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 2014 Recommendations: a Post-2015 Vision

1. Develop, secure wide political support for, and begin to implement a global plan during 2014-15 to end all preventable reproductive, maternal, newborn, child, and adolescent mortality for the 2016-2030 period—a new, broader, and more inclusive Global Strategy for Women’s and Children’s Health.

2. In 2015, create a results-based financing facility to support and sustain this new Global Strategy.

3. Between now and 2016, convene a Special Session of the UN General Assembly, led by the Secretary-General, to accelerate international collective action for women’s and children’s health—to align and harmonize the actions of partners, to promote leadership and stewardship, to ensure provision of global public goods, to manage externalities, and to provide direct country assistance.

4. In 2015, establish a Global Commission on the Health and Human Rights of Women and Children to propose ways to protect, augment, and sustain their health and wellbeing.

5. From 2015 onwards, hold a civil-society-led World Health Forum adjacent to the World Health Assembly to strengthen political accountability for women’s and children’s health.

6. In 2015, establish and fully resource a new Independent Expert Review Group to monitor, review, and propose actions to accelerate global and country progress towards improved women’s and children’s health during the period of the Sustainable Development Goals.

“Health should be at the centre of sustainable development”, proclaimed Ban Ki-moon in May, 2014. He continued: “Accountability will be an important part of the new development agenda.”

The UN Secretary-General was speaking during the Government of Canada’s Saving Every Woman Every Child Summit, held in Toronto shortly after the World Health Assembly.

The Toronto meeting was an important milestone during a year of accelerated commitments to the future of women and children. This future is expressed most strongly in the Millennium Development Goals (MDGs), notably MDG-1c (on nutrition), MDG-4 (on child survival), and MDG-5 (on maternal, sexual, and reproductive health). But with the era of the MDGs rapidly drawing to a close, and with negotiations over the precise nature of the Sustainable Development Goals (SDGs) reaching their political climax, the opportunities for women and children (and the dangers too) between 2015 and 2030 are increasingly being debated. Those debates have been fuelled this past year by an unprecedented array of initiatives and promises.

The CoIA, chaired by Prime Minister Harper of Canada and Tanzania’s President Jakaya Kikwete, was one of the most important follow-up initiatives after the launch of the UN Secretary-General’s Global Strategy for Women’s and Children’s Health. The Commission was set up to “determine the most effective international institutional arrangements for global reporting, oversight, and accountability on women’s and children’s health”. Its recommendations are shown in Appendix 1. The final CoIA recommendation was to create a time-limited independent Expert Review Group (iERG) to review progress on both the Global Strategy and implementation of the CoIA recommendations. The 12 recommendations we made in our first two reports to strengthen progress towards both the Global Strategy and the goals of CoIA are shown in Appendix 2. These recommendations are designed to support the goals of Every Woman, Every Child and CoIA. In January, 2013, WHO’s Executive Board requested the Director-General
to provide support to the iERG so that it could also assess progress in the implementation of the recommendations of the UN Commission on Life-Saving Commodities for Women and Children.

Our 2014 report takes a broad scope in its review of progress towards the objectives of Every Woman, Every Child and fulfillment of the recommendations from CoIA. But our overriding goal this year is to present our own post-2015 vision—for the future of women’s and children’s health and for the future accountability arrangements needed to ensure that commitments to that vision are met. The process we have adopted for this year’s iERG report is similar to that adopted for previous reports—invitations to key agencies and constituencies to submit evidence, stakeholder meetings and consultations, commissioning of country case studies, and an extensive review of all available published evidence. We introduced one innovation into this year’s report—we completed two country visits (to Malawi and Peru) to focus on national oversight mechanisms as part of a robust accountability process for women and children. The purpose of each country visit was to assess the completeness, use, efficiency, and effectiveness of the national oversight mechanism. We see this type of country visit as a logical extension of the iERG’s work on accountability—perhaps an example of the kind of strengthened accountability that might be adopted post-2015.

EVERY WOMAN, EVERY CHILD: THE FINAL APPROACH TO 2015

Seven countries of the iERG’s 75 priority nations show concordance between the two major MDG estimation methods for reaching the MDG-4 target of reducing, by two-thirds, under-5 mortality between 1990 and 2015—Bangladesh, Brazil, China, Egypt, Liberia, Nepal, and Peru. A further 16 countries are identified by one or other method (from the UN or the Institute for Health Metrics and Evaluation) as being on target for MDG-4. For the African Region: Benin, Eritrea, Ethiopia, Madagascar, Malawi, Niger, Rwanda, Tanzania. For the South East Asian Region: Indonesia, Myanmar, Nepal. For the Americas: Bolivia, Mexico. For Europe: Azerbaijan, Kyrgyzstan. For the Western Pacific Region: Cambodia. An important driver of success has been improvements in maternal education. But, as Jennifer Bryce and colleagues noted in 2013, the key to further reductions in child mortality is “ruthless… prioritisation of quality delivery at scale for a small number of interventions that address the major causes of child deaths in their specific context.” Overall progress towards MDG-4 for the iERG’s 75 countries of concern is shown in the figure below.

MDG-5A is the reduction, by three-quarters, of the maternal mortality ratio by 2015. No countries are concordant on reaching this target, according to UN or IHME methods. The countries identified by one or other method include: Cambodia, China, Eritrea, Lao PDR, Morocco, and Rwanda.

MDG-5B is universal access to reproductive health, measured by a range of indicators, such as contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and unmet need for family planning. There are substantial gaps across most iERG countries between their current status on these measures and the results target set for 2015 (see figure below).

Major and too often neglected priorities globally and in countries include: newborn mortality and stillbirths, sexual and reproductive health and rights, family planning, nutrition, the health workforce (especially midwives), women and children in zones of conflict, sexual violence, unsafe abortion, child marriage, and female genital mutilation.
Trends in under-5 mortality rate, 1990-2013 & MDG-4 target for the iERG’s 75 countries of concern

Deaths per 1000 live births

- UN-IGME estimates
- IHME estimates
- MDG-4 target for 2015

Trends in maternal mortality ratio, 1990-2013 & MDG-5 target for the iERG’s 75 countries of concern

Deaths per 100,000 live births

- UN-MMEIG estimates
- IHME estimates
- MDG-5 target for 2015
THE COMMISSION ON INFORMATION AND ACCOUNTABILITY FOR WOMEN’S AND CHILDREN’S HEALTH: LEARNING FROM COUNTRIES

Summary of global progress on implementation of the recommendations from CoIA

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Target year</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital events</td>
<td>2015</td>
<td></td>
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<tr>
<td>Health indicators</td>
<td>2012</td>
<td></td>
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<tr>
<td>Innovation</td>
<td>2015</td>
<td></td>
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<tr>
<td>Resource tracking</td>
<td>2015</td>
<td></td>
<td></td>
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<tr>
<td>Country compacts</td>
<td>2012</td>
<td></td>
<td></td>
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<tr>
<td>Reaching women and children</td>
<td>2015</td>
<td></td>
<td></td>
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<tr>
<td>National oversight</td>
<td>2012</td>
<td></td>
<td></td>
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<tr>
<td>Transparency</td>
<td>2013</td>
<td></td>
<td></td>
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<tr>
<td>Reporting aid</td>
<td>2012</td>
<td></td>
<td></td>
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<tr>
<td>Global oversight</td>
<td>2012</td>
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</tbody>
</table>

The target will be difficult or impossible 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

The key areas for recommendations from CoIA are shown in the figure above and Appendix 1. Since our 2013 report, we have seen substantial advances in meeting the goals and targets set by the Commission. 6 of the 9 goals have been upgraded in their progress. Our full report reviews progress in all of these domains, as well as the responses to the iERG’s twelve recommendations from our earlier 2012 and 2013 reports.

2014 is the first year the iERG visited countries with the objective of understanding more about their progress towards meeting the recommendations of CoIA. iERG teams visited Peru and Malawi, and the complete reports of these visits are published in the iERG’s 2014 report. There are several aspects of these reports that reveal common challenges. First, there was often a general lack of awareness of the Global Strategy for Women’s and Children’s health and CoIA. Second, national accountability mechanisms frequently suffered weaknesses that challenged the country’s efforts to use accountability as a mechanism to advance women’s and children’s health. Third, transparency of data was a commonly discovered problem. And finally, health systems were often under great pressure—undergoing reform, but with limited management and health worker capacity to deliver on ambitious political goals.

These visits showed why no single blueprint for success can simply be projected on (or parachuted into) a country. The differing political, economic, social, and environmental predicaments between countries all shape their health challenges and responses in unique ways. The iERG plans further visits to countries in our final year of operation.

THE UN COMMISSION ON LIFE-SAVING COMMODITIES FOR WOMEN AND CHILDREN: AN INTERIM REVIEW

Interventions matter. As the table overleaf shows, the UN Commission on Life-Saving Commodities takes an optimistic view of its progress to date (the table shows self-reported results from the Commission’s implementers). However, we raise signals of concern about financing (the lack of a well-resourced, results-based financing facility for women’s and children’s health), product innovation (difficulties securing commitments for research and development), implementation plans (weak demand-generation and communication programmes), and accountability (lack of progress of key milestones). The Strategy
and Coordination Team responsible for ensuring the Commission’s recommendations are delivered has identified its own challenges: translating global learning into country responses; misalignment in countries between WHO recommendations, essential medicines lists, treatment guidelines, and approved life-saving commodities; providers not being required to administer commodities where they could have the greatest impact; supply chain bottlenecks; and health workers not yet fully prepared for the latest treatment protocols. The Commission’s goals are supposed to be delivered by the end of 2015. The time window for success is extremely narrow.

Progress against UNCoLSC milestones per recommendation

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Year of completion</th>
<th>Specified milestone</th>
<th>Completed</th>
<th>Partial</th>
<th>Not commenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Shaping Global Markets</td>
<td>2014</td>
<td>Sign volume guarantee with at least one manufacturer of contraceptive implants, if appropriate pricing and volume terms can be agreed upon</td>
<td>x</td>
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<tr>
<td></td>
<td>2013</td>
<td>Aligning the market data collection efforts being undertaken by various groups (including CHAI, USAID, WHO, and the commodity TRTs) and consolidating this data in a web-based portal</td>
<td>x</td>
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<tr>
<td></td>
<td>2014</td>
<td>Evaluate the increase in availability and affordability of contraceptive implants</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Working with the commodity TRTs and other groups engaged in generating demand forecasts to consolidate this information at the global-level</td>
<td>x</td>
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<tr>
<td>2 Shaping Local Delivery Markets</td>
<td>2014</td>
<td>Develop toolkits for a portfolio of interventions to engage private sector suppliers (manufacturers and distributors) to produce, distribute, and promote appropriate products</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Identify appropriate supply interventions and begin implementing select supply side interventions for relevant life-saving commodities in targeted countries</td>
<td>x</td>
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<tr>
<td></td>
<td>2014</td>
<td>Expand implementation of supply interventions and supply side communication to regional initiatives (such as pooled procurement and local manufacturer engagement)</td>
<td>x</td>
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<tr>
<td>3 Innovative Financing</td>
<td>2012</td>
<td>Agree on the host of a results-based funding mechanism for life-saving commodities</td>
<td>x</td>
<td></td>
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<tr>
<td></td>
<td>2013</td>
<td>At least 10 EWEC countries enter into an agreement with the funding mechanism to increase access to life-saving commodities</td>
<td>x</td>
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<tr>
<td></td>
<td>2014</td>
<td>Guidance developed for countries to implement in-country RBF-approaches to strengthen access to life-saving commodities at all levels</td>
<td>x</td>
<td></td>
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<tr>
<td>4 Quality Strengthening</td>
<td>2012</td>
<td>Expert Review Panel for dispersible amoxicillin</td>
<td>x</td>
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<tr>
<td></td>
<td>2012</td>
<td>Development of optimal quality assurance for zinc (e.g., market surveillance approach Expert Review Panel)</td>
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<tr>
<td></td>
<td>2013</td>
<td>Expert Review Panel for chlorhexidine</td>
<td>x</td>
<td></td>
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<tr>
<td>Recommendation</td>
<td>Year of completion</td>
<td>Specified milestone</td>
<td>Completed</td>
<td>Partial</td>
<td>Not commenced</td>
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<tr>
<td>5 Regulatory Efficiency</td>
<td>2013</td>
<td>WHO-EML includes all 13 life-saving commodities</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Joint inspections or dossier reviews are implemented for at least 3 life-saving commodities</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Regulators in pathfinder countries agree on a common pathway for at least 5 life-saving commodities</td>
<td>x</td>
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<tr>
<td>6 Supply and Awareness</td>
<td>2013</td>
<td>Briefs/guidance and/or reference documents published on a range of supply chain topics</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Quantification and forecasting guidance for all life-saving commodities available to countries (including harmonized definitions of forecasting and quantification and forecasting algorithms)</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Toolkit for private sector engagement in supply chain functions available</td>
<td>x</td>
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<td></td>
<td>2014</td>
<td>Commodity-related functionality for an open source Logistics Management Information System (LMIS 1.0) developed, and pilot integration with HMIS in at least one country</td>
<td>x</td>
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<tr>
<td>7 Demand and Utilization</td>
<td>2013</td>
<td>Global demand generation implementation kit developed with adaptable communication strategies for at least 9 priority commodities</td>
<td>x</td>
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<td></td>
<td>2014</td>
<td>Country-specific communication strategies developed in at least two pathfinder countries that incorporate life-saving commodities from at least one health area (e.g. family planning)</td>
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<tr>
<td></td>
<td>2014</td>
<td>Demand generation programs implemented in at least 4 pathfinder countries that incorporate life-saving commodities from at least one health area (e.g. family planning)</td>
<td>x</td>
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<tr>
<td>8 Reaching Women and Children</td>
<td>2013</td>
<td>Eight EWEC countries have financial protection programmes with a commodity focus</td>
<td>x</td>
<td></td>
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<tr>
<td></td>
<td>2014</td>
<td>Evaluate the increase in use of (a sub-set of) life-saving commodities in concerned countries</td>
<td>x</td>
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<tr>
<td>9 Performance and Accountability</td>
<td>2014</td>
<td>The status of national availability and use of the 13 commodities and available guidelines (including m-applications) in 8 pathfinder countries for their use have been analyzed</td>
<td>x</td>
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<td></td>
<td>2013</td>
<td>Development of generic checklists for implants and safe birth, including use of MgSO4, has begun</td>
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<tr>
<td></td>
<td>2014</td>
<td>Training and scalable strategies for checklist use including e- and m-learning have been developed and deployed</td>
<td>x</td>
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<tr>
<td></td>
<td>2014</td>
<td>Feasibility assessments on the use of social audits to improve accountability have been carried out in 10 countries</td>
<td>x</td>
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<tr>
<td>10 New Product Innovation</td>
<td>2014</td>
<td>Form a coordinating group to lead reviews, prioritization and monitoring of product improvements/innovations</td>
<td>x</td>
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<td></td>
<td>2014</td>
<td>Prioritize four product improvement/innovation areas</td>
<td>x</td>
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<tr>
<td></td>
<td>2014</td>
<td>Secure commitments including donor and private industry earmarks for innovation and research and development</td>
<td>x</td>
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</table>
A SUSTAINABLE POST-2015 VISION FOR WOMEN AND CHILDREN

This year's iERG report is published at a crucial moment in planning for the post-MDG era. We wish to make two specific contributions—first, on the health of women and children; and second, on accountability.

First, we lay a foundation based on a comprehensive framework of human rights instruments and commitments. This framework now exists—technical guidance on the application of a human-rights-based approach to reduce maternal morbidity and mortality, similar technical guidance on a human-rights-based approach to reduce and eliminate preventable child mortality and morbidity, and General Comment 15 (the right of the child to the enjoyment of the highest attainable standard of health). These three documents make up an intergovernmental platform for accelerated action on women's and children's health. They underline the fact that we see health for women and children as a right and not a privilege. We believe that these human rights instruments, together with the mechanisms of universal periodic review and the human rights treaty bodies, provide a powerful force to reveal breaches of the universally agreed commitments to improve women's and children's health.

We propose to expand the well-established idea of a continuum of care to a cycle of wellbeing, embedding women's and children's health in a fuller life-course perspective (see figure). This life-course approach takes account of the multisectoral nature of advances in women's and children's health. We also believe that universal health coverage has special importance. That means ensuring women and children have access to care, that services are designed with women and children in mind, and that women and children are assured of financial risk protection.

Our second area of concern is accountability. Although accountability is gaining strength as a powerful means to accelerate political action, there is very little reliable evidence to guide us as to the appropriate mechanism of accountability to adopt. There are many models of accountability to draw on. There is no single perfect accountability mechanism that one can choose. The truth is that a pluralistic array of overlapping accountability processes, especially involving civil society, may be the only practical way forward. We have one caveat to our endorsements of pluralism. We believe that an officially legitimised (via the UN) independent accountability mechanism reporting directly to the UN Secretary-General is an essential component of global accountability. This globally configured entity gives accountability a powerful platform and convening point for advocacy and influence. Multiple actors alone—all engaging in mutual accountability—risk creating an unruly cacophony of voices with diminished impact.

What does it mean to talk about sustainable development for women and children? The traditional model of sustainability is tripartite—social, economic, and environmental. But this definition does not take us to the core of the meaning of sustainability. Sustainability is about all people, not just some people. It is about paying as much attention to the future as we do to the present. It means going beyond the control and eradication of disease to assert the importance of a healthy life and wellbeing. Sustainability is about the value we put on our lives and on the lives of our children. It is about the freedom to flourish, the opportunity to choose our futures without harming others, and to live in a state of dignity. If these qualities can be the measures against which the health and wellbeing of women and children are measured, we are confident and optimistic that the post-2015 era will present the greatest possibilities women and children have ever enjoyed.
A proposed new framework for women’s and children’s health in an era of sustainable development (from the continuum of care to a cycle of wellbeing)

Health Sector
- Health systems (UHC)
- Sexual and reproductive health and rights
- Adolescent health
- Pre-pregnancy care
- Maternal health
- Newborn health
- Child health
- Nutrition
- Early child development
- Risk behaviours / environment
- AIDS, TB, malaria
- NCDs
- Mental health
- Aging

Non-Health Sector
- Information (CRVS)
- Education
- Women’s political and socio-economic participation
- Good governance
- Economic development
- Infrastructure and urbanization
- Food security
- Environment (including water and sanitation)
- Realizing human rights
- Science and technology

Universal framework for human rights

Independent accountability mechanism

CONCLUSIONS AND RECOMMENDATIONS

The iERG makes 6 new recommendations to strengthen accountability and progress towards better women’s and children’s health. These recommendations are shown in the box at the beginning of this Executive Summary. The full explanations behind these recommendations are given in our complete 2014 report.

At an Accountability Stakeholders Meeting, held in Geneva in January, 2014, Dr Margaret Chan, Director-General of WHO, noted that accountability had become “the norm in any global health discourse, debate, or discussion.” But she also pointed out that women’s and children’s health was the “hardest test case” for accountability. “Why is every initiative,” she asked, “having a separate accountability mechanism? Countries ask why. Don’t have parallel systems. They undermine already limited capacity. I don’t mind telling you how unhappy many countries are.” Her challenge is important because she also argued that a “vigorous and independent mechanism for accountability” was essential for the post-2015 era.

This 2014 report from the iERG, in addition to describing progress on Every Woman, Every Child, the CoIA recommendations, and the Commodities Commission, has tried to set out its vision for women and children, and for accountability to those women and children, in an era of sustainable development. In our final report next year, we will seek to sum up the impact of this work and the lessons we should take with us into a very different political era.
APPENDIX 1: CoI RECOMMENDATIONS

**Better information for better results**

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

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

**Recommendation 3 - Innovation:** By 2015, all countries have integrated the use of Information and Communication Technologies in their national health information systems and health infrastructure.

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

**Recommendation 4 - Resource tracking:** By 2015, all 75 countries where 98% of maternal and child deaths take place are tracking and reporting, at a minimum, two aggregate resource indicators: (i) total health expenditure by financing source, per capita and (ii) total reproductive, maternal, newborn, and child health expenditure by financing source, per capita.

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

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

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

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

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

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

**Recommendation 10 - Global oversight:** Starting in 2012 and ending in 2015, an independent “Expert Review Group” is reporting regularly to the United Nations Secretary-General on the results and resources related to the Global Strategy and on progress in implementing this Commission’s recommendations.
APPENDIX 2: RECOMMENDATIONS FROM THE iERG 2012-13

iERG 2012 recommendations

1. **Strengthen the global governance framework for women’s and children’s health.**
   To maximise the impact of multiple initiatives in women’s and children’s health and to ensure coordination and coherence in their implementation, we recommend that a more formal global governance (or guidance) framework for women’s and children’s health be established. At present, there is a governance gap that must be filled by a mechanism inclusive of partner countries, multilateral agencies, donors, non-governmental organisations, health professionals, researchers, foundations, and the private sector. We advocate a renewed effort to promote effective interaction and cooperation between all partners dedicated to improving women’s and children’s health.

2. **Devise a global investment framework for women’s and children’s health.**
   The case for stronger accountability mechanisms to track resources for women’s and children’s health was one of the main conclusions of the Commission on Information and Accountability. But how will the needs for priority countries be fully costed and met? The likelihood is that a financing facility for women’s and children’s health will be established in the near future. The creation of a financing facility without a clearer idea of country needs and priorities would be a mistake. We recommend the creation of a global investment framework, taking account of national investments and allocations, to guide a more targeted and strategic approach to supporting women’s and children’s health. The success of the investment framework that exists for AIDS provides one possible model for doing so.

3. **Set clearer country-specific strategic priorities for implementing the Global Strategy and test innovative mechanisms for delivering those priorities.**
   Priorities across the continuum of care need to be sharpened during the 3 years remaining until the MDG target date of 2015. We make recommendations for reproductive health (contraceptive information and services, sexual health, and safe abortion services); maternal health (skilled birth attendants, facility-based delivery, emergency obstetric care, and postpartum care); stillbirths (addressing the complications of childbirth, maternal infections and diseases, and maternal undernutrition); newborn health (addressing the complications of preterm birth); child health (targeting pneumonia, diarrhoea, and malaria); and adolescent health (sexuality education and universal access to reproductive health services). We also recommend innovative approaches to scaling up coverage through equity-focused initiatives, community mobilisation, integration of services (especially with AIDS programmes), using the mass media, and poverty alleviation (such as conditional cash transfer schemes).

4. **Accelerate the uptake and evaluation of eHealth and mHealth technologies.**
   The potential for digital technology to accelerate improvements in women’s and children’s health is great—notably, in supporting country civil registration and vital statistics systems. Although eHealth and mHealth have generated much attention, the evidence on which to base decisions about implementation and scale up are weak or nonexistent. We urge partners to assist countries with the development and implementation of national eHealth plans, to focus on sustainable long-term investments in eHealth, to encourage coordination between providers, and to support evaluation.
5. **Strengthen human rights tools and frameworks to achieve better health and accountability for women and children.**
   Human-rights-based approaches have a crucial, but neglected, part to play in the delivery of the Global Strategy. A human-rights-based approach provides not only a goal but also a process to reach that goal. In 2011, the Committee on the Elimination of Discrimination against Women became the first UN human rights body to state that countries have an obligation to guarantee, and take responsibility for, women's timely and non-discriminatory access to maternal health services. They wrote: “The right to health means the availability, accessibility, acceptability, and quality of health care, as well as tackling the underlying determinants of health. Women and children have the right to hold States accountable for the health care they provide”. This decision was an important turning point in strengthening accountability for women's health. We recommend that human rights treaty bodies that interface with health routinely incorporate the health of women and children into their work.

6. **Expand the commitment and capacity to evaluate initiatives for women's and children's health.**
   Evaluation is a key component of accountability. We recommend that partners accelerate their work to establish a global research network to support the Global Strategy. Without reliable evidence, openly and freely accessible, to inform what works for women and children (and what does not), results will fall short of expectations and resources will be wasted. We also urge research funders to invest more in women's and children's health. Research itself can be a powerful accountability tool. We see evaluation—the relentless pursuit of results—becoming one of the foundations of effective independent accountability.

### iERG 2013 recommendations

1. **Strengthen country accountability:** Ministers of Health, together with partners, must demonstrably prioritise and evaluate country-led, inclusive, transparent, and participatory national oversight mechanisms to advance women's and children's health.

2. **Demand global accountability for women and children:** Advocate for and win an independent accountability mechanism to monitor, review, and continuously improve actions to deliver the post-2015 sustainable development agenda.

3. **Take adolescents seriously:** Include an adolescent indicator in all monitoring mechanisms for women's and children's health, and meaningfully involve young people on all policymaking bodies affecting women and children.

4. **Prioritise quality to reinforce the value of a human-rights-based approach to women's and children's health:** Make the quality of care the route to equity and dignity for women and children.

5. **Make health professionals count:** Deliver an expanded and skilled health workforce, especially in sub-Saharan Africa, which serves women and children with measurable impact.

6. **Launch a new movement for better data:** Make universal and effective Civil Registration and Vital Statistics systems a post-2015 development target.
THE 75 COUNTRIES WITH 98% OF THE WORLD’S MATERNAL AND CHILD MORTALITY

Our global oversight covers 75 countries. As stated in the Strategic Workplan, these include 49 countries in the UN Global Strategy and 26 additional countries in the Countdown to 2015 (marked with *). The countries are grouped according to WHO regional classification.

**African Region (AFRO)**

**Pan American Health Organization (PAHO)**
Bolivia*, Brazil*, Guatemala*, Haiti, Mexico*, Peru*

**Eastern Mediterranean Region (EMRO)**
Afghanistan, Djibouti*, Egypt*, Iraq*, Morocco*, Pakistan, Somalia, Sudan*, Yemen

**European Region (EURO)**
Azerbaijan*, Kyrgyzstan, Tajikistan, Turkmenistan*, Uzbekistan

**South-East Asia Region (SEARO)**
Bangladesh, DPR Korea, India*, Indonesia*, Myanmar, Nepal

**Western Pacific Region (WPRO)**
Cambodia, China*, Lao PDR, Papua New Guinea, Philippines*, Solomon Islands, Viet Nam

1 The six regions into which WHO placed the countries of the world are based on geography, tempered by politics, and not on stages of development.