



# 2015

*Every Woman,  
Every Child,  
Every Adolescent:*  
Achievements and  
Prospects

**EXECUTIVE SUMMARY**

The Final Report of the  
independent Expert Review  
Group on Information and  
Accountability for Women's  
and Children's Health

# IERG

# INDEPENDENT EXPERT REVIEW GROUP (iERG)

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## FUNCTIONS

- To assess the extent to which all stakeholders honour their commitments to the Global Strategy for Women's and Children's Health and the Commission on Information and Accountability (CoIA)
- To review progress in implementation of the recommendations of the Commission
- To assess progress towards greater transparency in the flow of resources and achieving results
- To identify obstacles to implementing both the Global Strategy and the Commission's recommendations
- To identify good practice, including in policy and service delivery, accountability arrangements, and value-for-money approaches relating to the health of women and children
- To make recommendations to improve the effectiveness of the accountability framework developed by the Commission

### The iERG's 2015 Recommendations: a Post-2015 Vision

- **Global accountability:** By 2016, establish and implement a global independent accountability mechanism to monitor, review, and act on results and resources for women's, children's, and adolescents' health, working across all 17 SDGs, reporting annually to the UN Secretary-General.
- **National accountability:** By 2016, in all countries establish and implement transparent, participatory, democratic, and independent national accountability mechanisms to monitor, review, and act on results and resources for women's, children's, and adolescents' health, with special attention to the translation of recommendations into action and reporting to Heads of State.
- **Accountability for sustainability:** In 2017, convene a global ministerial summit to report on progress towards the goals both of the new Global Strategy for Women's, Children's, and Adolescents' Health and the SDGs relevant to women, children, and adolescents; and to report on how national accountability informs and strengthens global accountability.

The independent Expert Review Group on Information and Accountability (iERG) was created in 2011 as a mechanism to strengthen accountability for women's and children's health. It was a body invented by the Commission on Information and Accountability (CoIA), chaired by President Kikwete of Tanzania and Prime Minister Harper of Canada (1). The idea of accountability is rooted in human rights. But sometimes the concept of accountability can seem far removed from the lived experiences of women, children, and adolescents. Measurement of progress, tracking of resources, and the construction of structures to deliver accountability in countries and globally can feel dry and abstract. In this, the iERG's fourth and final report, we wish to put the lived experiences of women and children at the heart of our concerns. The failure to deliver accountability is not merely a failure to meet the norms and standards of a political process. It is a fundamental violation of the dignity of the most vulnerable citizens living in our communities. For hundreds of millions of women and children worldwide,

the promises and commitments of national political leaders, as well as global heads of health agencies and development organisations, have fallen short of expectations. Our final report will certainly document successes. But as the true stories we begin with in the Introduction show, the egregious betrayals of the poor by the powerful continue to distort the history of women's and children's health. These deceptions are unacceptable. Accountability must make the realities of life for women and children worldwide its central concern. We hope this report goes at least some way to doing so.

2015 has been a year of reflection. The UN Secretary-General's signature health initiative, *Every Woman, Every Child*, was launched in 2010 (2). It has become one of the fastest growing movements in global health, attracting over 400 commitments by 300 partners, together with US\$60 billion of financing (3). Ban Ki-moon was right to say this year that, "The world is currently reducing under-5 and maternal deaths faster than at any time in history." In 49 priority countries targeted

by *Every Woman, Every Child*, achievements have been historic. 870 000 new health workers. A 49% increase in oral rehydration therapy for treating diarrhoeal disease. A 25% increase in skilled birth attendance. Progress has accelerated, and the Secretary-General's Global Strategy for Women's and Children's Health has made a crucial contribution to this acceleration.

But there is always a reckoning. As much as the global community should admire the achievements of the Global Strategy, it left substantial room for improvement. In 2010, a commitment was made, one that should not be forgotten (2):

"In the 49 countries of the world with the lowest income, progress would be incredible. Between 2011 and 2015, we could prevent the deaths of more than 15 million children under 5, including more than 3 million newborns. We could prevent... about 570 000 women from dying from complications relating to pregnancy and childbirth."

This headline promise was turned into an advocacy campaign for the Global Strategy: "Saving 16 million lives by 2015." But in the Progress Report on the Global Strategy, published earlier this year, the true figure was revealed—2.4 million deaths averted since 2010. This substantial difference between

what was promised and what was delivered is hard to comprehend. There are at least two possible explanations. First, that the Global Strategy failed. Second, that the calculation of 16 million deaths was exaggerated or an error. If the former explanation is true, the global community needs to conduct a careful autopsy on what went wrong and why. If the latter explanation is correct, how did the full technical capacity of WHO and partner agencies make such a mistake? It is not good enough, as the Progress Report does, to gloss over this discrepancy in numbers by saying that the Global Strategy has delivered "substantial gains."

2015 has also been a year of transition.

Ban Ki-moon has called the process leading to the post-2015 Sustainable Development Goals (SDGs), "The Road to Dignity" (4). 17 SDGs have been agreed upon, and health is one of those Goals (SDG-3) (Panels 1 and 2; see main report). Women's and children's health is embedded within that Goal. In parallel, a new Global Strategy has been drafted to meet the challenge of a more inclusive and complex era (5). Agreement about the SDGs and the elements of a new Global Strategy does not mean that the approach to women and children is "business as usual." There are already several critical differences in the approach and attitudes to women and children.

## PROGRESS IN WOMEN'S AND CHILDREN'S HEALTH

According to the latest figures available to the iERG, 6.3 million children under 5 died in 2013 (11, 12). Figures for the 75 iERG countries, taken from the Global Burden of Disease (GBD), are shown in Table 1 (see main report) (11). An alternative presentation, using data from the UN Interagency Group for Child Mortality Estimation, is shown in Figure 1. The headline message from these numbers is that although the 2013 estimate represents a 64% reduction in child mortality since 1970 (when 17.6 million deaths took place), most countries will not achieve the MDG-4 target—which requires a 4.4% rate of mortality decline annually. The GBD collaboration singles out five countries that have made especially strong progress—in Southeast

Asia, Cambodia, Lao PDR, and Viet Nam; and in eastern sub-Saharan Africa, Ethiopia and Rwanda. With annualised rates of decline in child mortality above 4%, these countries show that political commitment and judicious investments in health and (especially) maternal education can deliver results above expectation. The global causes of child death are shown in Figure 2 (see main report) (12). An alternative presentation of selected causes of child deaths is shown in Table 2 (see main report) (13). A particular concern is the growing importance of newborn mortality. In 2013, 2.8 million neonatal deaths occurred globally (14). Most of these deaths were preventable. Newborn mortality is falling, but more slowly than for under-5 deaths.



The result is that newborn deaths now account for 44% of total under-5 deaths. Deaths in newborns can be divided into two categories—early (0-6 days of age) and late (7-28 days of age). Most early neonatal deaths are caused by preterm birth (41%) or intrapartum (27%) complications. For late neonatal deaths, infections are the largest cause (almost half of newborn deaths). Equity analyses reveal severe disparities, despite often impressive average reductions in child deaths. Figure 3 (see main report) displays the proportion of under-5 deaths in the poorest and richest quintiles for a selection of iERG countries, together with several other nations included as comparators. The countries are ranked according to the percentage of all under-5 deaths that occur in the poorest quintile. Almost half of Brazil's under-5 deaths take place in this poorest quintile.

For maternal mortality (MDG-5a), the GBD study has reported estimates for 2013: 292 982 deaths, compared with 376 034 deaths in 1990 (15). Table 3 (see main report) shows their maternal mortality data for the 75 iERG countries of concern. Figure 4 shows data from the Maternal Mortality Estimate Interagency Group, with trends in maternal mortality in the 75 iERG countries. These data are divided by average annual rate of reduction for two periods: 1990-2000 and 2000-2013. Although not universally consistent, one can see many examples of acceleration in reductions in maternal mortality (in 56 countries, although with 19 nations showing decadal decelerations in progress). Figure 5 shows countries ranked by reduction trends in under-5 and maternal mortality, from best to worst. Countries that rank highly on both measures fall into the lower left of the diagram. If rankings on under-5 and maternal mortality were highly correlated, the points in the figure would cluster along the 45 degree line, which they quite evidently do not. The fact that they are as scattered as they are suggests that very different policies and influences may be affecting success in these two domains.

Achieving universal access to reproductive health services (MDG-5b) is the most off-track MDG of all. A report from the Guttmacher Institute in 2014 provides a comprehensive recent assessment of access to basic sexual and reproductive health

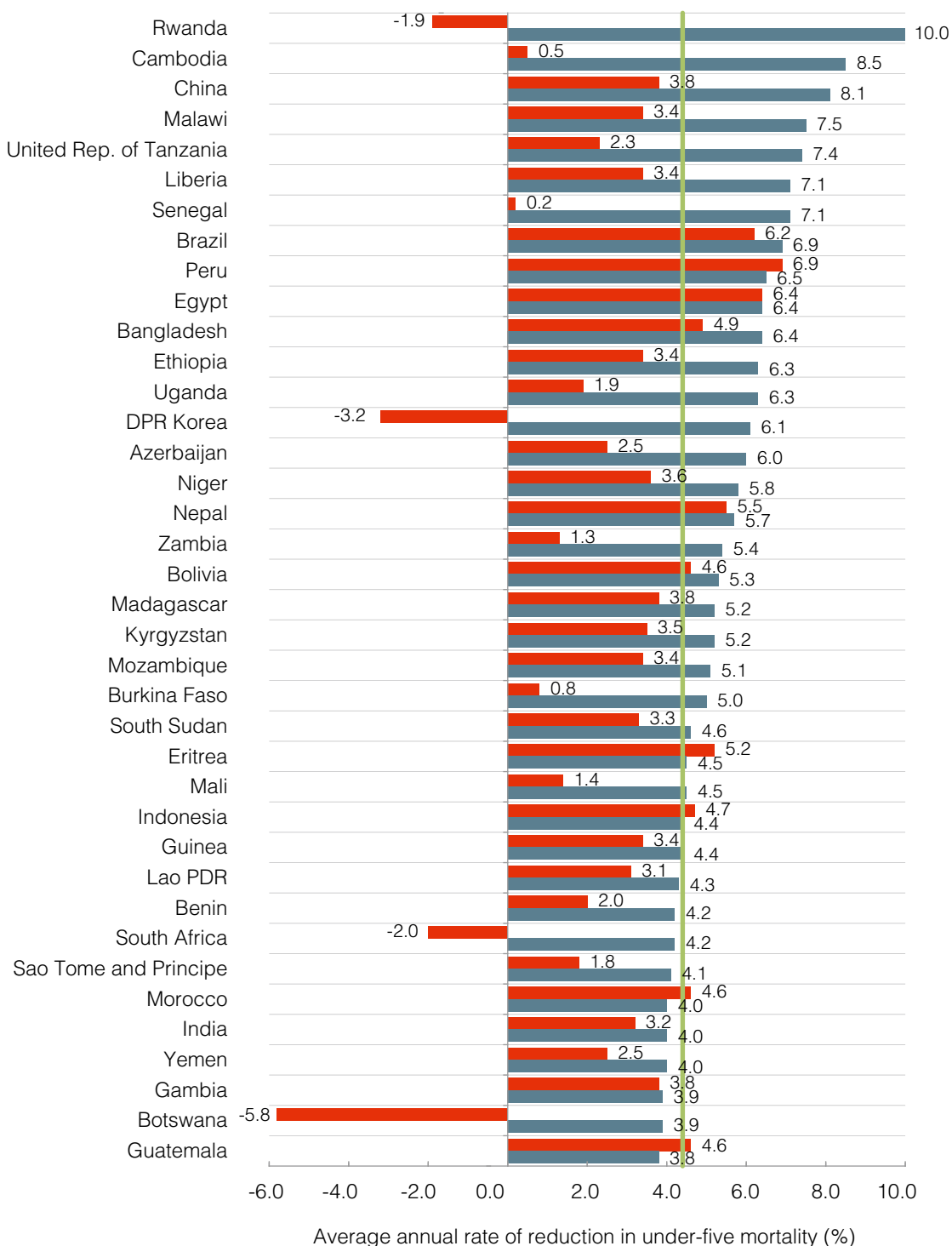
services (16a). Currently, 225 million women in developing countries wish to avoid pregnancy, but are not using modern contraceptives. If all women who sought to avoid pregnancy used modern contraception, the number of unintended pregnancies would fall by 70% and unsafe abortions would drop by 74%. If contraceptive needs were met and all pregnant women and their newborns received basic standards of care, maternal deaths would fall from 290 000 to 96 000, newborn deaths would decline to 660 000, and HIV transmission from mother-to-child would be nearly eliminated. For women aged 15-49, a package of essential sexual and reproductive health services, costing no more than \$25 per woman aged 15-49 years, would include: contraceptive services, pregnancy and newborn care, services for pregnant women living with HIV, and treatment of four other STIs. In its submission to the iERG, Family Planning 2020 (FP2020) provided its latest judgement on progress made and gaps remaining in improving access to modern contraceptives (Figure 6). The Guttmacher Institute also drew the iERG's attention to the neglected importance of unsafe abortion rates. Although estimates for safe and unsafe abortion have not been made since 2008, it is clear that unsafe abortion remains common in many low-income settings, especially among adolescents.

The iERG commissioned Professor Cesar Victora (University of Pelotas, Brazil) to examine socioeconomic, gender, and urban/rural inequalities for women's and children's health. His full findings are reported in Annex 3 (see main report). The key findings from this equity analysis are:

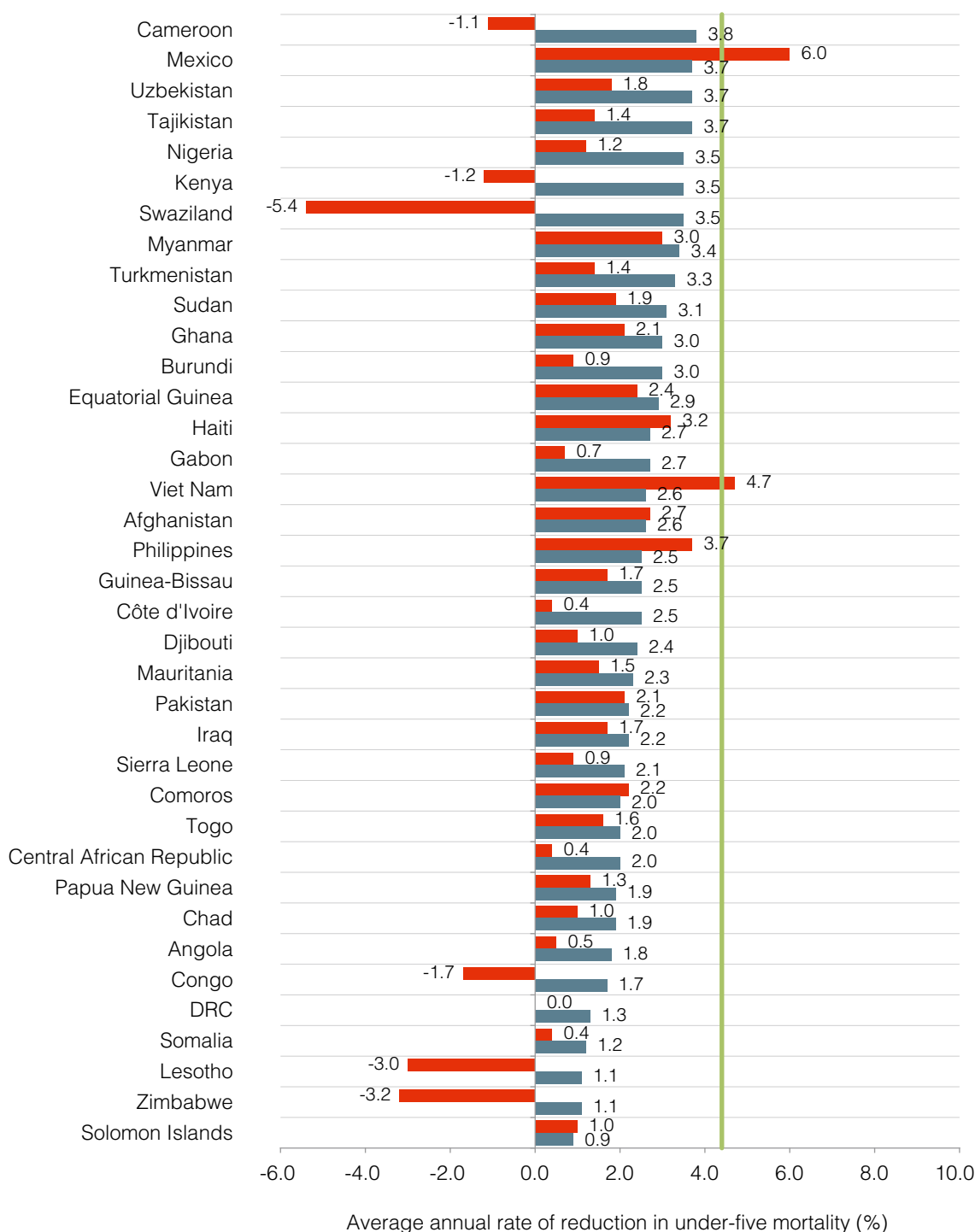
- Pro-rich inequalities are observed for all indicators, except for breastfeeding.
- The widest gaps are seen for skilled birth attendance.
- Postnatal care coverage is especially low across all quintiles.
- Pro-urban inequalities are seen for all indicators, except for exclusive breastfeeding.
- Boys and girls show similar coverage levels for post-natal care, exclusive breastfeeding, DPT3 vaccine, and pneumonia care seeking.

**Figure 1. Trends in child mortality in the 75 iERG countries, by average annual rate of reduction, 2000-2012**

— Average annual rate of reduction (%), 1990-2000    — Average annual rate of reduction (%), 2000-2012  
 — MDG4 target (4.4%)



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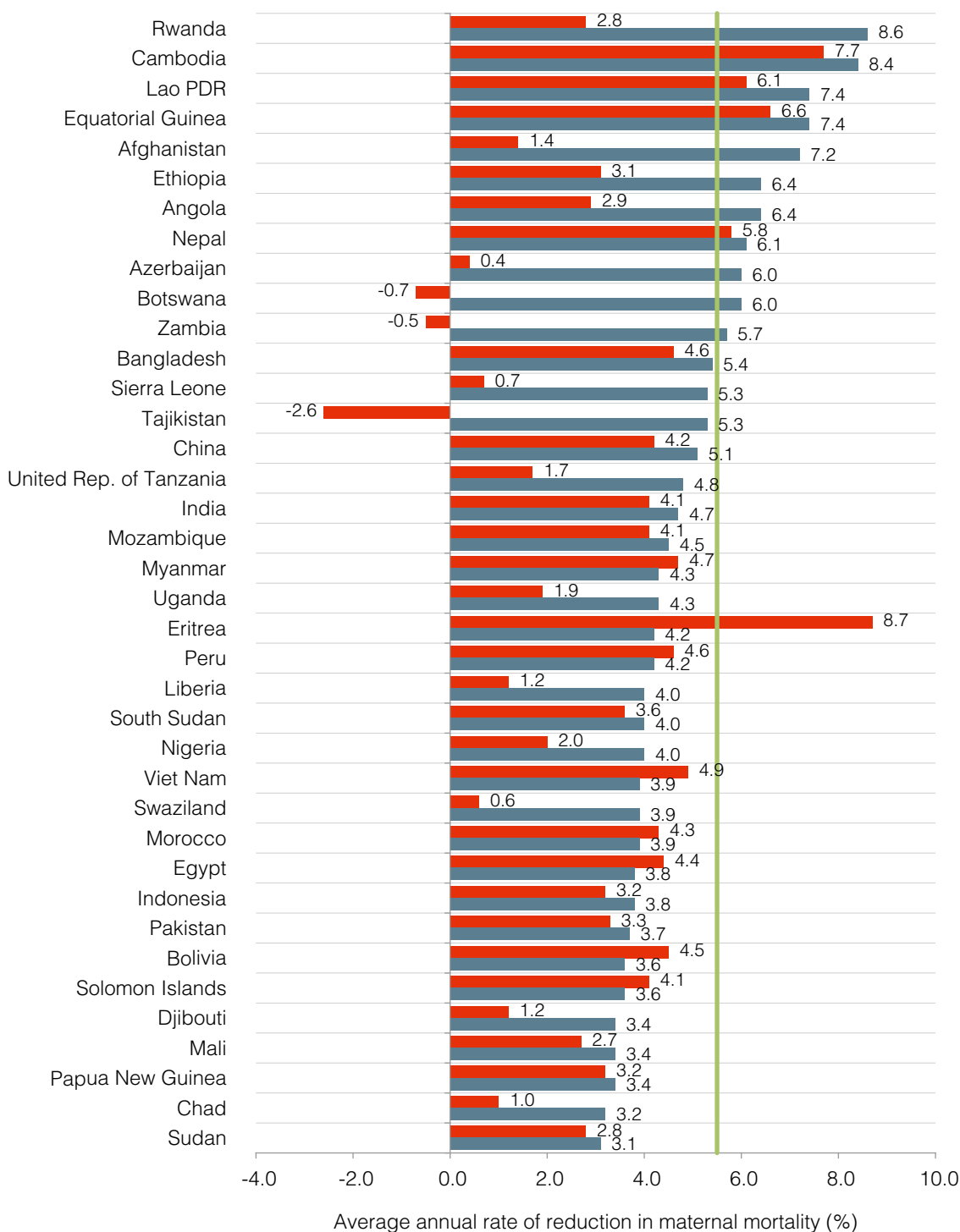


The goal for MDG4 was for countries to achieve a 4.4% average annual rate of reduction (AAR) in child mortality. In most iERG countries, the AAR for child mortality was faster in the years after 2000. However, in 10 countries, the AAR for child mortality was faster during the period from 1990-2000 compared to 2000-2012.

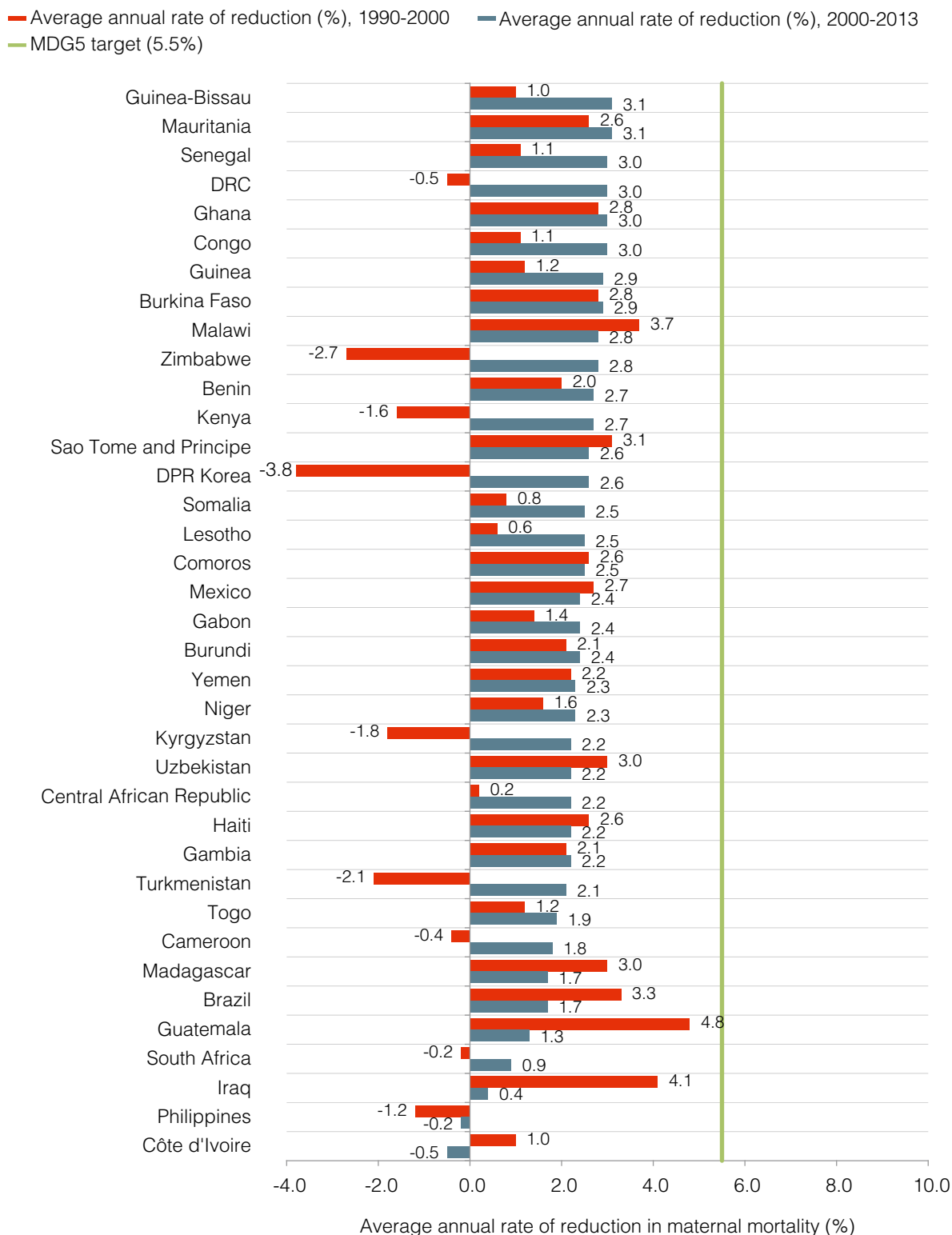
Source: UN Inter-agency Group for Child Mortality Estimation, 2013. Figure adapted from "Fulfilling the Health Agenda for Women and Children: The 2014 Report," Countdown to 2015.

**Figure 4. Trends in maternal mortality in the 75 iERG countries, by average annual rate of reduction, 2000-2013**

— Average annual rate of reduction (%), 1990-2000    — Average annual rate of reduction (%), 2000-2013  
— MDG5 target (5.5%)



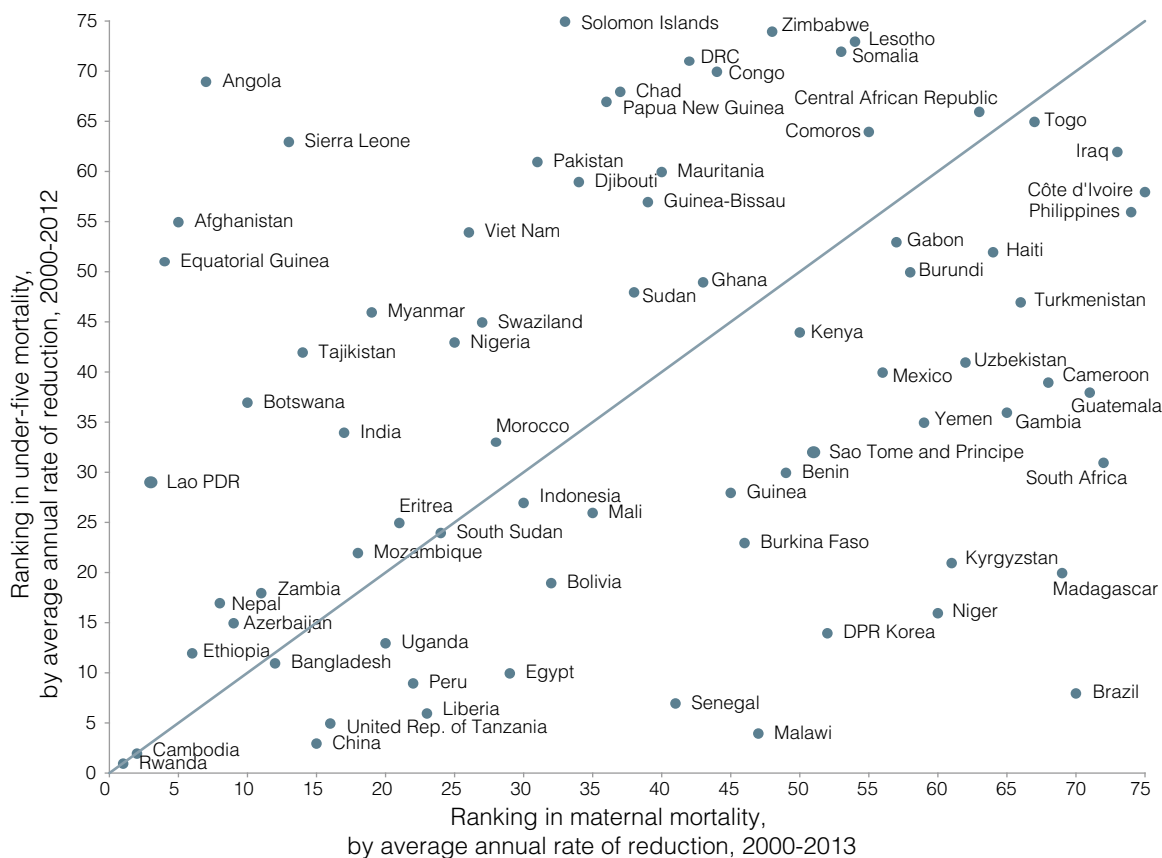




The goal for MDG5 was for countries to achieve a 5.5% average annual rate of reduction (AAR) in maternal mortality. In most iERG countries, the AAR for maternal mortality was faster in the years after 2000. However, in 19 countries, the AAR for maternal mortality was faster during the period from 1990-2000 compared to 2000-2012.

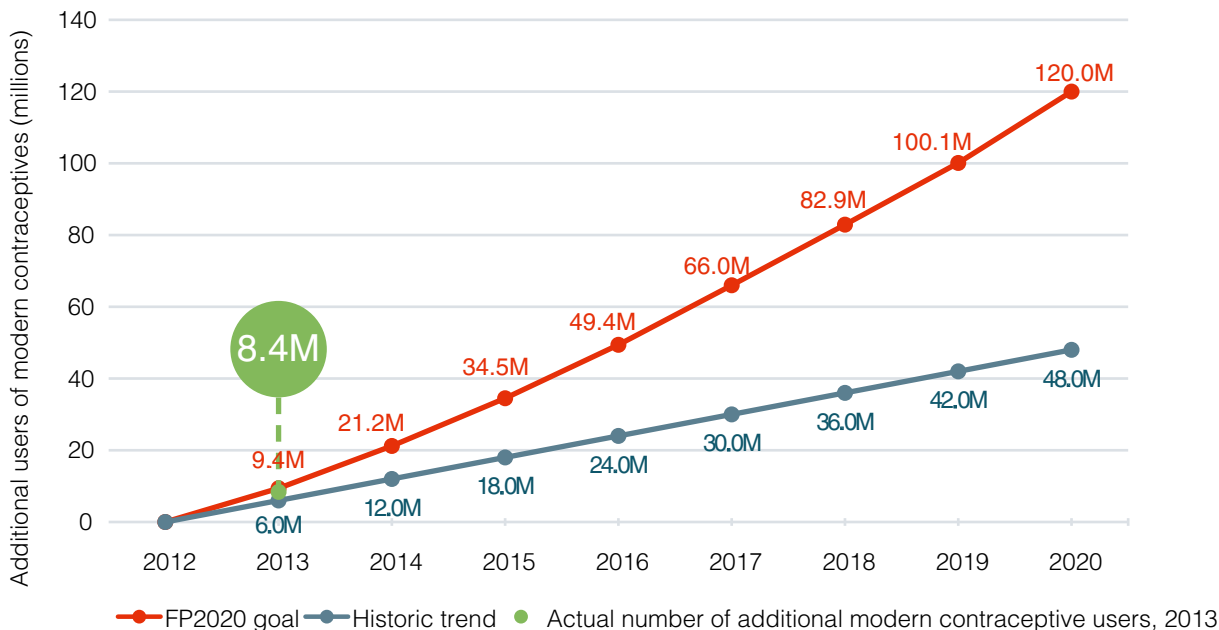
Source: Maternal Mortality Estimate Inter-agency Group, 2014. Figure adapted from "Fulfilling the Health Agenda for Women and Children: The 2014 Report," Countdown to 2015.

**Figure 5. 75 iERG countries ranked by reduction trends in under-five and maternal mortality**

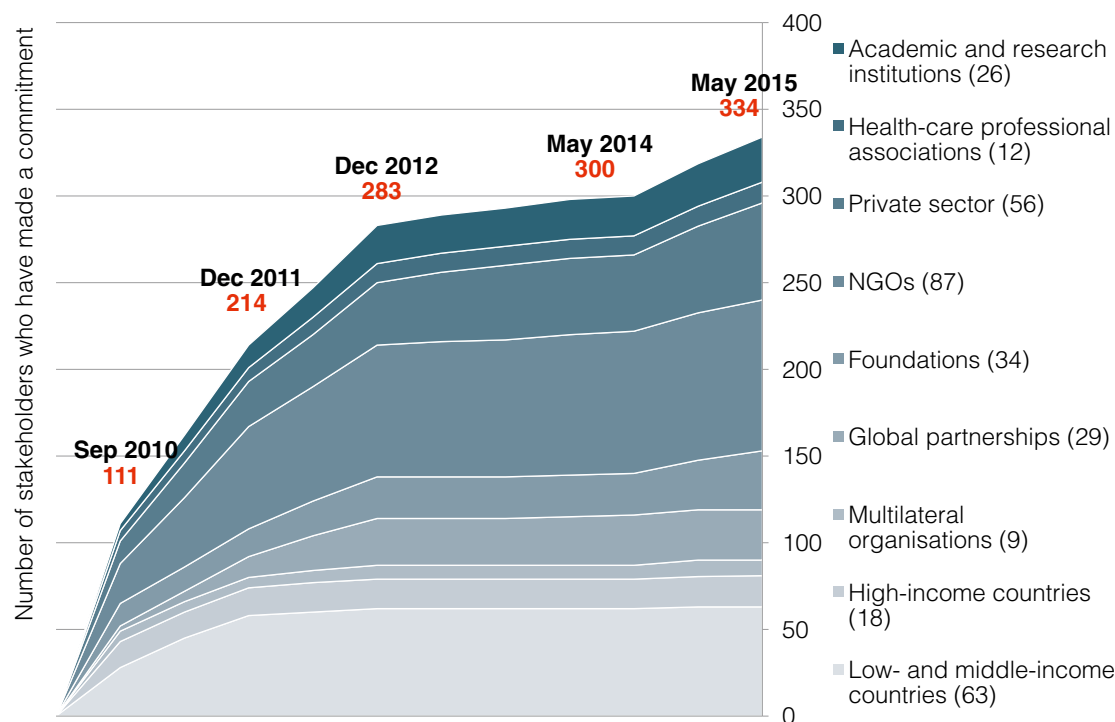


Source: UN Inter-agency Group for Child Mortality Estimation, 2013. Maternal Mortality Estimate Inter-agency Group, 2014. Figure adapted from "Fulfilling the Health Agenda for Women and Children: The 2014 Report," Countdown to 2015.

**Figure 6. Global contraceptive users: FP2020 goal vs. historic trend**



Source: Brown et al, 2014. Developing the '120 by 2020' Goal for the Global FP2020 initiative. *Stud Fam Plann*. Figure adapted from "2015 Report to the independent Expert Review Group," FP2020.

**Figure 7. Stakeholders with commitments to the Global Strategy, by constituency, September 2010–May 2015**

Source: *Every Woman Every Child* website. Figure adapted from "Global Strategy: Update on Implementation of Financial Commitments," PMNCH, 2015.

- For family planning, there are consistent pro-rich coverage patterns.
- Inequalities are largest in Africa.
- Adolescents have a much greater unmet need for contraception.
- For antenatal care, in every region there are pro-rich coverage patterns.
- At the global level, there are important inequalities in total fertility: ranging from 2.8 children/woman in the richest quintile to 5.4 in the poorest quintile.
- At the global level, the average number of children per urban woman is 3.1, compared with 4.6 among rural women.
- In all regions, fertility and stunting are inversely related to wealth.

Issues of equity received insufficient attention during the era of the MDGs, as these findings starkly and shockingly indicate. Although equity is frequently discussed, it is seldom prioritised in policies and programmes. Post-2015, whatever mechanism for accountability is chosen for women, children, and adolescents, equity must be made a supreme priority. UNICEF has put equity-focused

programming at the heart of its recent work on reducing child mortality, to its enormous credit and largely thanks to the personal leadership of its Executive Director, Anthony Lake. As Lake wrote in UNICEF's analysis of equity in the MDGs, "If development is to be truly sustainable, it must be truly equitable—and seek to reach every child. For children who have equal opportunities will in turn create greater opportunities for their own children and the generations that follow" (16b).

The architecture of accountability for *Every Woman, Every Child* has led to a strong collaboration between the Partnership for Maternal, Newborn, and Child Health (PMNCH) and the iERG. In three past PMNCH reports, commitments to the Global Strategy have been documented and issues investigated in ways that have been synergistic and complementary to the work of the iERG. In 2015, PMNCH is not producing an annual report. However, we are fortunate that the Partnership has continued tracking financial flows to RMNCH. Here, we present a summary of their latest findings:

- The number of stakeholders committing to women's and children's health has increased from 111 in 2010 to 334 in 2015 (Figure 7).
- Since May, 2014, an additional 34 commitment makers made pledges to the Global Strategy—17 of them in support of the Every Newborn Action Plan.
- Financial commitments to the Global Strategy have reached US\$45 billion (once double-counting has been removed); 9 financial commitments have been made since May, 2014.
- As of May, 2015, US\$31 billion of the US\$45 billion committed has been disbursed (Figures 8 and 9; see main report).
- Annual disbursements for women's and children's health have increased substantially since the launch of the Global Strategy: donors disbursed US\$11.9 billion for RMNCH in 75 priority countries in 2013, an increase of 25% since 2010; in 2013, RMNCH ODA to these 75 countries grew by 15%, a substantially higher figure than 2011 (0.5%) and 2012 (7.8%) (Figure 10; see main report).
- Previously underfunded areas, such as family planning, have seen steep increases in financial support—50.5% since the launch of the Global Strategy (from US\$452.9 million in 2010 to US\$681.6 million in 2013) (Figure 11; see main report).
- There are persistent geographic inequities in RMNCH funding—DRC and Guinea, for example, continue to receive relatively small amounts of ODA (Figure 12; see main report).
- However, there are signs that for some countries, advocacy around equity may be having an impact—eg, countries with high maternal mortality (such as Sierra Leone, Chad, and Côte d'Ivoire) saw rises in RMNCH support in 2013 after a phase of decline.
- Countries are increasingly demonstrating their commitment to women's and children's health—domestic public sector spending on RMNCH increased 115% from 2006 to 2013 for our 75 countries of concern (Figure 13; see main report).

## THE COMMISSION ON INFORMATION AND ACCOUNTABILITY: A FINAL REPORT CARD

**Figure 14. Summary of global progress on implementation of the recommendations from CoIA**

Recommendation	Target year	2013	2014	2015
Vital events	2015			
Health indicators	2012			
Innovation	2015			
Resource tracking	2015			
Country compacts	2012			
Reaching women and children	2015			
National oversight	2012			
Transparency	2013			
Reporting aid	2012			
Global oversight	2012			

- The target will be difficult to achieve
- Progress is being made, but continued and concerted effort is needed to achieve the target
- The target is on track or has already been achieved
- No or too few data are available to judge progress
- Multiple indicators show both absence of data and progress being made

Figure 14 shows our summary of progress on implementation of the CoIA recommendations. We have included our assessments from the previous two years for comparison. Our 2015 assessments are based on 75 Country Profiles we provide for the first time with this report. These Profiles benchmark progress at the end of the MDG era (and at the conclusion of the iERG's work). Each Country Profile consists of two pages. The first page gives basic demographic data for each country, information on reproductive health and health systems, and data on health coverage, including, where available, data on health equity. Progress towards MDGs 4 and 5 is shown, specifically the three impact indicators of Maternal mortality ratio, Under-5 and Neonatal mortality rates, and Under-5 stunting. The second page provides information on progress against each of the CoIA recommendations that are relevant for countries (thus excluding recommendations on reporting aid and global oversight). This information is intended to help policymakers and their partners assess progress and prioritise further actions to save women's and children's lives. When reading Figure 14, several clarifications and explanations are important.

- We have introduced a new category of descriptor—a grey panel—indicating no or too few data are available to judge progress.
- The introduction of this new category has changed our assessments in 5 CoIA areas—for Reaching Women and Children (percentage of national expenditure used for RMNCH) and for Transparency (a health sector performance report for the preceding year is available in the public domain), we had previously reported that progress was being made. We have now changed that judgement. In both areas, we believe there are insufficient data to draw any reliable conclusions on progress.
- In 3 further categories—Vital Events, Resource Tracking, and National Oversight—we had previously made judgements based on what we believed were available data. However, it is now clearer that in all 3 cases, critical data are missing. Given this partial lack of data, we are marking partial progress with grey colour coding indicating lack of information.

- In 3 categories, based on a fuller appreciation of the available data, we have revised our appraisal downwards compared with 2014—in Vital Events, Health Indicators, and Reporting Aid.
- Overall, we judge that only one CoIA recommendation has been fully delivered—the establishment of the iERG. Progress is being made in 6 CoIA areas. One area demonstrates considerable resistance to progress. And in 5 areas, lack of data is stopping a fuller evaluation.

Leadership globally to implement the CoIA recommendations has fallen especially to the H4+, a partnership of UN agencies including UNICEF, UNFPA, WHO, the World Bank, UNAIDS, and UN Women. The H4+ leads collectively at the global level, and coordinates technical assistance in countries. Its work is broad, encompassing initiatives such as *A Promise Renewed*, the Commission on Life-Saving Commodities, the Every Newborn Action Plan, and *Every Woman, Every Child*. In their submission to the iERG, the H4+ helpfully sets out the obstacles to delivering the aspirations of CoIA. In summary, these obstacles are:

- Coordination: a continuous challenge, especially in countries lacking compacts and health sector reviews.
- Inclusion: of external partner organisations, especially civil society.
- Resource mobilisation: to fund joint work plans.
- Monitoring and evaluation: to learn lessons and document best practices.
- Scaling up: to achieve adequate reach and coverage.
- Capacity: countries report challenges of being forced to choose among multiple priorities.
- Instability: political shifts and humanitarian crises can disrupt RMNCH activities.
- Human resources: a further capacity challenge, to implement, provide, and lead RMNCH services.

For the first time, we report the financial and policy commitments of key donors to women's and children's health (see main report). The single page reports total ODA, health, and RMNCH expenditures. It lists major pledges, and reports the latest Aid Transparency Index assessment.

The results reported here deserve careful assessment and discussion among all key constituencies involved in women’s and children’s

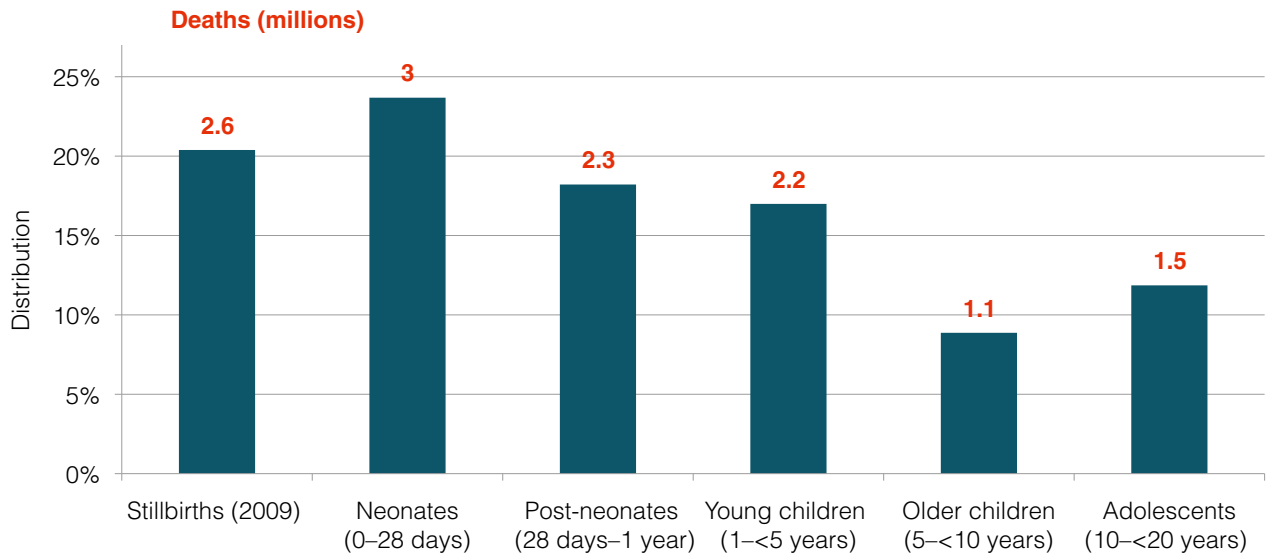
health in order to judge whether partners are living up to their promises.

## POST-2015: ACCOUNTABILITY FOR SUSTAINABLE DEVELOPMENT

The place of health in the post-2015 development arena is very different from the place it occupied during the MDG era. Health dominated the MDGs—3 out of 8 goals were health related, based on the notion that poverty was substantially precipitated, driven, and perpetuated by poor health. The poverty-reduction focus of the MDGs put health in pole position in development policy and practice. The era of sustainable development represents a sea change in perspective. The triple helix of sustainable development has economic, social, and environmental strands—health is a part of this framework, but it is not the major part. The SDGs (Panel 1; see main report) cover a far-reaching and daunting range of issues. But, despite this recalibration, the health sector should not feel disenfranchised. Although health has been decentred from the development conversation, SDG-3 expands the health agenda considerably. In addition to securing the importance of the “unfinished business” of the MDGs—reproductive,

maternal, newborn, and child health, together with major infectious diseases—the new health SDG opens up territory on, for example, non-communicable diseases, universal health coverage, the health workforce and financing, and global health risks and security. The universality of the health goal—“Ensure healthy lives and promote wellbeing for all at all ages”—gives a new Global Strategy the best possible opportunity to craft a vision that encompasses a broad range of health and non-health determinants. It makes equity its guiding principle. And it makes health political. Universal Health Coverage cannot be delivered through market mechanisms. It is the responsibility of governments, who must themselves respond to the demand for good quality health services from their electorates. The central importance of the health system for governments means that health becomes a Head of State issue, not simply a subject for the Minister of Health.

Figure 15. Age distribution of under-20 mortality in low- and middle-income countries, 2010



Source: Jamison et al, 2013. Global health 2035: a world converging within a generation. *Lancet*.



Adolescents are the main new challenge for any post-2015 Global Strategy. The new Global Strategy has explicitly included adolescents in its post-2015 vision. The iERG drew attention to the importance of adolescents in its 2013 report. Adolescents often get little attention from the health sector since they are wrongly thought to be healthy and unimportant to development. But adolescents are central to the major challenges in global health. There are approximately 1.2 billion adolescents aged 10-19 years. Adolescence is a critical stage in life, characterised by rapid biological, emotional, and social development and during which every person can develop the capabilities required for a productive, healthy, and fulfilled life. Figure 15 shows the age distribution of child and adolescent mortality in low- and middle-income countries. The considerable number of deaths among adolescents draws attention to a very different pattern of ill-health in this important group.

- Unintentional injuries
- Harmful alcohol use
- Tobacco use
- Overweight and obesity
- Mental ill-health
- Infectious diseases, including HIV
- Sexual and reproductive health disorders
- Risks from pregnancy and childbirth, including in the context of forced marriage
- Unsafe abortion

Attention to adolescent health will be essential if maternal mortality goals are to be met (28). Adolescence provides a critical interface in global health between women's and children's health and non-communicable diseases and mental health. Mental health will assume an increasingly important place in our thinking about health and wellbeing post-2015, and there will be no more important area where this is so than for the adolescent (29). The concern for adolescent health also opens up linkages with early child development, since many of the determinants of adolescent health begin well before adolescence starts. Early child development will therefore be a further important dimension for the new agenda for women's and children's health post-2015. The new Global Strategy has given adolescents an independent

place in the continuum of care. But although health interventions will be important, adolescent health is about more than the health sector. Adolescent health in some ways needs to be demedicalised. The main drivers of adolescent health are largely outside of the health system—education, labour markets, economic policies, legislative and political systems, food systems, and the built environment. Education is especially important—not only because of its overall impact on health, but also because of the clear opportunity to prevent many of the adverse effects related to reproductive health through comprehensive sexuality education, about which there is new momentum with countries committing to making it universally accessible. How the SDGs and a new Global Strategy engage with these broader sectors will be one of the greatest challenges for the health community post-2015. We see hopeful signs. The World Bank has prioritised gender equality as a means to reduce poverty and promote prosperity. The Bank sees gender equality as a core development objective in its own right. But there are clouds to consider too. We note concerns that sexual and reproductive health and rights may be deprioritised in the new Global Strategy. We therefore urge those charged with implementing the Global Strategy to make sexual and reproductive health a priority for women and adolescents post-2015.

A further issue that has been even more neglected than adolescent health is stillbirths. A stillbirth is strictly a pregnancy loss after 22 weeks of gestation. The WHO definition is different—WHO defines a stillbirth as the death of a child whose birthweight is at least 1000g or whose gestational age is at least 28 weeks (a third-trimester stillbirth). Little or no funding is dedicated to stillbirth prevention. Yet 2.6 million women each year experience a stillbirth. Most babies who die in the last 3 months of pregnancy should have survived. 1.2 million babies begin labour alive and die before birth—an intrapartum stillbirth. These intrapartum stillbirths are a highly sensitive marker of the quality of care in a health system. The causes of stillbirth are known and they can be mostly addressed through good quality care. It is an entirely reasonable goal to make 2030 the deadline for preventing stillbirths in all settings. Yet stillbirths

have remained uncoun- ted in global frameworks for women's and children's health. No longer. A new series of papers to be published in *The Lancet* in 2015 will try to ignite the concern of the global community into this deeply neglected area. New estimates of stillbirth deaths will be reported, together with risk factors and the economic costs of stillbirth. Evidence of what works to prevent stillbirths will be reviewed, and an implementation plan will be designed. The goal will be to offer a roadmap for addressing stillbirths, one that will make a major impact by 2030, the deadline for the SDGs.

There is no single perfect model of global accountability. In our 2014 report, we set out 12 principles for accountability rather than endorse a single approach—legitimacy, independence, framework, terms of reference, reliable data, parsimony, country engagement, review mechanisms, participation, regular reporting, resourcing, and monitoring impact. These principles still seem to us to have merit. For example, although a Progress Report on the Global Strategy was published in 2015, that report was not independently researched and written, thus weakening its force as a document measuring the impact of *Every Woman, Every Child*. WHO recognises the importance of independence. In its evidence to the iERG, WHO notes that,

“Independent accountability remains essential for the post-2015 period: There is multi-stakeholder consensus on the need for independent accountability for women's and children's health post-2015, and this is a priority in the development of the new Global Strategy for Women's, Children's, and Adolescents' Health.”

The model for independent global accountability should include the following key elements:

- A framework definition of independent accountability: Monitoring, Review, Act
- Legitimacy established through a UN agency governing body or related political process
- Full administrative and technical resourcing

- Clear roles and responsibilities for reporting among, and working with, partners
- Indicators that measure impact and that are sensitive to change, disaggregated for equity considerations and aligned with related global processes (eg, SDGs)
- Emphasis on donor as well as country accountability
- Attention to implementation of the findings and recommendations from the independent accountability mechanism
- Host the administration of the independent accountability mechanism within an existing entity engaged in delivering the Global Strategy, but ensure the independence of the accountability research and writing process
- Establish a reporting line between the independent accountability mechanism and the UN Secretary-General, through the Director-General of WHO
- Ensure that accountability reports and recommendations are presented in high-level fora with sufficient time and engagement to allow debate and discussion
- Link global and national accountability mechanisms

The iERG's proposal for independent accountability for a renewed Global Strategy is reproduced in Annex 6 (see main report). All parties in the discussion recognise and accept the importance of an Independent Advisory Panel to replace the iERG. The disagreement relates to who has primary responsibility for producing the independent assessment of the Global Strategy's progress—should it be, for example, the Independent Advisory Panel itself, with technical and administrative support from PMNCH or should it be PMNCH, with advisory input from the Independent Advisory Panel. We prefer the first option: we see a critically important role for PMNCH, but we see their comparative advantage as one of technical and logistical support, an important gap in the current accountability arrangements of which the iERG is a part.

Two particular groups have an important part to play in strengthening any independent accountability

process, globally or nationally—civil society and the research community. The engagement of civil society strengthens social accountability. It also builds community trust and confidence about programmes and policies. The meaningful participation of civil society in accountability mechanisms changes the dynamics of power in decision making. Greater attention can be given to equity, dignity, human rights, and quality, together with groups or issues that may have been marginalised—eg, adolescents, donors, unsafe abortion, sexual and reproductive health and rights, and mental health. The participation of civil society will also make transparency and data availability priority concerns. The research

community also has a neglected part to play in strengthening accountability. Through their attention to reliable data and independent analysis, scientists can use research methods—and tools of research, such as peer review, presentation, publication, and, not least, academic freedom—to hold policymakers accountable for their programmes and decisions. This work ranges from the calculation of estimates of mortality to the evaluation of specific health programmes. The engagement of the scientific community in calling for stronger accountability in global health is one example of research recognising its larger social and political role in society (39).

## CONCLUSIONS AND RECOMMENDATIONS

When young children observe something unexpected, their learning is enhanced (40). This finding should encourage us. The expectation of *Every Woman, Every Child* was that 16 million lives would be saved across 49 countries from 2010 to 2015. Unexpectedly, that figure was incautious. The actual number of deaths averted was 2.4 million. This discrepancy should propel us to think harder, to use this disappointing result to learn how to do better. As we enter the era of sustainable development, our approach to the health of women, children, and adolescents will be challenged and tested still further. Complexity, fragility, and uncertainty are the hallmarks of our world today. Populations are growing rapidly in regions of the world already under severe demographic pressure. Multilateralism is in decline. Globalisation is increasing inequalities within countries. Political, economic, environmental, and health crises are overwhelming institutions we once relied on to protect us. Public trust in governments is falling. Technological advances are inspiring, but also disruptive. This is the context in which we have to consider the future of women and children.

Surveying the SDGs, the health of women, children, and adolescents is not confined to SDG-3. Rather, it is distributed across many SDGs—SDG-1 (poverty reduction and social protection); SDG-2 (food security and nutrition); SDG-4 (education and

early childhood development); SDG-5 (sexual and reproductive health and rights, sexual violence, forced marriage, and female genital mutilation); SDG-6 (water, sanitation, and hygiene); SDG-8 (economic growth); SDG-10 (inequality and social protection); SDG-11 (urban health, disasters); SDG-16 (homicide, conflict, violence, accountable institutions, and CRVS). How sensible is it to create an accountability mechanism that focuses either on one SDG or a narrow interpretation of a new Global Strategy? Instead, would it not be more productive to monitor and review issues that directly or indirectly influence the health of women, children, and adolescents? For example, many of the multilateral institutions charged with a health responsibility also have strong commitments to other areas of the SDGs. To take one particular instance of cross-linkage: WHO/UNICEF produce an appraisal of progress towards MDG-7 on environmental sustainability. MDG-7 is not a core health MDG, but it incorporates targets on water and sanitation, clearly important determinants of health. The global MDG target for drinking water was met in 2010, whereas the target for sanitation was missed by almost 700 million people. The need for integration of accountability across the spectrum of health and the determinants of health therefore seems compelling. In taking account of these various factors, we have formulated 3 final recommendations from the iERG:

**Global accountability: By 2016, establish and implement a global independent accountability mechanism to monitor, review, and act on results and resources for women's, children's, and adolescents' health, working across all 17 SDGs, reporting annually to the UN Secretary-General.**

**National accountability: By 2016, in all countries establish and implement transparent, participatory, democratic, and independent national accountability mechanisms to monitor, review, and act on results and resources for women's, children's, and adolescents' health, with special attention to the translation of recommendations into action and reporting to Heads of State.**

**Accountability for sustainability: In 2017, convene a global ministerial summit to report on progress towards the goals both of the new Global Strategy for Women's, Children's, and Adolescents' Health and the SDGs relevant to women, children, and adolescents; and to report on how national accountability informs and strengthens global accountability.**

We believe that implementation of these recommendations could do much to create the conditions for one of the most remarkable successes global health is likely to see during the SDG era. The global community is developing ambitious targets for reduction in child and maternal mortality for the SDG period. Different studies and different agencies have put forward different goals, but all are ambitious. As we discuss in the main report, one goal is a two-thirds reduction in both maternal and child mortality rates over the 20-year period 2010-30 (24). The iERG commissioned the same team that derived the “40 by 30” target to project how many deaths would be averted globally, relative to a 2015 baseline, if the goals from their *Lancet* paper were to be met. Applying the methodology of that paper, but adjusting the base year to 2015, 34 million child deaths and about 1.5 million maternal deaths would be averted globally in the SDG period. These numbers assume that the world will meet its ambitious goals. The iERG believes that this striking outcome is both

technically and financially feasible for the world to meet. But the question remains as to whether it is politically feasible too. See Panel 9 for a fuller description of these estimations.

In concluding our work, we ourselves need to be accountable to the *Every Woman, Every Child* movement, and most importantly, to the women, children, and adolescents who are the subject of our concern. Two questions demand answers:

**Since the launch of the work of the Commission on Information and Accountability and iERG, do countries and partners have better information to track results and resources?**

**Do those countries and partners have stronger and more sustainable systems of accountability, nationally and globally?**

On the first question, we believe we have shown (Figure 14) that progress has been achieved in several critical areas—notably, acceleration of CRVS strengthening, innovation, agreement of country compacts, and awareness and advocacy for global and national accountability. In other areas, there are simply too little data to make confident judgements either way (on resource tracking, reaching women and children, and transparency). And in a few domains, we have been disappointed by lack of progress—eg, on the uptake and use of indicators to monitor change, and on the energy and commitment given to addressing inequalities (41). But on the second question, we are even more cautious. Globally, the iERG concludes its work in 2015. Although accountability is much discussed and partners seem committed to the principles of accountability, the precise arrangements for creating a sustainable mechanism to deliver independent global accountability for women's, children's, and adolescents' health are unclear. We are concerned that the gains made in establishing independent accountability as a central part of the Global Strategy and SDG process post-2015 are at risk. In countries, although there has been considerable discussion of, and advocacy for, accountability, the evidence that resilient processes for monitoring, reviewing, and acting are in place is not available. There are documented examples of

successful country accountability mechanisms (42). We believe that countries have an extraordinary opportunity to make accountability the foundation for their accelerating development.

As we complete our term of office, we have looked back over the past 4 years to reflect on the lessons learned from the idea and practice of independent accountability.

- Independent accountability can be done and delivered, despite often challenging limitations of information and resources.
- Although global accountability was strengthened with the advent of an iERG, the connection with country accountability was weak. Indeed, our country level activity was the least developed part of our work. The country visits we undertook in 2014 were an important step in the right direction, one that we hope will be repeated and developed in future years. These visits allowed much more comprehensive national assessments of progress. But country visits by the iERG cannot substitute for strengthened national capacities for independent accountability. Such country accountability systems should be more formally linked to whatever global mechanism is put in place.
- The independent accountability mechanism needs to be supported in developing stronger relationships with country development partners. One possible solution is to designate a national accountability representative within each country WHO team whose responsibility is to survey and shepherd progress on CoIA recommendations.
- Accountability must be accompanied by tangible actions and remedies at global and national levels for its full value to be realised. The link between the sensory inputs of independent accountability and the effector outputs of action must be strengthened.
- Between its global and country concerns, independent accountability can also operate regionally. It would have been helpful if the iERG had been able to take fuller advantage of regional health institutions (eg, with the Regional Offices of WHO).
- The iERG was constantly aware of the value of the independence it was granted by CoIA. That independence is partly guaranteed from the broad array and diversity of its members in age, professional background, philosophy, expertise, and geography. The complementarities of backgrounds and skills within the iERG membership were a major advantage to its work. The independence we were given enabled us to commission reports and case studies to illustrate critical points of concern.
- We learned that to make the most of the evidence we received, we should not only measure and report on progress in our monitoring role, but also develop policy proposals for action and remedy.
- We were repeatedly made aware that for our recommendations to have maximum impact, our reports had to be channelled to the highest reaches of global decision-making. Although we sought more formal presentation and discussion of our annual reports at key global meetings, we were disappointed with the progress we made in this regard.
- The hosting, resourcing, and autonomy of the mechanism for independent accountability are critical to its success. The secretariat function of the iERG is a vital part of its work. We believe that the technical capacity of this secretariat should be strengthened in future iterations of independent accountability.



### Panel 9. Estimates of child and maternal deaths averted for the period 2015–2030

The iERG sought to calculate an estimate for the number of child and maternal deaths averted globally between 2015 and 2030 if the SDG targets proposed by Norheim et al were achieved (24). We commissioned Professor Ole Norheim to make this calculation. He has previously proposed that an overarching target for the health SDGs could be a 40% reduction of all premature deaths (deaths before 70), and a two-thirds reduction of child and maternal deaths (compared with 2010 death rates, adjusted by population size for the year 2030).

For the period 2015–30, we estimated child and maternal deaths that would occur annually, adjusted by the number of live births for the year 2030, assuming a linear decrease in mortality from the year 2015 to 2030. This adjustment is necessary to get comparable numbers when population size changes over time. We used the same method as described by Norheim et al (24). The “40 by 30” sub-target proposed for child and maternal mortality is a two-thirds reduction of deaths that would have occurred if 2010 death rates were applied to the 2030 population. The only difference in this calculation is that we used 2015 as the baseline for estimating deaths averted. We calculated deaths averted by comparing the (adjusted) number of deaths in 2015 with each year up to 2030, and then adding them up.

When we look at projections from 2015 to 2030, we see that about 34 million child deaths could be averted in the period 2015 to 2030 if the “40 by 30” target is achieved by 2030 (Table A). About 1.5 million maternal deaths could be averted in the same period (Table B).

**Table A. Estimated child deaths averted globally (2015–2030), if 2/3 of 2010 deaths are averted by 2030\***

Year	Child deaths	Live births	Annual targets (adjusted to 2030 population)	Deaths averted compared to 2015
<b>2010</b>	6 900 000	131 900 000	6 800 000	...
...	...	...	...	...
<b>2015</b>		135 400 000	6 000 000	
<b>2016</b>		135 200 000	5 600 000	400 000
<b>2017</b>		134 700 000	5 200 000	700 000
<b>2018</b>		134 000 000	4 900 000	1 000 000
<b>2019</b>		133 400 000	4 600 000	1 400 000
<b>2020</b>		133 000 000	4 300 000	1 600 000
<b>2021</b>		132 900 000	4 000 000	1 900 000
<b>2022</b>		132 900 000	3 800 000	2 200 000
<b>2023</b>		133 100 000	3 600 000	2 400 000
<b>2024</b>		133 300 000	3 300 000	2 600 000
<b>2025</b>		133 500 000	3 100 000	2 800 000
<b>2026</b>		133 600 000	2 900 000	3 000 000
<b>2027</b>		133 700 000	2 700 000	3 200 000
<b>2028</b>		133 800 000	2 600 000	3 400 000
<b>2029</b>		133 900 000	2 400 000	3 500 000
<b>2030</b>		134 000 000	2 300 000	3 700 000
<b>Sum</b>				<b>34 000 000</b>



**Table B. Estimated maternal deaths averted globally (2015–2030), if 2/3 of 2010 deaths are averted by 2030\***

Year	Maternal mortality ratio (per 100 000 live births)	Live births	Annual targets (adjusted to 2030 population)	Deaths averted compared to 2015
<b>2010</b>	230	131 900 000	308 000	...
...	...	...	...	...
<b>2015</b>		135 400 000	264 000	
<b>2016</b>		135 200 000	248 000	16 000
<b>2017</b>		134 700 000	233 000	31 000
<b>2018</b>		134 000 000	219 000	45 000
<b>2019</b>		133 400 000	205 000	59 000
<b>2020</b>		133 000 000	193 000	71 000
<b>2021</b>		132 900 000	181 000	83 000
<b>2022</b>		132 900 000	170 000	94 000
<b>2023</b>		133 100 000	160 000	104 000
<b>2024</b>		133 300 000	150 000	114 000
<b>2025</b>		133 500 000	141 000	123 000
<b>2026</b>		133 600 000	132 000	132 000
<b>2027</b>		133 700 000	124 000	140 000
<b>2028</b>		133 800 000	116 000	147 000
<b>2029</b>		133 900 000	109 000	155 000
<b>2030</b>		134 000 000	103 000	161 000
<b>Sum</b>				<b>1 476 000</b>

\* = Adjusted to live births in 2030 (UN Population Division medium fertility projections).

Note: This panel is adapted from a submission by Professor Ole Norheim to the iERG.

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