improve measurement of results.

- 65 countries have completed eHealth profiles and 27 have eHealth strategies. Half of the strategies include eHealth initiatives in support of women’s and children’s health.

Better tracking of resources

- 18 countries have begun implementing the System of Health Accounts 2011, which provides detailed expenditure data on reproductive, maternal, newborn and child health (RMNCH) and other programmes. Results are available for eight countries; an additional 33 countries intend to conduct a national health account exercise in 2014-15.

- Partners such as UNAIDS, UNFPA, GAVI, the Global Fund and WHO have adopted the System of Health Accounts 2011 approach.

- 44 countries have compacts or similar partnership agreements in place, which include text on budget transparency for partners. Non-state and civil society actors are increasingly signing compacts.

Better oversight

- 58 countries are conducting annual health sector reviews to assess progress and performance and improve the following year’s implementation. Almost all cover RMNCH issues. Over 80% of countries report broad participation in the reviews.

- The Inter-Parliamentary Union is playing a vital role in raising the profile of RMNCH in many countries, including the establishment of parliamentary committees on RMNCH.

- The progress in implementing commitments is assessed regularly by the Partnership for Maternal, Newborn & Child Health; progress on indicators is assessed by the Countdown to 2015.

- OECD has adapted its system on tracking Official Development Assistance and will report for the first time on RMNCH resource flows in 2014.
Country accountability frameworks (CAFs) are developed by stakeholders to translate the ten recommendations of the Commission into practical steps for implementation. At the time of this publication, 63 of the 75 targeted high-burden countries have developed such frameworks, and have received catalytic funds to support its implementation.

63 countries have completed an assessment, prepared a country accountability framework, and received catalytic funding.

The process of developing the CAFs has provided a platform for bringing together donors and country stakeholders around accountability. The CAF builds on the International Health Partnership (IHP+) common framework for monitoring, evaluation and review of national health strategies, and places accountability soundly at the country level, with leadership of national governments, and engagement of parliaments, civil society, and development partners. Principles include focusing on national leadership and ownership of results, strengthening country capacity for monitoring and evaluation, and reducing the burden of reporting by aligning efforts with the national monitoring and review platforms.

The implementation of CAFs is now well under way. Regular progress reports are received from all countries and rapid mid-term assessments\(^1\) led by WHO in collaboration with national stakeholders and development partners have been conducted in Bangladesh, Myanmar, Kenya, Tajikistan, Togo, the United Republic of Tanzania, and Zambia to assess how the accountability work is resulting in change at the country level.

- **Strong examples of national accountability exist in countries.** There are growing examples of country-driven national accountability mechanisms. Increasing numbers of countries have developed scorecards to monitor progress on MDGs 4 and 5. Ministers of health regularly review progress and discuss challenges with their staff. National health sector reviews include broad participation. Togo, for example, has a bottom-up review process for their health sector operational plans that includes inputs from district, regional and national levels. In Kenya, the Ministry of Health is developing guidelines on social accountability; this supports active community participation, including budget hearings and citizen report cards, in the oversight of health facilities. The Churches Health Association of Zambia formed and supports neighbourhood health committees, which hold health workers and other district stakeholders accountable for local health services.

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\(^1\) Full assessment reports will be posted at: [http://www.who.int/entity/woman_child_accountability/countries/](http://www.who.int/entity/woman_child_accountability/countries/)
There is unprecedented momentum and regional action for CRVS. Political mobilization and technical assistance to countries for CRVS are being driven by UN Regional Commissions, in particular the UN Economic Commission for Africa (UNECA) and the UN Economic and Social Commission for Asia and the Pacific (UNESCAP). WHO and UNICEF regional offices are playing an essential role in Africa, Asia and the Middle East. Ministers are committing to CRVS priorities in the countries through regional mechanisms.

Monitoring of results and tracking of resources are improving. Many countries are focusing on a core set of health indicators as part of their national plan. Progress is reported and reviewed on an annual basis. The System of Health Accounts 2011 (SHA2011) now enables countries to produce standardized, cost-effective and robust statistics on expenditure on a yearly basis. The recommendation of the Commission is a driving force for implementing a rigorous health accounts methodology.

Innovation in ICT is increasing. Most countries are embracing innovation especially in relation to information and communication technologies (ICT), however most of these are pilot activities and have not yet been taken to scale. eHealth strategies have been developed in many countries, and include mapping the multitude of ongoing small-scale activities. Web-based health facility reporting systems are now being taken to scale nationally in dozens of countries.

The accountability framework is contributing to reducing fragmentation. It provides a platform for countries and development partners to work together towards common strategies and increase the efficiency of investments. In Kenya, the accountability work stimulated intense discussions between the Reproductive and Maternal Health unit and the Child Health unit to streamline efforts to improve outcomes for newborns.

Engagement of civil society organizations (CSOs) and parliamentarians is important but challenging. CSOs play an active role in accountability and in raising awareness about women’s and children’s health. However, coordination among the many CSOs in countries continues to be a challenge. Promising models of parliamentarian engagement exist with the Inter-Parliamentary Union (IPU) leading international mobilization and influencing country and regional action for women and children. Zambian Parliamentarians from the Committee on Health and HIV/AIDS have been sensitized and trained to advocate at policy levels for women and children’s health.

In addition to the specific improvements in accountability, there are important lessons, which have implications for the future.

Catalytic funding has indeed been catalytic. The accountability framework has catalysed action and leveraged additional investments, particularly from partners such as GAVI and the Global Fund. Countries received US$ 250 000 each in catalytic funds which they chose to allocate across implementation priorities, linked to the framework. These funds were primarily used to bring actors together around a common priority such as a CRVS assessment, a revision of the strategy on maternal death surveillance and response, an eHealth strategy or a common monitoring system. Moving forward, countries will increasingly need to leverage funds and technical support in order to reach the goals in their CAFs.

Scaling up and institutionalization remain challenges. Important first steps have been taken, such as conducting assessments, developing national strategies and piloting innovations. However, scaling these to national implementation in a sustainable manner takes time, and may require the strengthening of sub-national management teams to implement such approaches as MDSR. Togo is implementing the MDSR approach, but at present only in three out of six regions in the country, while Kenya is implementing it in 36 out of 290 sub-counties.

The socio-political context affects progress. Political changes, such as the devolution of the health ministry in Kenya or changes in government due to elections in Bangladesh, can slow progress. These realities need to be taken into account and technical support adapted to fit the country context.
Accountability in the United Republic of Tanzania

The United Republic of Tanzania provides a number of examples of national accountability that are contributing to improved women’s and children’s health. Political commitment has been vital to catalysing action in Tanzania, particularly from President Kikwete, co-chair of the Commission, who continues to demonstrate his leadership for accountability.

- In May 2014, President Kikwete kicked off the national countdown to 2015 event in Tanzania, pledging a renewed commitment to RMNCH and calling for the use of scorecards to properly document quarterly evaluation of RMNCH.

- The recommendation on resource tracking has resulted in increased emphasis on harmonization of the different systems of financial tracking. Tanzania has embraced the SHA 2011 methodology for tracking resources that provides detailed sub-analyses of funds spent by disease, by condition, and by category, including for RMNCH. Tanzania will soon publish 2012-2013 accounts data. The challenge remains to institutionalize this as an annual exercise.

- Good data are available for monitoring progress and performance. The health facility reporting system is now web-based, regular household surveys are conducted and national health facility assessments provide information on service delivery and quality. The web-based district health information system, based on a unified plan for monitoring and evaluation, became operational in 2013.

- The national eHealth strategy, launched in 2013, is overseen by a steering committee for which the Ministry of Health serves as secretariat. An inventory was carried out in order to move towards one common system, in line with the national strategy. Multiple innovations and improvements have already been implemented, including a logistics management information system and a system for information on human resources for health.

- As a basis for developing an integrated national plan for birth and death registration, the government will conduct a multi-sectoral assessment to examine current CRVS systems and assess the potential for innovative approaches.

- The Health Sector Strategic Plan uses a core set of indicators, targets and regular review processes with the participation of regions and districts, development partners, civil society organizations and parliamentarians. A comprehensive mid-term review was conducted in 2013, including a thorough analytical report by independent national institutions and the Ministry of Health, as well as an independent external review supported by development partners.

**Trends in under-five and neonatal mortality rates in Tanzania, 1990-2012**

- Under-five mortality rate
- Neonatal mortality rate
- MDG target for under-five mortality

**Trends in maternal mortality ratio in Tanzania, 1990-2013**

- Maternal mortality ratio
- MDG target for maternal mortality


http://www.who.int/woman_child_accountability/countries/Tanzania_COIreport_2014.pdf?ua=1
Accountability for women’s and children’s health has triggered actions and guided investments.

- The partnerships emanating from the accountability framework are unprecedented. The implementation is broad-based and inclusive; it provides the foundation for increased collaboration and reduced fragmentation between sectors, as well as within different departments of the Ministry of Health. The term “CoIA” has become a common acronym, indicating buy-in from multiple partners.
- A national eHealth strategy, developed with major actors, is in its final stages. An integrated, electronic information system for MNCH at the community clinic level has been piloted and will soon be scaled up to the national level. The Ministry of Health and Family Welfare achieved 100% ICT connectivity between community health workers, community clinics and all hospitals.
- Bangladesh had not conducted a national health accounts exercise since 2007. However, with the push from the Commission recommendations, the SHA 2011 is ongoing and the results, including results on RMNCH, will be completed and released by the end of 2014.
- Data produced and collected from the 11 Commission indicators are routinely reviewed during meetings held in community clinics where community health workers join the meetings to validate data, review activities, and identify needs for improving action. Community health workers report back on progress in the next meeting, thereby closing the accountability cycle of “review, monitor, act”.
- Bangladesh recently reached a milestone of having more than 100 million individuals registered in its CRVS system. Yet Bangladesh has multiple parallel systems of registration, including birth registration (often late), voter registration, a personal ID card and health census number. Since 2010, several ministries have been discussing the development of a National Population Register but this has not resulted in a common drive towards a coordinated system. In early 2014, the Cabinet Secretary took charge of a collaborative effort that involves six ministries, and an ambitious strategic and investment plan was developed in a short period of time.
- The Prime Minister has expressed commitment to the health of women and children; parliamentarians and journalists have been educated about the Commission recommendations. CSOs and the Ministry of Health collaborate on increasing visibility of women’s and children’s health.

“Before, population surveys were the only ways to understand the MNCH situation. There was a considerable lag period between surveys that resulted in lost opportunities to take timely action to avert preventable deaths for women and children. The Commission’s model is very helpful for generating data and taking appropriate timely decisions and responses.”

Professor Dr Abul Kalam Azad, Director, Management Information System, Bangladesh

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**Trends in under-5 mortality rates, Bangladesh, 1990-2012**

- Under-five mortality rate
- MDG target for under-five mortality

**Trends in maternal mortality ratio in Bangladesh, 1990-2013**

- Maternal mortality ratios
- MDG target for maternal mortality ratios

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Assessment report available at: http://www.who.int/entity/woman_child_accountability/countries/
Better information for better results

Registration of births, deaths and causes of death

The Commission’s recommendation on registration of births, deaths and causes of death has accelerated global and regional mobilization and coordination to improve civil registration and vital statistics in countries. Resulting investments have supported dozens of CRVS assessments, which lay the foundation for national plans.

Political momentum is driving improvement plans for these systems. Fifty-one countries have conducted an assessment of their CRVS systems, including 28 that have done a comprehensive assessment that provides the basis for the strategic multi-sectoral plan. Most of these countries have also established a national coordination mechanism to implement the multi-sectoral plans. Four countries (Bangladesh, Ethiopia, Mozambique, and the Philippines) have completed high-quality case studies and long-term investment plans.

There is an emergence of innovative approaches. Countries are taking initiative to launch new ways to register births and deaths, such as: linking health facilities and the registration system in Uganda; annual civil registration month in the Philippines; sample registration systems with verbal autopsy in Malawi, the United Republic of Tanzania, and Zambia; use of biometric data in India; and new ways to link massive databases in Bangladesh.

Countries will need to coordinate and invest to develop sustainable CRVS systems through national assessment and planning; the health sector will have a crucial role to play in this. Global funding approaches, such as a trust fund and loans/grants, must be tailored towards directly enabling countries to make this critical leap forward in their development. Regional approaches including the UN, development banks, technical interactions and collaboration should be the backbone, providing support to countries.

CRVS essential to establishing legal identity and providing services after Typhoon Haiyan

In the Philippines, civil registration is considered a central element in everyday life. The value of the CRVS system was recently reinforced in the aftermath of Typhoon Haiyan, where the system was fundamental to re-establishing legal identity and securing access to services and emergency relief.

The Philippines has recognized the critical importance of developing the CRVS system as a vital national resource, especially for protecting the rights of citizens, facilitating public service delivery, and monitoring health status. An annual national awareness campaign reminds people of the importance of civil registration. The Philippines notes the strategic challenges that must be addressed including linking different levels of government, reaching vulnerable or geographically isolated populations, and collecting information about events that occur outside of health facilities. An estimated 7.5 million Filipinos have still not had their births registered.

“...the CRVS system is considered as the gold standard for health information in the Philippines... Still, we believe we can do better, and so efforts continue...”

Dr Enrique T. Ona,
Secretary, Department of Health,
Republic of the Philippines.

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4 Philippines case study and investment plan available at: http://www.who.int/healthinfo/civil_registration/TechnicalConsultation_April2014/en/
Maternal death surveillance and response and quality of care

The work on accountability has created a shift from simple maternal death reviews to more comprehensive maternal death surveillance and response. The most significant difference between the two approaches is the operative term “response”. In addition to requiring that each maternal death be a notifiable event, MDSR requires the investigation of causes of death: who died, when, where and why. This then paves the way for the carefully targeted interventions and improvements in quality of care that will ensure maternal survival.

At the time of this publication, 45 countries report having a national policy that requires all maternal deaths to be notified. The recent Global Policy Survey on maternal, newborn, child and adolescent health indicates that in 29 of 61 surveyed countries, the policy specifies notification to a central authority within 24 hours of death. Facility-based maternal death reviews are being implemented in 46 countries, while community-based maternal death reviews are in place in 23 countries. More work is still required to improve the responses to the recommendations generated by the death reviews.

Maternal Death Surveillance and Response (MDSR) in Cambodia

Since 2004, the National Reproductive Health Programme (NRHP) of the Ministry of Health in Cambodia has been implementing maternal death audit (MDA) activities. Each case review includes a verbal autopsy and a facility-based review. It was found that the number of maternal deaths reported through the health system was much lower than expected (according to the DHS ratio). Therefore, there was the need for more timely reporting and in 2009, a maternal death surveillance, or Situation Room was established with the aim of generating improved information about maternal deaths in public and private health facilities and in the community. The information collected through the Situation Room is added to the information received through existing MDA reporting systems and is followed by a case investigation, case audit, related recommendations and implementation of those recommendations. In 2011, a systematic national review of all cases of maternal death took place in order to review the quality of MDA outcomes and processes. Principal findings indicated that most recommendations did not specifically address the crucial moments where a woman’s life could have been saved. Specific requests by the members of the maternal death provincial committees lead to a revision of the existing MDA protocol. WHO’s technical assistance was provided to NRHP to update the MDA protocol. Through catalytic funding support, training materials have been developed. Capacity for training has been built in all 24 provinces and roll out training has been conducted in 14 provincial committees.

The maternal mortality ratio is estimated to have dropped from 1200 deaths per 100 000 live births in 1990 to 170 per 100 000 in 2013. Skilled birth attendant-assisted deliveries went from 46% in 2007 to 70% in 2010, and deliveries in a health facility rose from 24% to 59% over the same period.

More births are taking place in health facilities than ever before. However, there has been limited progress in improving outcomes for mothers, newborns and children due to a significant gap between coverage and quality of care. Improving quality of services provided and making quality an integral part of scaling up interventions is essential for better outcomes for mothers, newborns and children.

Detailed surveys related to quality of clinical paediatric care have been carried out in facilities in Angola, Ethiopia, Kyrgyzstan and Tajikistan, and results have been used to improve quality. The results of these inquiries led to ensuring the presence of adequate functioning equipment in facilities, improving competencies of health workers and institutionalizing quality of care within the health system. This approach is being expanded to cover maternal and newborn care in additional countries.

The coverage of essential interventions for maternal, newborn and child health has increased over the last two decades.
Health information systems and indicators

Every Newborn Action Plan underpins improved quality of care

Because of the remarkable progress in reducing the number of under-five deaths worldwide, the proportion of these deaths that occur in the neonatal period increased from 37% in 1990 to 44% in 2012. In 2012, 2.9 million children died within the first month of their life, mostly of preventable causes.

The most recent World Health Assembly in May 2014 responded to the urgent need to intensify action to prevent these deaths and stillbirths. The 194 Member States endorsed the Every Newborn Action Plan, charting the path to achieve equitable and high-quality coverage of essential referral and emergency care for the health and well-being of newborns and their mothers around the world.

The Commission recommended the use of one single list of 11 indicators on RMNCH, disaggregated for gender and other equity considerations. The 11 Commission indicators are part and parcel of the Countdown to 2015 reports including the accountability reports published in 2012 and 2013, and the forthcoming 2014 report on progress in the 75 high-burden countries.

A recent assessment showed how global investments in disease- and programme-specific monitoring have led to very large numbers of indicators, diverse indicator definitions and reporting periodicities, fragmented data collection, and uncoordinated efforts to strengthen country institutional capacity. This results in an untenable burden of reporting and hampers overall analysis and decision-making. A working group of 19 health agencies, under the auspices of the global health agency leaders, is now working to reduce the number of indicators and thus the reporting burden on countries.

The accountability framework has brought about improvements to country health information systems. In Afghanistan, 27 out of 34 provinces have conducted health information systems data quality assessments, the results of which are being used to improve policies and programmes. Innovative approaches such as the use of web-based reporting systems have opened a new array of possibilities to enhance the speed of reporting and feedback, the assessment of data quality, transparency and data communication. The roll-out of the district health information system “DHIS 2.0” in over 40 countries is a major shift, as it increases the availability and use of facility-based statistics, it is also a critical foundation for increased transparency.
Innovation driving the improvement of health information in Uganda

Uganda went country-wide with their online DHIS 2.0 implementation in August 2012 after a speedy roll-out that took less than six months, taking advantage of the rapidly improving mobile internet coverage in East Africa. In addition to health management information system aggregate data, Uganda is at the forefront of the use of the new patient tracking capabilities in DHIS 2.0. A pilot project to track mothers and children is under way to improve the continuum of care, and different client platforms are being explored to reach out to local health workers and pregnant women. These platforms include laptops, smartphones, feature phones, and SMS messaging. In the four ‘Saving Mothers, Giving Life’ pilot districts in Western Uganda, key indicators on maternal health are being collected in the community using mobile phones. Village Health Teams are submitting data directly to the online national DHIS 2.0 system using SMS. The intention is to then make this information available for data analysis by online users at each level across the country.

eHealth and innovation

Information and communication technologies are instrumental in improving activities such as surveillance of maternal and child deaths, facility reporting, sharing and administration of data, and CRVS. Countries are increasingly using eHealth to strengthen their information systems. Sixty-five countries have completed eHealth profiles that will provide a baseline for measuring the uptake of ICT for women’s and children’s health. Twenty-seven of these have eHealth strategies, developed through a stakeholder process that reflects national priorities and provides the foundation for the systematic, coordinated use of ICT.

The first survey to study the impact of eHealth and innovation on women’s and children’s health reveals encouraging findings: over half the countries use a combination of both paper and electronic formats and they regularly collect data on the key indicators on women’s and children’s health. The survey results also indicate that eHealth activities are often scattered. This suggests the need for stronger inter-sectoral collaboration and promotion of eHealth, and highlights the need to ensure that electronic information systems are more integrated and harmonized.

Joint publication by the World Health Organization and the International Telecommunication Union: eHealth and innovation in women’s and children’s health: A baseline review based on the findings of the 2013 survey of CoIA countries by the WHO Global Observatory for eHealth: http://apps.who.int/iris/bitstream/10665/111922/1/9789241564724_eng.pdf?ua=1&ua=1
Text messaging-based alert system contributes to improved maternal and child health in Rwanda

The Musanze District in Rwanda introduced short message service (SMS) to monitor pregnancies and reduce communication bottlenecks linked to maternal and newborn deaths in areas with limited resources. Community health workers (CHWs) serving villages in the pilot district use their mobile phones to send coded information on new pregnancies registered in their catchment area, to request referrals, and to report danger signs to healthcare staff in their corresponding health centre as well as in the district hospital. In response, for normal pregnancies, the system sends the CHW automated reminders for upcoming clinical appointments at specific dates for each woman registered. In case of emergency, when a CHW reports a life-threatening event, the SMS triggers an alert system that immediately advises the CHW on managing the danger sign and preparing the patient for transfer. Simultaneously, the system forwards an SMS request to the closest ambulance vehicle to transport the mother and child to the nearest health facility for emergency obstetric and neonatal care. The system also informs the health facility manager about the danger signs, name of the village, and telephone number of the CHW in charge, to ensure that the facility is prepared for immediate intervention once the ambulance arrives. An additional individual at the district health office is also informed to ensure that an ambulance will be sent, in case the original transport reached is out of service.

From June 2010 to May 2011, trained CHWs specialized in maternal health monitored a total of 11,502 registered pregnancies. Compared to the 12-month period preceding the pilot intervention, the number of first antenatal care visits of registered pregnant women in the district increased by 24%. The system registered a 48% decrease in the number of newborn deaths, a 44% decrease in the number of deaths of children between one and 11 months old, and a 53% decrease in those between 12 and 59 months old. The number of deaths in utero occurring in the district showed the greatest decline, of 69%. Maternal deaths fell by 25%. The proportion of pregnant women who delivered at a healthcare facility in the Musanze District rose from 68% to nearly 95%.

By early 2012, the system had been rolled out to 18 districts, and a total of 15,000 phones had been distributed to more than 7,000 trained CHWs. In addition, it was integrated into the national eHealth Enterprise Architecture. The RapidSMS system can now provide reports at the national, district, and health-facility levels, aiding the Ministry of Health with the identification of diseases affecting women during pregnancy, main causes of child mortality, and the type of medications needed.

Better tracking of resources

Tracking resources

For over a decade, the health accounts methodology has been the international reference for tracking expenditures on health. The revised version, SHA 2011, is a significant step towards improved resource tracking for health. It standardizes the measurement of expenditure by beneficiary, including expenditure by disease, by condition and by category, and allows for tracking expenditures over time. Partners including UNAIDS, UNFPA, GAVI, Global Fund and WHO have endorsed the SHA 2011 approach. It is considered “the best value for money,” as higher-quality data are obtained at a lower cost by pooling resource-tracking efforts at country level. At the same time, members of the OECD have agreed to tag their development assistance for health on RNMCH from 2014 onwards; this will facilitate an understanding of donor promises and disbursements in this area.

In just two years, over 50 lower-income countries have adopted the methodology. In 2013, 18 of the 50 countries were implementing SHA 2011; data are available from nine of the countries on expenditures for reproductive and/or child health. For the six countries where initial SHA 2011 data have been controlled for quality, the average total expenditure on RNMCH remains low at US$ 9 per capita, ranging from US$ 4 to US$ 15. However, on average these expenditures represented 34% of total current health expenditures.

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7 SHA 2011 emphasizes the full distribution of health expenditures by disease. It assures the institutionalization and yearly production and use of health expenditure information. This is in contrast to other “project-based” health accounts work that focused on producing the numbers as the main deliverable.
8 Unweighted average, official exchange rates.
(from 25% to 48%); this is a substantial share considering that all other diseases and conditions combined account for only 64% of total health expenditures. Although in absolute terms the amount spent on RMNCH is low, it represents a relatively high share of the total current health spending. These two facts combined illustrate that the available resources for health overall remain low in these countries.

As shown in the figure, out-of-pocket payments by households often remain the greatest source of funds spent on RMNCH, despite many countries making these services nominally free or heavily subsidized. Out-of-pocket payments are the most inequitable source of health financing, preventing many people from seeking needed services and pushing many who purchase them into poverty. These countries also rely heavily on assistance from external partners, who contribute 37% on average to overall expenditure on RMNCH.

These data provide a baseline for the analysis of trends in RMNCH spending over time. At the moment, only two of the countries have more than one data point, with one country showing no change in the share of total or government health spending going to RMNCH, and one showing a decrease. For example, in Burkina Faso, spending on RMNCH fell from the equivalent of US$ 11 per capita in 2011 to US$ 9 in 2012, particularly by development partners. Nonetheless, RMNCH expenditure accounted for 30% of the government health budget.

This tracking is invaluable for understanding progress towards reducing the burden of mortality and morbidity relating to RMNCH. There is a need to provide timely and intensive support to the 33 countries that plan to conduct the health account exercise in 2014–2015. Equally important is to ensure that countries conducting second- and third-year exercises are able to do so without external resources and competencies.

Households and development partners fund the bulk of RMNCH expenditures
Results from initial SHA 2011 analysis [6 data points]

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<td>Households</td>
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Country compacts and health reviews

Compacts are a tool for strengthening mutual accountability for commitments to put aid effectiveness principles into practice in health. The basis for a country compact, or an equivalent partnership agreement, is “the three ones: One country health strategy, One results framework and One budget”. Forty-four countries have compacts or similar partnership agreements in place.

Increasing numbers of compacts include indicators to track progress on commitments made. In some countries, for example Mozambique, these indicators have been integrated into the national health monitoring framework. The fourth global monitoring of these commitments through IHP+, beginning in May 2014, will provide information on the issues listed below. It will also collect information on the engagement of civil society in developing and implementing national health priorities. At present 25 countries are participating in this exercise; the global synthesis report will be released in November 2014.

IHP+ monitors whether:

- health development cooperation is focused on results that meet developing countries’ priorities;
- civil society operates in an environment that maximizes its engagement in and contribution to development;
- health development co-operation is more predictable;
- health aid is on budget;
- mutual accountability among health development cooperation actors is strengthened through inclusive reviews;
- developing countries’ systems are strengthened and used.

Some recent compacts, including those in Burkina Faso and Senegal, have included specific tracer indicators related to maternal and child health in their monitoring framework. Examples of such tracer indicators are the maternal mortality ratio, infant and child mortality rates, prevalence of contraception, rates of antenatal-care, proportion of HIV-positive pregnant women receiving appropriate treatment, proportion of deliveries attended by a skilled birth attendant, and proportion of fully-vaccinated children.

Non-state and civil society actors are increasingly signing compacts. More than one in every three compacts agreed by IHP+ partner countries since 2010 was signed by non-state or civil society actors, compared to only one in five previously. Some of these CSOs provide services for mothers and children, such as the Church Health Associations of Kenya and Sierra Leone. Other CSO signatories are strong advocates for maternal and child health, such as Save the Children and “Bien-être de la femme et de l’enfant” in Niger.

Most compacts include text on mutual budget transparency between external partners and the host country, commonly stating that partners agree to report on their expenditures, to use national financial systems where possible and to disburse funds in a predictable manner.

IHP+ revised its governance and management arrangements in 2013 to improve oversight while maintaining the inclusiveness that is one of its hallmarks. IHP+ has now grown to 63 signatories. The principal governance change has been to create a high-level IHP+ Steering Committee of 16 members that meet twice a year. The committee includes six members from implementing countries; four from multilateral agencies; four from bilateral agencies and two from civil society.

Mauritania: Compact leads to better harmonization

After two years of preparation, Mauritania signed their national compact in May 2012. This compact is designed to coordinate the support provided by all partners involved in health, and to harmonize efforts to implement the national health strategy. There were 16 signatories, including the Minister of Economic Affairs and Development, the Minister of Health, the Minister of Finance, bilateral and multilateral development agencies, international civil society organizations and the private sector.

Positive changes are already apparent. Contributions from all partners have been aligned with the national health strategy. The Government has increased its engagement and financial contribution to the health sector. Development partners have been more transparent about their own financial priorities.

All partners who signed the compact are represented on the coordination committee, which meets quarterly, and on the technical committee which meets monthly. All partners collaborate to produce one single annual report that examines the implementation of the national health strategy and the level of partner engagement.

“We hope that all the conditions are met to effectively put in place the national health strategy and health sector plan. However, there are challenges, particularly in relation to monitoring and evaluation. We have not finished building this yet. We also need greater harmonization to allow us to work under one single budget.”

The Director of Programming for Cooperation in the Ministry of Health

Ensuring the quality of a country’s national health plan requires regular review and analysis. Health sector reviews provide an opportunity to emphasize issues and promote appropriate budget allocations related to women’s and children’s health. Fifty-eight countries are conducting annual health sector reviews, to build a clearer picture of the gaps in their health-care provision and to serve as the basis for strengthening national accountability mechanisms.

9 http://www.internationalhealthpartnership.net/en/news-events/article/mauritanias-country-compact-what-difference-has-it-made-325406/
During the next phase of implementation, guidance and support will be provided to countries to improve their review processes, particularly in two areas: greater inclusion of civil society, development partners and ministries other than health, parliamentarians and media; and strengthening capacity to implement recommendations from the reviews.

**Benin’s bottom-up participatory approach strengthens accountability in health sector reviews**

Benin has a bottom-up participatory approach for conducting its joint annual review. The measurement of district performance is based on financial as well as health indicators. The country undertakes a decentralized analysis of health sector performance, involving health and other key ministries, development partners and civil society. The reviews include a strong focus on RMNCH, with special attention to specific indicators such as: DPT3 vaccination coverage, contraceptive utilization, and prenatal consultation rates. The country is showing progress: for example, the percent of children under five years of age getting scheduled check-ups has increased from 81.2% in 2011 to 94.3% in 2013.

In line with the accountability framework, Benin evaluates the progress made towards implementing the previous year’s health sector review recommendations. The system includes a three-level scale: implemented, non-implemented and ongoing. Such a system facilitates tracking results, flags issues requiring further attention and ensures a system of accountability among the government, partners and civil society.

**Better oversight**

**Transparency, advocacy and action**

The role of civil society, parliamentarians and media is to bridge the information gap and make information available and understood by citizens. Members of these three groups from ten Angophone and Francophone countries in Africa are learning to understand national budgeting processes and undertake budget advocacy to increase transparency for funding women’s and children’s health. Civil society coalitions are applying new skills to national budget advocacy plans. The high level of interest for this type of training demonstrates one of the unmet needs being addressed by the accountability work.

**Budget advocacy in Sierra Leone**

In 2012, a civil society budget tracking coalition in Sierra Leone was successful in reversing a proposed reduction of the financial allocation to health. The coalition, which was trained on budget advocacy, contributed significantly to Sierra Leone’s decision to explicitly include the tracking of government allocations and disbursements in the 2013-2014 budget strategy. This tracking aims to redress challenges around the timely distribution of health funds from the central to local government, and to ensure the fulfilment of the government commitment to increased funding for RMNCH.

Following its landmark 2012 resolution, “Access to health as a basic right: The role of parliaments in addressing key challenges to securing the health of women and children”, the Inter-Parliamentary Union (IPU) continues to facilitate parliamentary exchanges in countries with high maternal and child mortality rates. For example, more than 200 parliamentarians from Kenya, Uganda, the East African Legislative Assembly and the Pan-African Parliament were reached to raise the profile of RMNCH in their countries and regions.

The media is a powerful actor for shaping regional and national priorities for health. African media familiarized with the Global Investment Framework for Women’s and Children’s Health at the African Union (AU)-UN Economic Commission for Africa Conference recognized the urgency for African governments to prioritize investment in health and human capital as a pre-requisite to achieving Africa’s Agenda 2063 on Sustainable Industrialization and the post-2015 Development Agenda.
Kenya: The First Lady leads advocacy efforts for women and children

Kenya has signed onto the Maputo Plan of Action (Maputo PoA) for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights, to the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (better known as the Maputo Protocol) and to CARMMA.

Kenya has a strong legal and policy framework that governs RMNCH. In particular, the revised Constitution of Kenya recognizes the right to health. The new government that came into power in April 2013 announced support for women’s health as part of its manifesto promises and in June 2013 the President announced free maternity services including postnatal care across all government hospitals in Kenya. The First Lady of Kenya launched the “Beyond Zero” campaign in December 2013 whose goal is to accelerate progress in HIV control and in the promotion of maternal, newborn and child health. In April 2014 she completed the London marathon to raise awareness about the high rates of infant and maternal mortality in Kenya. This level of political commitment is testament to the window of opportunity to improve women’s and children’s health.
Reporting aid for women’s and children’s health

The Organisation for Economic Co-operation and Development’s Development Assistance Committee (OECD-DAC) gathers data from the world’s main aid donors to define and monitor global standards in key areas of development. Every year, its 29 members, along with 17 non-DAC countries, 30 multilateral organizations and the Bill & Melinda Gates Foundation report their individual aid activities to the OECD-DAC’s Creditor Reporting System (CRS). The CRS has become the internationally recognized source of comprehensive data on the geographical and sectoral breakdown of aid to recipient countries. However, the CRS classifies aid activities by sector (e.g. health, infrastructure or water and sanitation) but not by beneficiary groups (e.g. women of reproductive age and children). In addition, certain activities (general budget support, for example) are not susceptible to allocation by sector, and some spending in a broad range of sectors can contribute to RMNCH (for example, health systems strengthening, nutrition and water and sanitation). Accordingly, RMNCH expenditures could not be easily identified through the CRS data.

In response to the Commission’s recommendation, the OECD-DAC has adopted a new policy marker for RMNCH10, which will allow, for the first time, more specific information on aid spending towards RMNCH. DAC members and other entities reporting to the DAC statistical system11 have been requested to apply the policy marker to their 2013 aid flows, data for which will be available in December 2014. The data are collected on a test basis and will be evaluated after a two-year trial period. It will be important to monitor which countries and organizations actually apply the RMNCH policy marker in scoring their RMNCH activities.

The Partnership for Maternal, Newborn & Child Health (PMNCH) 2014 Accountability Report

The PMNCH 2014 Accountability Report will provide an update on the commitments made, their implementation, and their alignment to the Global Investment Framework for Women’s and Children’s Health as a blueprint for accelerating progress to 2015 and beyond. The suggested structure of the report recognizes that some commitments have been monetized by those who made them (and are referred to as ‘financial commitments’), while many others, that also make a significant contribution to the achievement of the Global Strategy goals, have not been monetized to date. The three parts of the report are as follows:

- Updating financial commitments and disbursements made to the Global Strategy, with an estimate of disbursements made to date against the commitments.

- Alignment with the Global Investment Framework. Evaluate the alignment of commitments made to date to the Global Investment Framework, assessing whether the right investments are being made to accelerate progress for women’s and children’s health.

There is now an opportunity for Every Woman Every Child12 to host, with PMNCH and other partners including Family Planning 2020, a single harmonized, integrated online platform that will be the global standard and repository of information related to reporting on commitments to the Global Strategy. This is an opportunity to synergize the commitment-tracking work of the various initiatives. The ambition of including a continued emphasis on women and children in the post-2015 development agenda also demands better tracking of commitments as early as possible to establish a sound baseline.

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10 Reporting instructions for the policy marker can be found at: http://www.oecd.org/dac/stats/documentupload/Addendum%203.pdf
11 DAC reporting is available at: http://www.oecd.org/dac/stats/methodology.htm
12 http://www.everywomaneverychild.org/
Global oversight

The independent Expert Review Group (iERG) has the core functions of assessing the extent to which all stakeholders honour their commitments to the Global Strategy and of reviewing progress in the implementation of the recommendations of the Commission. As part of its work, the iERG has submitted two reports to the United Nations Secretary-General. Each report has six additional recommendations to accelerate progress on MDGs 4 and 5; stakeholders discussed the iERG reports from 2012 and 2013 and prioritized which recommendations to take forward.

iERG recommendation from 2012: The Global Investment Framework for Women’s and Children’s Health

The Global Investment Framework, developed in response to a recommendation by the iERG, presents a compelling case for increasing investments in women’s and children’s health. It shows how, with an increase of US$ 5 per capita per year to 2035 in 74 high-burden countries, a nine-fold social and economic return can be achieved and millions of lives can be saved. The investment framework looks at the evidence available on effective interventions across the RMNCH continuum, and the impact they would have in the countries with the highest maternal and child mortality. The analysis suggests that by using the additional investments to support these interventions, it would be possible to avert 147 million child deaths, 32 million stillbirths, and five million maternal deaths by 2035.

An increase of US$ 5 per capita per year to 2035 would bring significant reductions...

...in child mortality

**Average under-five mortality rate (74 countries)**

Deaths in children under five years of age per 1,000 live births

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...and maternal mortality

**Average maternal mortality ratio (74 countries)**

Deaths per 100,000 live births

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The report *Health for the world’s adolescents* [www.who.int/adolescent/second-decade](http://www.who.int/adolescent/second-decade) was launched at the 2014 World Health Assembly in follow-up to its 2011 Resolution, Youth and health risks. *Health for the world’s adolescents* is more than a report. It is an online resource that provides visualization of regional and country data on adolescent health, gives links to all WHO guidance concerning adolescents across the full spectrum of health issues, and explores universal health coverage for adolescents. It describes in a multimedia format why adolescents need specific attention, distinct from children and adults, and features adolescents’ own perspectives on their health needs.

It offers an overview of four core areas for health sector action with examples of programmes and materials from around the world on:

- providing health services;
- collecting and using data to plan and monitor health sector interventions;
- developing and implementing policies that promote and protect health;
- mobilizing and supporting other sectors.

The report concludes with fundamental actions for strengthening national health sector responses to adolescent health.

The website will be the springboard for consultation with a wide range of stakeholders leading to a concerted action plan for adolescents.
MOVING TO A SECOND PHASE OF IMPLEMENTATION

The substantial progress on implementing the recommendations of the Commission demonstrates how a global movement with a small amount of catalytic funding can generate results and leverage the interest, resources and engagement of a global community. After only two years and a half there is: (i) an intensified focus on accountability at country level; (ii) a greater prioritization of critical issues for RMNCH, including CRVS, MDSR, resource tracking, eHealth, and monitoring of results; and (iii) additional support for RMNCH.

To date, US$ 40.2 million\textsuperscript{14} have been invested in the accountability work, thanks to the generous contributions of the governments of Canada, Germany, Norway, and the United Kingdom. More than half of the funding has gone to 63 countries for the development and implementation of their country accountability frameworks. The frameworks vary from country to country in terms of prioritizing actions and allocating catalytic funding. Overall, countries are prioritizing: monitoring of results (26%); MDSR (22%); CRVS (21%); resource tracking (12%); advocacy (9%); health sector reviews (6%) and eHealth (6%). The high demand from countries for assistance to implement their CAFs reinforces the need to continue the accountability work.

It is recommended that:

1. Building on the lessons from Phase I, a second phase should continue to maintain the momentum and advance present gains.
2. The focus of Phase II should be on countries that have demonstrated results during the first phase and have the political commitment to continue the work.
3. In addition, support should be extended to a few fragile states or countries with weak health infrastructures that have expressed an interest to implement accountability mechanisms.
4. Phase II should focus on three main components: i) strengthening measurement and tracking, ii) strengthening analysis and review, and iii) dissemination, advocacy and transparency.
5. Phase II should have an explicit emphasis on maximizing opportunities to leverage national and partner funding.

The workplan for Phase II is costed at US$ 30 million and will require increased investments from donors\textsuperscript{15}.

\textsuperscript{14} Programme support costs of 13\% included.
\textsuperscript{15} http://www.who.int/entity/woman_child_accountability/resources/Accountability_Workplan_PhaseII.pdf?ua=1
CONCLUSIONS: INTENSIFYING EFFORTS TO 2015 AND BEYOND

The global agenda for improving women’s and children’s health remains unfinished. There is still a significant imbalance between development spending and burden of disease as measured by Disability Adjusted Life Years (DALYs); over 35 countries received less than US$ 5 in development assistance for health per MNCH DALY. Countries in South Asia and Sub-Saharan Africa receive some of the lowest development assistance for health per DALY.

Progress in reducing maternal and child mortality is faster than ever in recent years. Yet, in many countries, particularly in sub-Saharan Africa, unacceptably high numbers of women and children are still dying from preventable causes. Many countries will not achieve MDG 4, and even fewer will achieve MDG 5.

Because the overall mortality rate among children under five years of age has fallen faster than neonatal mortality, newborns now account for 44% of all child deaths. The Every Newborn Action Plan, approved in May 2014 by the World Health Assembly, is a roadmap towards ending newborn deaths from preventable causes.

Fertility is high in many countries. Family Planning 2020 aims to provide an additional 120 million women and girls in the world’s poorest countries with access to contraceptive information, services and supplies by 2020.

There are great inequities in coverage for essential interventions and health outcomes. Efforts must reach the poorest and most vulnerable groups. WHO and the World Bank are working closely with multilateral and national partners to advance universal health coverage, an instrument for sustainable and equitable economic growth which offers universal access to quality services and contributes to poverty alleviation.

While acknowledging the progress in global efforts to harmonize data collection and minimize the reporting burden, global health leaders also recognize that there is ample scope for reducing the numbers of indicators, streamlining reporting periodicities and coordinating data collection efforts. WHO, the World Bank and other partners are working towards a unified set of health indicators for better alignment and investment in countries.

Multiple information-collection processes have emerged, each with its own procedures for tracking financial and non-financial commitments to the Every Woman Every Child initiative. The office of the UN Secretary-General is working with WHO and PMNCH to streamline the existing accountability processes into one platform for reporting and tracking financial and non-financial commitments.

Accountability is now a widely accepted concept but greater transparency and inclusive participation are necessary for accountability to work. The involvement of civil society in accountability for RMNCH is increasing slowly but still requires further attention.

The country accountability frameworks have generated better information for better results and better tracking of resources. Yet oversight, both globally and nationally, requires greater transparency, civic involvement and political engagement. Going to scale and institutionalizing better monitoring of results, tracking of resources and oversight is still a major challenge in many countries.

Despite global momentum, RMNCH is still not high enough on the political agenda in many countries and globally, and resources do not appear to be increasing sufficiently.

The accountability framework has proved to be a powerful tool to guide global, regional and country action towards increased transparency, aligned investments, improving the collection and use of data in programming, and developing innovations including eHealth. This momentum, coupled with the essential high-level political mobilization that has been generated, must be sustained and expanded.

## ANNEX 1: SNAPSHOT OF PROGRESS TOWARDS THE COMMISSION’S 10 RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Work Area</th>
<th>Recommendation</th>
<th>Target</th>
<th>Result May 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Vital events and Maternal Death Surveillance and Response (MDSR)</td>
<td>Countries have plans for strengthening national accountability processes.</td>
<td>50 countries with CAFs by 2013</td>
<td>63 CAFs have been completed and funded.</td>
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<td><strong>2</strong> Health Indicators</td>
<td>By 2015, countries improve systems for registration of births, deaths and causes of death and health information systems.</td>
<td>50 countries with civil registration and vital statistics (CRVS) assessments and plans by 2015</td>
<td>51 countries have conducted an assessment of their CRVS systems. 28 of these have completed a comprehensive assessment that lays the foundation for the strategic multi-sectoral plan. Most of these countries also have established a national coordination mechanism.</td>
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<td><strong>3</strong> eHealth and Innovation</td>
<td>By 2015, countries integrating information and communication technologies in national health information systems and health infrastructure.</td>
<td>50 countries making improvements in MDSR by 2015</td>
<td>45 countries have a national policy, including 28 countries requiring notification to a central authority within 24 hours of death. 46 countries are implementing facility-based maternal death reviews. 23 countries have put in place community-based maternal death reviews. 13 countries have carried out assessments on service availability and readiness.</td>
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<td><strong>4</strong> Resource Tracking</td>
<td>By 2015, countries are tracking and reporting: 1) total health expenditure by financing source, per capita; and 2) total RMNCH expenditure by financing source, per capita.</td>
<td>By 2015, 50 countries developed reimplementing national eHealth strategies</td>
<td>27 countries developed and implementing national eHealth strategies linked to RMNCH. 65 countries completed eHealth profiles that serve as baseline for monitoring the uptake of ICT.</td>
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<td><strong>5</strong> Country Compacts</td>
<td>By 2012, “compacts” in place between governments and development partners.</td>
<td>By 2015, 50 countries have formal agreements with donors</td>
<td>44 countries have a compact or partnership agreement; 9 in process. More than 1 in 3 compacts since 2010 signed by civil society or non-state actors.</td>
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<td><strong>6</strong> Reaching Women and Children</td>
<td>By 2015, governments have capacity to review health spending and relate spending to commitments, human rights, gender and equity goals and results.</td>
<td>Linked to Recommendations 2 and 4</td>
<td>PMNCH tracks implementation of commitments and spending.</td>
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</table>
## Accountability for Women’s and Children’s Health

**Snapshot of progress towards the Commission’s 10 recommendations**

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<th>Work Area</th>
<th>Recommendation</th>
<th>Target</th>
<th>Result May 2014</th>
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<tr>
<td>7 National Oversight (Health Sector Reviews, Advocacy and Action)</td>
<td>By 2012, countries have transparent and inclusive national accountability mechanisms.</td>
<td>58 countries (where data are available) report having regular review mechanisms. Not all reviews have inclusive participation of civil society; not all have mechanisms for implementing recommendations from the reviews.</td>
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<td>7</td>
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<td>20 countries are engaging political leaders and financial decision-makers in health</td>
<td>Global partner databases for 11 core indicators publicly available through Countdown to 2015. Inter-Parliamentary Union unanimously adopted resolution Access to health as a basic right: The role of parliaments in addressing principal challenges to securing the health of women and children. IPU developed an accountability mechanism to support implementation of its resolution. Civil society, parliamentarians and media in ten African countries were trained to understand national budgets and undertake budget advocacy for improved women’s and children’s health. Civil society coalitions are developing proposals to apply new skills to national budget advocacy plans.</td>
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<td>8 Transparency</td>
<td>By 2013, stakeholders publicly sharing information on commitments, resources and results achieved annually, at both national and international levels.</td>
<td>50 countries with mechanisms for sharing and disseminating data</td>
<td>Global partner databases for 11 core indicators publicly available through Countdown to 2015. 20 countries have web-based facility reporting systems (DHIS 2.0).</td>
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<td>9 Reporting Aid for Women’s and Children’s Health</td>
<td>By 2012, OECD-DAC to agree on improvements to Creditor Reporting System (CRS) to capture RMNCH health spending by development partners.</td>
<td>By 2012, development partners agree on the method</td>
<td>Partners agreed on method (2012). OECD guidance developed and will be introduced in the CRS in the latter half of 2014.</td>
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<td>By 2013, OECD has developed guidance and instruction to support new method, and donors using new method</td>
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<td>10 Global Oversight</td>
<td>2012–2015, an independent Expert Review Group (iERG) reporting to the United Nations Secretary-General on the results and resources related to the Global Strategy and progress on CoA recommendations.</td>
<td>Members appointed Report due September 2012 and every year until 2015</td>
<td>iERG report was submitted to the Secretary-General during the United Nations General Assembly in 2012 and 2013. Six new recommendations were issued, including one on meaningfully engaging young people and including an adolescent indicator in all monitoring mechanisms. A youth member was appointed to the iERG.</td>
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17 Household survey data are the main source of data for the 11 indicators and many countries do not have up-to-date, accurate data on the 11 indicators.

18 The Commission suggested a target date of 2012 for this recommendation. However, during the stakeholder meeting that resulted in the original strategic workplan for implementing the recommendations, the date of 2015 was deemed more realistic.
## ANNEX 2: SNAPSHOT OF COUNTRY PROGRESS WITHIN SELECTED WORKSTREAMS

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<tr>
<th>Country</th>
<th>Country accountability framework</th>
<th>CRVS [assessment, plan developed and in progress]</th>
<th>MDSR system in place</th>
<th>Timely and accurate data available for monitoring core indicators</th>
<th>National eHealth strategy developed and being implemented</th>
<th>Country reporting on expenditure by indicators by financing source</th>
<th>IHP+ compact or similar partnership agreement operational</th>
<th>National health sector review process with stakeholder participation</th>
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19 Progress in the workstreams may not be solely attributable to country accountability framework activities.
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<tr>
<th>Country</th>
<th>Accountability framework</th>
<th>CRVS (assessment, plan developed and in progress)</th>
<th>MDSR system in place</th>
<th>Timely and accurate data available for monitoring core indicators</th>
<th>National health strategy developed and being implemented</th>
<th>Country reporting on expenditure by indicators by financing source</th>
<th>IHP+ compact or similar partnership agreement operational</th>
<th>National health sector review process with stakeholder participation</th>
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Legend:

- Result is achieved or is likely to be achieved before the deadline
- Progress is being made, but a continued effort is necessary to achieve results
- Workstream has not been prioritized / work has not begun

20 Countries where a policy exists for maternal death notification plus facility based death review and/or community maternal death review.
21 Countries where DHIS 2.0 is operational/in progress and where data quality mechanisms are in place.